

CHAPTER SIXORGANISATIONS OF THE VISUALLY HANDICAPPED

There is a cardinal and fundamental distinction underlying any discussion about blind organisations and that is the distinction between organisations for and of the blind. In Britain the traditional pattern has been one of charitable provision for the blind by organisations run by the sighted, of which the leading example is the Royal National Institute for the Blind. These are all organisations for the blind. The organisations for blind people do not of course fully express the points of view and needs of blind people themselves and so blind people have formed their own organisations. Amongst those are what can be referred to as two general purpose organisations, the National League of the Blind and Disabled and the National Federation of the Blind. The League is a trade union for people employed in the sheltered workshops for the blind and is affiliated to the Trade Union Congress and to the Labour Party. The League is also the oldest and the largest organisation of disabled people in the United Kingdom. The Federation is a national pressure group which exists to bring about an improvement in the standard of life for all blind people and has no formal ties with any political party, trade union or religious body. Both of these organisations are concerned with the whole field of blind welfare. An interesting development of the last twenty years has been the emergence of a whole host of special small interest groups among the blind. These include the Association of Blind Piano Tuners, the Association of Blind and Partially Sighted Teachers and

Students, the Society of Blind Lawyers, the Association of Visually Handicapped Telephonists, the British Retinitis Pigmentosa Society, the Association of Visually Handicapped Officer Workers and most recently the Association of Blind Asians.¹

Jacobus tenBroek, the former President of the National Federation of the Blind of the United States, has put forward a convincing case for why organisations of the blind should exist. He believes that only the blind themselves

'can be fully aware of their own problems. Only the blind themselves can feel an unremitting motivation to secure their rights and further their welfare. Only the blind themselves can know the full significance and impelling urgency of the ideal of integration . . . The right to participate fully in the community as equal partners and their share in the democratic process is denied if the blind permit others to speak for them and to plan for them.'²

Milband has also observed that:

'Those who do not speak for themselves are not likely to be effectively spoken for by others.'³

The value of self help has long been recognised by blind people and organisations of the blind have existed for many hundreds of years. There is evidence that nearly a thousand years ago the blind paupers of China banded together for mutual protection and assistance. Subsequently other guilds and associations were formed and achieved full social and legal status. However, it was in medieval Europe that the guilds and brotherhoods of the blind were most successful.

'The unattached person during the Middle Ages,' Lewis Mumford has observed, 'was one either condemned to exile or doomed to death; if alive, he immediately sought to attach himself, at least to a band of robbers. To exist, one had to belong to an association: a household, a manor, a monastery, a guild; there was no security except in association, and no freedom that did not recognise the obligations of a corporate life.'

Hospital brotherhoods of the blind were founded in order to emulate monastic life and existed mostly in France. For example, in the 13th century the Congregation and House of the Three Hundred was organised in Paris and was a unique experiment in self government by the blind. Many free brotherhoods of the blind also flourished in Germany, Italy and Spain and most of these brotherhoods were in the form of guilds. The brotherhoods of the blind followed the example of the medieval guild movement. Each trade was organised into a free guild and the blind organised themselves into free brotherhoods.

The brotherhoods provided the blind with economic subsistence, mutual protection and religious inspiration at a time when blindness was widely regarded as a punishment for sin or as a communicable disease. Many of the brotherhoods were formed for the purpose of begging and the blind beggars would pool their incomes and each receive an equal share. Each brotherhood usually adopted a saint as its patron and constructed a series of statutes which all the members had to obey. The blind brotherhoods helped to represent the blind within the medieval community. Some of the free brotherhoods were very successful. For example, the brotherhood of Palermno in Italy established a music academy.

In Britain and Europe the gradual break up of the medieval order and the emergence of the modern world was not progress but a retreat for the blind. The exclusion of the blind from normal opportunities through the separate legal system of the Poor Law and the movement from group status to individual contract left the blind without their

protective guilds and disorganised and dependent upon charity. Organisations of the blind, trade unions and other independent organisations among the poor were discouraged by the authorities and under the administration of the Poor Law various separate institutions were developed to care for the blind, the handicapped and the poor. Within these institutions the blind were in effect segregated not only from the sighted world outside but also from one another and in these circumstances organisations among the blind were not possible. It was not until the final quarter of the 19th century that voluntary organisations of the blind began again to take shape in the form of small and local groups.

The emergence of the National League of the Blind

In the 1890's the National League of the Blind was formed. This was a trade union for employees in workshops for the blind. The League was also the first organisation of disabled persons in Britain to speak for themselves and to run their own organisation. In order to understand why the League was formed it is necessary to understand something about British trade union history. In Britain trade unions started to emerge in the late 17th century, although such organisations tended to be sporadic and only exist for short periods of time⁴ and national trade unions were not established until the 1850's. With the decline of the Chartist movement the period of 'model unionism' was ushered in.

These unions were only for skilled workers and had a moderate political programme.⁵ Trade unionists like Thomas Burt and

Robert Applegarth sought to organise stable unions based on dependable members, high rates of contribution and centralised control. The objective was to avoid strike action and secure union recognition from the government. The Amalgamated Society of Engineers was founded in 1851 and was the first 'new model' union. It was soon followed by groups such as the bricklayers and the carpenters. In the trade union legislation of the 1870's the trade unions were legalised and the 'model unions' were increasingly recognised as a legitimate and significant pressure group in local and national politics.

But 'model unionism' was not very influential outside London and only a small number of workers in London and the provinces were members of a union.

However, in the 1880's the development of trade unions amongst unskilled manual workers began and there were strikes at South Metropolitan Gas Company and at the matchmakers Bryant and May. Michael Jackson has listed some of the differences between this 'new unionism' of the unskilled workers and the older 'model unionism':

'New unionism' as it became known, differed significantly from the 'model unionism' of the skilled workers. The 'new unionism' workers were less well paid and consequently could not afford the high subscriptions demanded by the skilled unions; their unions were less conservative in administrative terms, building on numbers rather than stable organisation, and in political terms being closely linked to socialist ideals and the strike weapon.⁶

In 1889 the famous London Dock strike, the strike for the 'Dockers' Tanner', attracted widespread support and financial assistance was even received from Australia. The strike was successfully lead by Ben Tillet and was a source of inspiration for other unskilled manual

workers. In the next few years 300,000 workers either became members of existing unions or established new organisations.

In 1891 a small group of unskilled blind men in the workshops for the blind started a small society in South London. These men were inspired by the success of the London Dock strike of 1889 and they wanted to improve the low wages and poor conditions in the blind workshops. At that time the workshops were run by voluntary societies and the average weekly earnings were only seven shillings and one penny. These wages were very low and considerably less than the national average wage.⁷ However, the organisation was small and ill conceived and it quickly collapsed. In 1893 a second attempt to form a union was made and branches were established in London, Oldham, Manchester and Cardiff and in a number of other towns. This was the start of the National League of the Blind. F. Le Gros Clark has observed that the formation of a trade union

'was of course, at that time almost the only way the active blind could take for freeing themselves from complete dependence on charities and on the slow processes of legislation.'⁸

In the 1890's these branches of the League were held together in a loose way and there was no central office, central funds or national officials. The only link between the branches was by letter and therefore it is not surprising that this second attempt to organise the blind was soon threatened with extinction. By 1897 the situation was critical and the branches in the northern districts were losing their enthusiasm. Since 1895 there had been no contact with the London branch and some men wanted to dissolve the union. However,

attempts were made to reorganise and centralise the work of the branches in the north of England. This work was organised by Ben Purse of Manchester, Peter Miller of Hull and Harry Halewood of Birkenhead and in November 1897 a conference was held in Manchester. At the conference Purse was elected as the first General Secretary and an Executive Committee was appointed. New branches in the north were established and new members enrolled.

In 1899 William Banham was appointed as secretary of the London section and under his enthusiastic leadership the League became a nationally organised trade union. On 12 June 1899 a national code of rules was drawn up and on 21 December 1899 the League was registered as a trade union. In 1898 the northern branches had produced a monthly journal in Manchester entitled The Blind Advocate, but this was abandoned after only a few issues. Banham revived the journal and used it to promote the ideas of the League. The slogan of the League, 'We desire work rather than beggary', was emphasised in the journal. Banham next directed his energies to ending the divisions between the branches in London and the north and on Easter Monday in 1900 a successful joint conference was held in Derby and the two sections became united once again. Also in 1900 a representative Executive Council was elected and Banham was appointed as General Secretary, so becoming the first full time officer of the League. In 1901 Ben Purse was appointed as the National Organiser and held this post until he resigned in 1916. Under Purse's direction the League was established upon a sound foundation. In 1902 the League

affiliated to the Trade Union Congress and by 1904 27 branches were spread throughout the country. In 1906 the first branch in Scotland was opened in Edinburgh and branches in Glasgow, Inverness, Aberdeen and Dundee soon followed. By 1914 branches of the League were spread throughout the country.

The campaigns by the League to improve the general condition of the blind

Like the other 'new unions' for unskilled manual workers, the League had a left wing political bias. At that time most of the welfare of the blind was administered by voluntary agencies and the League vigorously attacked voluntarism in blind welfare, and boldly asserted that the voluntary societies did not meet all the needs of the blind. As an alternative it proposed that the state should directly finance and administer a universal system of social welfare for the blind. In the sheltered workshops, the League attempted to eradicate exploitation and intimidation of the blind employees and improve wage levels and working conditions.⁹ The League also wanted the workshops for the blind to come under public control. These political principles of the League were enshrined in its first published programme. This programme had five objects. The first was to promote brotherly love and unity among the blind. The second was to procure state aid in place of the voluntary societies. The third was to secure the application of the Factory Acts in all institutions for the blind. The fourth was to remove all obstacles to the employment of the blind. The final object was

'in all possible ways to improve the moral, social and political condition of the blind throughout the country.'

In the 1890's and in the early years of this century the League alerted the public conscience to the unsatisfactory living conditions of the blind. For example, a survey carried out by the League's own paper, The Blind Advocate, in 1896, estimated that two out of every seven of the blind population were classed as paupers. The survey estimated that there were 36,711 blind people in Britain and of these 3,000 were either under school age or at school. It was estimated that approximately 5,000 of the adult blind were receiving outdoor relief and 3,300 were in workhouses. Between 3,000 and 4,000 of the blind did not receive any assistance from the state or charities. The survey also mentions the fact that only 42 per cent of those trained for employment could find regular work and this meant that large numbers of blind people had to exist by begging. The League used these and other facts in its relentless campaign for more state assistance for the blind.

However, in the late 19th and the early 20th centuries little public approval was found for the political propaganda and campaigns of the League. The voluntary principle and private benevolence were still highly respected and there was a strong dislike of statutory 'interference' and a fear that collectivism would encourage improvidence. In the face of hostile criticism the League turned to the labour movement and to the Labour Party to support its campaign for more state assistance for the blind. Between the 1890's and the 1920's the League lobbied many prominent trade unionists and politicians on the issue and the League received some strong support. For example, in 1899 John Keir, a notable blind trade unionist, was successful in having his motion

adopted by the Scottish Trade Union Congress calling for legislation for the blind. In 1902 the Trades Union Congress carried a similar resolution which was put forward by the League. Between 1907 and 1925 the Labour Party supported six private members' Bills concerning the welfare of the blind. The Member of Parliament W. C. Steadman supported the League's campaign and in 1907 he introduced, with the full support of the Labour Party, the Blind Aid Bill. This Bill was to provide for the 'Technical Education, Employment and Maintenance of the Blind' and received support from all sides of the House of Commons. However, the government was not persuaded to make the money available for the bill. The League persisted with its campaign and in 1912 Burgoyne introduced a second Blind Aid Bill, although once again the government did not provide any support for the bill. Also in 1912 a deputation saw the Home Secretary and it was advised to come back again when an understanding had been reached between the League and the voluntary societies. The League was undaunted by this and continued its campaign for state intervention.

On 11 March 1914 George J. Wardle, the Member of Parliament for Stockport, was provided with an unexpected opportunity to bring forward private business in the House of Commons, and with the support of the Labour Party and with the backing of the League he brought blind welfare to the attention of Parliament for a third time. Wardle proposed the following motion:

'That, in the opinion of this House, the present system of voluntary effort in aid of the blind people of this country does not adequately meet their necessities, and that the

state should make provision whereby capable blind people might be made industrially self-supporting, and the incapable and infirm maintained in a proper and humane manner. ¹⁰

The debate revealed that the unsatisfactory nature of some charities for the blind and the poor condition of voluntary finance had convinced most of the charitable organisations that some assistance from statutory sources was now required. In the debate, the representatives of the Labour Party and of the trade unions emphasised, firstly, the failure of philanthropy to meet the total needs of the blind, secondly, the unsatisfactory employment conditions and wages of the blind, and finally, that the state had a duty to see that the employable blind could support themselves. Although both sides were now ready to accept some statutory intervention the government was still not prepared to admit the need for new legislation. In a typical Parliamentary reply Sir Herbert Lewis, the Parliamentary Secretary to the Local Government Board, outlined the benefits already enjoyed by the blind under the existing schemes. These included Poor Law assistance, old age pensions and education policies. Lewis argued that these schemes 'were increasingly generous', although he also promised a Departmental Committee of enquiry if the resolution before the House of Commons was carried. There was general support for Wardle's resolution and on 7 May 1914 the Departmental Committee was set up.

Although the government was not considering new legislation it now recognised that more precise information on the blind was necessary. There were several reasons for this subtle change in the government's position. The most important reason for the change

was the determined campaign by the League and their Labour supporters in the House of Commons. In February 1914, for example, Philip Snowden had asked Asquith if, in view of the number of the blind who were in workhouses or were begging on the streets, he did not think there should be an authoritative enquiry. It would have been embarrassing and politically unwise for the government to have done nothing. There were several other reasons for the change in the government's policy. Madeline Roof has observed that by that time

'we have a few signs of a changing attitude towards assistance to the blind, when both statutory and voluntary agencies were beginning to view the possibility of more generous State aid as beneficial to the blind without harming the cherished principles still held to be applicable to the 'indigent' as a class.¹¹

In 1905, an international conference of organisations for the blind was held in Edinburgh and this recommended legislation and state assistance for the blind. Since that time there had been calls by workers for the blind for more statutory assistance. The government was also concerned with the condition and finance of the charitable organisations for the blind and wanted more information on this.

The Inter-Departmental Committee was set up with the following reference:

'to consider the present condition of the blind in the United Kingdom and the means available for (a) their industrial or professional training, and (b) their assistance, and to make recommendations'.

The Committee was made up of Members of Parliament and representatives of government departments, charitable organisations and the League. In 1917 the Departmental Committee issued its report and recommended that the social condition of the blind called for the more

active intervention of the state. The Committee had been strongly influenced by the arguments of the League and used them in its recommendations to the government.

The report of the Departmental Committee led to the establishment of a special department in the Ministry of Health for the general care and supervision of blind people. This department was empowered to make government grants to approved bodies.

However, the government still showed no eagerness to take the major step of introducing special legislation for the blind. So the League decided to launch a new public campaign for an Act of Parliament. A protest was held in the gallery of the House of Commons and supporters of the League were dispersed by the police when, in open defiance of the law, they attempted to hold a public meeting in Trafalgar Square while Parliament was in session. The League also made an appeal to the Labour Party. This was successful and the Labour Member of Parliament Ben Tillet introduced a bill entitled The Blind (Education, Employment and Maintenance) Act. On 13 February 1920 the Bill came before the House of Commons and on 12 March it received its second reading. Although the Bill received all party support the League was not confident that it would become law. It was decided, therefore, to encourage public support by organising a march.

On Easter Monday in 1920 approximately 250 members of the League marched from Manchester, Leeds and Newport. They passed through all the major provincial towns on their way to London and to

meet their expenses, collections were organised. The marchers slept where they could in church halls and workhouses and endured some hardship. The three groups joined together 40 miles outside London, entered London in one column and converged on Trafalgar Square. The march attracted a great deal of sympathy and interest from the general public and the popular press and this helped to influence the policy of the government. On 30 April 1920 Lloyd George, the Prime Minister, received a deputation from the Executive of the League and a speech was made by Ben Purse. In his reply Lloyd George assured the deputation that its representations would be fully considered by the government. Lloyd George's assurances had already been given substance on 26 April 1920, when the Minister of Health introduced a government measure to the House of Commons. Ben Tillet then dropped his bill and the government proceeded with its own bill. On 16 August 1920 the Bill became law under the title of the Blind Persons Act. For nearly a quarter of a century the League had campaigned for state aid for the blind and the Blind Persons Act was the climax of that campaign. Without the campaign by the League it is unlikely that the Act would have been passed.

However, the 1920 Blind Persons Act was permissive and not mandatory and this was the central weakness of the Act. There was a large variation in the facilities provided by different local authorities for the welfare of the blind. In particular, the Act failed to improve the condition of the unemployable blind. So in the 1920's the League lobbied Members of Parliament to try to persuade them to strengthen

the Act. The work of the League was rewarded and two attempts were made to amend the Act, to give the unemployable blind a guaranteed weekly pension. In 1924 Tom Groves M. P. submitted an amending Bill to the House of Commons. The Bill was well received but shortly afterwards the government went out of office and the Bill did not become law. In 1925 Sir Robert Young tabled a second amending Bill. His Bill provided for the municipalisation of all blind welfare services and for the payment of a weekly pension of one pound five shillings to all unemployed and unemployable civilian blind persons above the age of sixteen. However, the Bill was talked out at its first reading. The Golden Jubilee Souvenir Brochure of the League recalls that these two failures to get the Blind Persons Act amended

'convinced the League that progress along that road was barred, and it resolved to concentrate on the Local Authorities with the object of inducing them to use the powers they possessed to make provisions in their welfare schemes which would give a decent standard of life to those unable to work, and employment under good conditions to those who were. If no more than the Blind Persons Act could be placed on the Statute Book for the time being, the League resolved that it should not remain a dead letter. The attention of the Authorities would be continually directed to their obligations, and if they did not carry out these obligations humanely and generously, they would not be able to plead ignorance as their excuse. ¹²

The League was faced with the daunting task of persuading more than 200 local authorities to use the powers conferred upon them by the Act. The branches and District Councils of the League appealed to every local authority in Britain to implement the Act and as a result improvements in blind welfare began to take place in some areas. The local authorities in Bolton, Manchester, Birkenhead and Middlesex

quickly improved their blind welfare services and they were soon followed by other towns in various parts of the country. However, the League's campaign had little effect in rural districts and services for the blind in rural areas did not improve until the National Assistance Act was passed in 1948. Some local authorities established Blind Persons Act Committees to administer the powers of the Act. The establishment of the Committees made it possible for blind people to be co-opted as members and the League was represented on many of these Committees. For the first time the members of the League could work directly with councillors and aldermen. In areas where the League was represented on the Committees there was rapid progress in local services for the blind.

In the 1930's the League continued its campaign for more state aid for the blind. In 1933 the League delegate to the Labour Party National Conference moved a resolution directing attention to the unsatisfactory position which obtained in blind welfare and calling upon the Labour Party to formulate a policy on blind welfare. Meetings were held between representatives of the League and the Labour Party and a programme was drafted. This was approved by the Labour Party National Conference in 1934 and was subsequently published as *The Blind Persons' Charter*.¹³ The Charter declared that the policy of the Labour Party was:

'To enable the blind to stand on their feet, to be independent, to be citizens as their sighted colleagues are citizens, and to get rid of the atmosphere of charity which is often so well meaning and often so disastrous to self respect.'

The Charter had five objectives: First, to improve the medical services

for blind children who were under school age. Second, the provision of the widest educational opportunities for the blind. Third, the introduction of increased employment facilities for the employable blind. In blind workshops the Labour Party wanted to introduce a minimum wage which would be equal to the municipal minimum wage in the area where the workshop was situated. Fourth, the payment to the unemployable blind of pensions equal to pensions paid to the war blinded.

Finally, the Labour Party wanted blind welfare to be established as a public service under the direct control of the local authorities. They would be supported by a grant from the Exchequer to meet 75 per cent of the cost. The Charter is historically significant because it was the first programme on blind welfare put forward by a political party in Britain.

By 1935 it was clear to the government that a second Blind Persons Act was required. At that time only about one third of the local authorities were using all the permissive powers conferred on them by the Blind Persons Act of 1920 and welfare services still varied from area to area. However, the government did not intend to make a major amendment to the Act. The only effect of the new government measure would have been to lower the age at which a blind person could claim a state pension from fifty to forty. The League rejected this proposal and demanded legislation based on the policies of the Blind Persons' Charter.

In October 1936 the League decided to encourage public support by organising a second march to London and once again the three groups

set out from Manchester, Leeds and Newport. The march followed a series of marches of the unemployed and was only four days ahead of the famous Jarrow march and so the second march was not as spectacular as the first one. On 1 November 1935 the march ended with a public demonstration in Trafalgar Square and Members of Parliament were lobbied. The League received an assurance from Sir Kingsley Wood, the Minister of Health, that he would introduce amending legislation which would make it compulsory for County and County Borough Councils to completely divorce blind welfare from the Poor Law. The march helped to secure this concession. In less than a year a new Bill was introduced into Parliament and this eventually became the Blind Persons Act of 1938.

In the years before the Second World War the League did not only campaign for Acts of Parliament for the blind. Between the late 19th century and 1920 the League also campaigned vigorously for the prevention of blindness, in particular for the eradication of ophthalmia neonatorum - blindness of the newly born. In the very first issue of The Blind Advocate, dated September 1, 1898, the editorial directed attention to the large amount of blindness which was caused by ophthalmia neonatorum. In 1913 the League approached the Trades Union Congress to cooperate in an effort to persuade the Local Government Board to issue an order making ophthalmia neonatorum a notifiable disease. Meetings were held with the Local Government Board and in 1914 the disease became notifiable. This policy had some positive results. For example, in 1907 a survey by

Dr. N. B. Harman revealed that 36 per cent of blindness among children in schools in London was traceable to ophthalmia neonatorum. In 1920 another study found that this figure had dropped to slightly under 12 per cent.

The activities of the League in the workshops for the blind

In the 1920's and the 1930's conditions were sometimes very bad in the sheltered workshops and the League vigorously campaigned for better wages and working conditions. However, at that time the Rhondda Workshops had excellent conditions and set a high standard for all other workshops for the blind to follow. The story of this unique workshop is worth telling. The Rhondda Valley was then a highly productive coalmining area with well over 30 pits, but before 1919 there were no employment opportunities for the blind. In 1919 a small number of blind people in the Rhondda heard of the League and a branch of the League was opened in the valley. The Rhondda branch of the League was concerned about the lack of work for the blind and asked the miners for assistance. It was agreed to establish a committee representing the Rhondda branch of the League and the miners and this committee then proceeded to establish the Rhondda Institute for the Blind. In order to finance the Institute, the miners in the Rhondda Valley agreed to have one penny deducted from their weekly pay. In 1924 this money was used to open a new three storey workshop for the blind in Llwynpia and employment was provided for over 60 blind people. The workshop was entirely supported by the miners and no central or local government finance

was used. This was a unique arrangement and a unique example of working class and union solidarity.

It is important to emphasise that in 1924 the National League of the Blind was campaigning throughout Britain for the establishment of a guaranteed minimum wage for people in workshops for the blind. Wages in the workshops were based on piecework and in some cases there was a small additional payment referred to as 'augmentation'. The piece rates used in the workshops were those agreed to cover able bodied workers in those trades. Brush making, basket making and mat making were the three categories of employment. The union covering these trades outside the workshops was small and weak and so the rates of pay were low. This meant that blind people undertaking these skilled jobs and being paid at the same rate per article as the able bodied workers had a low standard of living. However, at no time in the history of the Rhondda Institute for the Blind did piecework operate and this was one of the most significant developments in workshop employment and remuneration of blind workers.

The Rhondda Institute for the Blind operated a unique system. In the workshop every trainee received a wage according to their age. Trainees who were over twenty one years of age received a weekly wage of two pounds ten shillings. Many of the trainees were over 21 because they were ex-miners who had lost their sight because of an industrial accident or disease. Young people also joined the workshops and so a scale of wages was developed commencing at

16 years of age. A person was paid the rate according to the age of entry. A worker of 16 years of age received 15 shillings a week, with two shillings and sixpence increment every six months until he was eighteen. Then the six monthly increment became five shillings per week until a maximum of two pounds ten shillings was reached. Trainee workers making good progress were also awarded with a merit rise and by this method it was possible to receive the guaranteed wage of two pounds ten shillings before reaching the age of 21. In the other workshops the blind workers had to suffer long periods of training, on meagre and inadequate training allowances. The Rhondda Institute for the Blind was unique and lead the whole country in providing a guaranteed wage which was not based on piecework.

The Rhondda Institute for the Blind had a number of other interesting and progressive features. The hours of employment were lower than those in other workshops for the blind. The Committee paid the National Insurance contributions for the employees. The Rhondda Institute for the Blind was also the first workshop for the blind in Britain to operate a sickness scheme for the blind workers. The Rhondda Branch of the League held one third of the seats on all the Committees controlling the workshop and this was a very early step in industrial democracy. Above all, the miners upheld the principle that the blind workers had a right to a reasonable wage and the wage was set at a level which was higher than the wage for the day workers in the mines. The Rhondda Workshops were permeated with trade unionism and every blind worker had to be a member of the National League of the Blind.

For over twenty five years the miners were mainly responsible for the employment of the blind in the Rhondda Valley. However, the mining industry was in decline and the lack of resources affected the operation of the Rhondda Workshops. Therefore, in the early 1950's the workshops were taken over by Glamorgan County Council and today the Council still runs the workshops.

In the 1930's there was a sharp contrast between the Rhondda Workshop and the conditions in London. In the London area in 1936, for example, only two blind workshops had a guaranteed minimum wage, namely the West Ham Municipal Workshop for the Blind and the Blind Employment Factory in Waterloo Road. All the other workshops had piecework, plus an augmentation of fifteen shillings a week. The working conditions were very bad and the relationship between the management and the League was extremely poor. In April 1936 Tom Parker was appointed as the Organiser of the London and Home Counties Area of the League.¹⁴ Parker recalls that one of the first cases he investigated in London

'was that of a man earning one pound seven shillings and sixpence per week in the then Greenwich Workshops for the Blind and at the end of the week, having to go to the London County Council Welfare Department to receive domiciliary assistance under the Blind Persons' Act of 1920. The L. C. C. used to disregard the first seven shillings and sixpence of the earnings, and bring the balance up to the amount the individual would have received if he had not been employed. He was in effect receiving seven shillings and sixpence per week after working 44 hours more than he would have received, if he had stayed at home. An interesting contrast can be found in the fact that the Blind Workshops employees in London today are paid more per hour, than some of them were paid per 44 hour week, when I came to London in April 1936.¹⁵

Parker immediately became involved in the public campaign for better wages and better working conditions and applied pressure through the London Labour Party. By August 1936 the League had persuaded the London County Council to introduce a minimum wage of two pounds five shillings per week for workshop employees. The other Authorities with blind workers in the London Workshops also adopted this policy. This was a remarkable leap forward in the workshops at that time and was achieved through union pressure.

For many years it had been the ambition of the League to achieve parity with the local authority manual workers as far as wages were concerned. So in 1938 the League submitted a resolution to the Trades Union Congress requesting the T. U. C. to issue a circular to every local authority. This proposal was adopted unanimously by the delegates and the circular was quickly sent out. The Trades Union Congress Circular of 1938 requested local authorities to pay to blind workers a wage equal to the minimum rate paid to municipal workers in their area. The circular was supported by the League's branches and District Councils. However, progress was slow and it was not until 1940 that the first workshop for the blind agreed to place blind workers on the municipal minimum wage of its district. This was the workshops in Glasgow, which was under the management of the Local Authorities in the West and South West of Scotland. Gradually other workshops followed the lead of the workshops in Glasgow. This policy meant that in the early years of the Second World War many of the members of the League were protected from the worst of the

hardships which followed the rapid rise in the cost of living. The League continued its campaign for better wages and after 1945 a breakthrough was achieved in certain areas. On 1 January 1947 Middlesex decided that its blind workers in the London Workshops should have the municipal rate of wages. However, Tom Parker recalls that it required public demonstrations

'and the breaking up of a London County Council meeting before London came into line. Tough days, but the fight had to be fought.'¹⁶

By 1951 most of the workshops fixed their wage rates on this principle. In 1951 the Local Authorities Advisory Committee recommended that all blind people employed in Workshops for the Blind should receive the manual workers rate of wages Group 2. This was an historic decision because it set a national uniform standard for the level of wages in the workshops. It also marked the culmination of a long campaign by the League to improve the wages and conditions in the workshops.

The history of the League since 1945

In the first half of the 20th century the League was an effective pressure group in the development of Britain's general blind welfare services. It campaigned vigorously for Acts of Parliament for the blind and was a strong critic of organisations for the blind. However, Madaline Roof, has observed that after 1945 the League,

'having gained its objective of State responsibility for blind welfare, kept its special interest in the blind worker in industry. No longer in open conflict with other national bodies, it took its place as one of many groups serving the interests of the blind, although it still kept its political association with the Labour Party, and its trade union affiliation.'¹⁷

Since the 1950's the history of the League has been fairly uneventful and the League has been mainly concerned with protecting the interests of its members in the workshops. In 1951, for example, the General Secretary of the League, T. H. Smith, was one of the seven members of the Working Party on the Employment of Blind Persons and since that time members of the League have served on many working parties.

Since 1950 there have been some important changes in the membership of the League. In 1950 Michael Barrett, the present General Secretary, had the rules of the League changed so that partially sighted people who were employed in the workshops could become members of the League. In the 1950's and the 1960's seeing severely disabled persons were admitted to the workshops for the blind as approved workers and the League insisted that they enjoyed the same working conditions and wages as the blind workers. Unfortunately owing to the constitution of the League these workers had been unable to join the League. But on 1 January 1968 the constitution of the League was changed and the seeing disabled persons in the workshops are now able to join the League. The League encouraged the entry of sighted workers into the workshops because with their help a wide range of goods can be produced.

Throughout its history the League has been a small organisation and today it only has one full time officer, its General Secretary and Treasurer, one full time clerical assistant and three part time clerical assistants. The branches of the League are all run by lay

officers who give their time and services voluntarily. The workshops continue to be the main concern of the League. In the workshops the wages and the working conditions are regulated by the National Joint Council for Workshops for the Blind on which the League constitutes the trade union side. The industrial relations in the workshops are generally good and the workers benefit from the wages and conditions which the League secured in the first half of this century. The League has maintained a close interest in general blind welfare and in 1985 it had eight members serving on the Royal National Institute for the Blind's Executive Council, one from each of its six areas, plus the General Secretary and the President. These representatives also serve on the Standing Committees and Sub-Committees which have been established to formulate the policies of the Institute. However, the activities of the League are not confined to committee work. Despite its small size the League is still a very strong campaigning organisation and since 1970 it has been involved in the campaign for a blindness allowance. In 1975 it organised a march and a lobby of Parliament, which some 1,500 blind and partially sighted people attended. In 1979 the League organised another march and lobby of Parliament and in 1980 it established a coordinating committee with the National Federation of the Blind and the Royal National Institute for the Blind to campaign for a blindness allowance. However, the campaign has not yet been successful.

Today the League has a declining membership and this is the central problem facing the union. At its height the League had over

7,000 members. However, by 1982 this figure had dropped to 3,115 members and by 1985 there were only 2,900 members of the League in 60 branches.¹⁸ The fundamental reason for this decline is that the League has taken its membership traditionally from blind people working in sheltered employment and their numbers have fallen from 4,000 to 1,600 in 1985. The League has also recruited from the increasing numbers of people with other handicaps who are coming into the workshops, but not in sufficient numbers. The League has found that many of the people with other handicaps are not very interested in trade union affairs. Many are mentally handicapped and they tend not to be active supporters of the union. However, many of the issues that concern the blind also concern people with other handicaps and the League could use this theme in a recruitment campaign among the seeing disabled. Fortunately some non-visually handicapped recruits are now prominent members of the League. For example, in 1985 Derek O'Hara was the delegate for the Halifax branch at the League's triennial conference. Indeed, some members of the League believe that the decline in membership is not inevitable. For example, since 1982 the Glasgow branch of the League has had a successful recruitment campaign and even the retired members are being kept on. Area secretaries and branch secretaries have a special responsibility to recruit new members, but they face a difficult task.

In the past, the League was an orthodox trade union within the blind workshops and in the future the League will continue to organise the people in the workshops. But in an effort to find new members

the League has now changed its rules to extend the membership to any disabled person over the age of 16 years, irrespective of where they work or indeed if they work. New branches may be formed where ten or more people come together and find officers. These changes will effect the work of the League and in the future the League is also likely to become a general pressure group for the blind and the disabled within the community.

The early history of the National Federation of the Blind

The National Federation of the Blind has had a long history. In 1924 the National Union of the Professional and Industrial Blind was established. Later it changed its name to the National Association of Blind Workers and then in 1947 was reconstituted as the National Federation of the Blind. Some of the founder members of the Federation were staff members of the Royal National Institute for the Blind and they wanted to create an effective pressure group for all the blind which was not tied to any political party, trade union or religious body. This meant that in the 1950's and the early 1960's there was a contrast between the membership of the Federation and the membership of the League. The non-political status of the Federation was attractive to middle class blind professionals and some of them joined the Federation. This tended to give the Federation a privileged and a middle class image and some people thought of the Federation as a pressure group of blind professionals. On the other hand, the League was affiliated to the Labour Party and to the Trade Union Congress and its members were employed in the

blind workshops and tended to be manual workers and working class.

In its early history the Federation was concerned with a range of issues. For example, in the 1950's it campaigned for opportunities for qualified blind workers in local government service. The Federation also carried on a campaign to persuade all local authorities to establish home worker schemes for the blind. The Federation had some success with these campaigns. The Federation had a notable success in 1964. In that year Dr. Anthony de Silva, then the President of the Federation, was responsible for obtaining from the then British European Airways the air travel concession corresponding to that available from British Railways, as it was known at that time. Although this concession was restricted to journeys within the United Kingdom it was understood at the time to be by far the most comprehensive air fare concession ever achieved in any country and was the forerunner of similar concessions by other airlines in Britain.

The new leadership and the participation campaign

In the 1950's and the early 1960's there were criticisms that the leaders of the Federation were too uncritical of organisations for the blind and the representation they offered to organisations of the blind. But in the mid 1960's there were signs of a new spirit coming to the Federation and there was a gradual and a subtle movement to the left. A number of young blind intellectuals were joining the Federation who were more openly critical of the organisations for the blind and the services they offered. The main figures in this new group were Fred Reid, a blind lecturer at Warwick University,

Martin Milligan, Colin Low and several others. In the late 1960's this new group gradually took over the leadership of the Federation and transformed the character of the organisation. Like the League, the new leadership of the Federation were closely linked to socialist ideals and believed in vigorous campaigning to achieve their ends. In particular, Reid, Milligan and Low wanted blind people to be active participants in matters affecting all aspects of their lives and they wanted the blind to have better representation on organisations for the blind. At that time representatives of organisations of the blind had little power or influence within organisations for the blind. At the Federation Delegate Conference in 1969 Milligan put down a resolution which stated that the Federation sought that representatives of organisations of the blind should have at least 50 per cent of seats on any body whose sole proclaimed aim was to serve the blind.¹⁹ The resolution was adopted by the conference and became the official policy of the Federation. Until then the Federation had never set out any precise demands concerning participation and this was an historic decision. The new policy was quickly put into effect and in 1970 the Federation formed a Participation Committee and Milligan and Low were made members of it. Then in 1971 the Federation launched a campaign for 'an equal say in our own affairs'.²⁰

'People have a right to participate to the fullest possible extent in those aspects of life which most vitally concern them, and to control those aspects of life which exclusively concern them',

it declared. The Federation asserted that the problems of the blind are best understood by the blind themselves and boldly demanded that

at least half the places on the governing bodies of all local and national bodies dealing with the blind should be taken by representatives of the blind. It urged that this should be done for reasons not only of justice but of efficiency, since the then current system often failed to deal with

'the realities of problems as they are encountered by blind people in their everyday lives.'

The Federation argued that representation of the blind on blind charities was simply not good enough and this was a strong challenge to traditional charitable organisations. The local voluntary societies for the blind were picked out for particular criticism. Many of these societies had no blind people on their committees and most of the voluntary bodies were not even representative of the sighted. Social classes one and two, comprising 20 per cent of the British population, had 40 per cent of the places and the Federation argued that

'committee lists indeed have a distinct ring of Victorian philanthropy in their concentration on the titled, the military and the clerical.'

The Federation made a particularly strong criticism of the venerable Royal National Institute for the Blind. In 1968 Fred Reid had declared that the institute

'wields vast power over the lives of blind men and women, yet it is answerable to no one for its actions. Not in any real way to the blind themselves. Not at all to the state.'²¹

In the early 1970's there were 110 seats on the RNIB's Executive Council and only 12 of these were occupied by representatives of organisations of the blind. Twenty four seats were for so called 'national members', who were selected for their personal qualities. These people were answerable to nothing but their own consciences

and were said to be less than radical in their outlook. Ten of them were blind but this did not greatly impress the Federation and it dismissed them as 'a self-perpetuating body of self-proclaimed experts'. The Federation concluded that the composition of the RNIB's Executive Council was 'a disgraceful state of affairs'. In the summer of 1972 the Federation started a very vigorous campaign to change this and the proclaimed objective was that organisations of the blind should occupy at least half the seats. In effect the radicals in the Federation wanted the RNIB Council to become a representative parliament of the blind where the voice of the blind consumer would be loudly heard. The difficulty was that no one could change the constitution of the RNIB Council except the RNIB Council and they were not inclined to change it in that direction. The campaign became more intense and in 1974 the Federation threatened to hold public demonstrations against the RNIB if something was not done to increase the voice of the blind on the RNIB's Council and committees. This threat eventually led to certain concessions, and certain changes were made. The RNIB Council was enlarged from 110 seats to 120 seats and the number of seats occupied by representatives of organisations of the blind jumped from 12 to 30. This meant that organisations of the blind now had a quarter of the seats of the Council, which was a major breakthrough. Since 1974 there have been further improvements and from July 1984 representatives of organisations of the blind constituted almost a third of the Council. The Federation has not yet reached its goal of half the

RNIB Council seats for organisations of the blind, but progress is being made all the time and more progress can be expected. The Federation's campaign has also been helped by the work of John Wall and Duncan Watson, who is a former President of the Federation. In 1975 Watson became the chairman of the RNIB and Wall became vice-chairman and together they have presided over a decade of accelerating participation. Watson has encouraged blind people to play a major part in policy making and has tried to ensure that representatives of organisations of the blind become chairman of key committees within the RNIB. This policy has been successful and blind people now chair most of the Institute's committees. (In 1975 Wall was the only blind chairman of a standing committee). These chairmen also sit on the Policy and Resources Committee, which is the inner cabinet of the RNIB, and in this way blind people now have real influence within the Institute and help to shape its major policies.²²

However, the participation campaign has not been totally successful and the Federation regrets

'that there still exists amongst some bodies the outdated attitude that the blind should expect what other people consider is good for them.'²³

At the time when the Federation launched its participation campaign the Guide Dogs for the Blind Association had no representative of the blind on its council. The National Library for the Blind only had two blind people on its council and neither of these were representatives of organisations of the blind. Despite public demonstrations by the Federation these two national organisations still give only token

consultative status to organisations of the blind. In addition, many of the local voluntary societies for the blind are still not accountable to the blind. Some do not have blind representatives on their committees and no association has an executive committee on which 50 per cent of the seats are taken by representatives of organisations of the blind. The members of the Federation hope that in the future these organisations will 'come to terms with everyday practice' and recognise that the blind have

'a right to play their part in the running of organisations for the blind as consumers of their services.'²⁴

The six campaigns of the Federation

In the early 1970's the members of the Federation directed most of their efforts into their participation campaign. However, the Federation also developed several other ideas to improve the lives of the blind and the organisation now has six major campaigns.

Together these campaigns are the six pillars of an integrated society.²⁵ The first campaign is for the development of a comprehensive range of essential specialist social work services to meet the needs of all the visually handicapped. The members of the Federation believe that these social services should be sensitive and responsive to the special needs of the visually handicapped. However, it is generally recognised that in the past few years there has been a distinct deterioration in the social work services available to the blind. So at the Federation's conference in Edinburgh in 1983 a campaign was launched under the banner Save Our Services. The aim of this

campaign is to identify the weaknesses in social service provision and present the findings to national and local government for corrective action. The second campaign is for integrated education for visually handicapped children in ordinary schools. The members of the Federation believe that more blind children could and should be educated in ordinary schools, provided that there is an adequate support unit to meet their special and individual needs. The third campaign is for a great extension in the range of job opportunities for the visually handicapped in open and sheltered employment, but always in genuinely integrated conditions. The members of the Federation believe that each blind person should be provided with the necessary support to become a productive member of the workforce. The Federation does offer an employment advisory service and this helps to place blind people in suitable employment. The fourth campaign is for the introduction of a blindness allowance to meet the extra costs imposed by blindness and to ensure that the additional problem of poverty is not also incurred. The Federation was the first organisation of blind people in Britain to demand a blindness allowance. Only later did the League make this demand and the RNIB later still. The fifth campaign is for the full participation of representatives of organisations of the blind on the governing bodies of all major organisations for the blind. The Federation has taken the lead amongst organisations of the blind in making this demand. The final campaign is for the creation of a safe and congenial environment in which blind people can live and participate with the minimum of difficulty to

themselves and inconvenience to other people. This campaign has many strands to it and particular emphasis is given to road safety, travel concessions, ensuring that guide dogs are allowed into shops and restaurants, ensuring that street furniture is well sited and on keeping the pavements free of obstacles. In June 1979, for example, the Federation launched a 'Give us back our pavements' campaign to bring to the attention of the public some of the problems experienced by blind people. The blind are inconvenienced by cycles being used on pavements, by cars being parked on pavements and by over-hanging trees and hedges. The purpose of this campaign is to persuade people to clear up cluttered pavements. Members of the Federation have also contacted their local council and police to make sure that they are implementing all the laws that will clear up the dangerous and cluttered pavements. Fred Reid, Martin Milligan, Colin Low and several other ideologues worked out the rationale of these six campaigns and through these campaigns the Federation seeks the fuller integration of blind people into society.

On a day to day level the Federation acts as a pressure group. The members of the Federation believe that the lives of blind people can be improved

'by persuading those responsible for making provision for them, whether government departments, local authorities or voluntary agencies, to widen and improve their services and by promoting the full integration of visually handicapped men and women into the community. If the blind are to achieve as great a degree of self-reliance and independence as possible, we in the Federation consider that society must permit the creation of the right kind of framework by cooperating with visually handicapped people themselves and by providing the right kind of tools and aids for this to be achieved. '26

The achievements of the Federation

The Federation is the permanent voice of the blind in official circles and this is ample justification for its existence. The members of the Federation are convinced that the blind are considered more often and are consulted earlier because of the relentless work of the Federation over the years. The campaigning work of the Federation is on many fronts and the Federation can justly take credit for a number of specific advances in blind welfare which have resulted directly from its work. In 1962, for example, a blind person's tax allowance of £100 for registered blind people was introduced after a campaign by the Federation. Another campaign led to the creation of several home worker schemes for blind people. The work of the Federation also led to a large increase in the representation of organisations of the blind on the Braille Authority of the United Kingdom and on the Executive Council of the Royal National Institute for the Blind. In 1977 the work of the Federation led to an increase in the representation of organisations of the blind on the National Uniform Type Committee from 2 out of 23 seats to 10 out of 24. The work of the Federation led to the inclusion of section 10 in the Education Act of 1976, which required local authorities to make provision for the education of handicapped children in ordinary schools and not in special schools. The Federation has campaigned to improve access for guide dogs in public places. This campaign led to the issuing of DHSS circular LAC (76) 16 which urged that guide dogs should be exempted from restrictions placed on dogs entering restaurants,

food shops and so on. The work of the Federation also led to the creation of a Guide Dog Owners Liaison Committee between representatives of the Guide Dogs for the Blind Association, the Federation and the Circle of Guide Dog Owners. The Federation is concerned with the mobility of the blind and British Rail introduced the Disabled Persons' Railcard after a campaign by the Federation. A two for the price of one concession on inland journeys by air was introduced after another campaign. The Manpower Services Commission introduced the Personal Reader Service for blind people in employment after the Federation had put forward a case for this. In recent years, the Federation has criticised the RNIB's services and this has led to several improvements. For example, after a campaign by the Federation the RNIB introduced a hire-purchase scheme for the purchase of expensive goods worth more than £20. The Federation has been critical of the arrangements for booking holidays at RNIB hotels. The RNIB introduced improvements in the service, so that people can now book direct themselves and take small children if they wish. The Federation has also criticised the limited range of literature of use to blind people and the RNIB now publishes a wider range of literature.

In the 1980's the Federation has continued to influence the government and organisations for the blind. For example, in the early 1970's a Federation Delegate Conference resolution called for distinctive pavement surfaces to indicate the location of pedestrian crossings. This idea has now been taken up by the Government and

these surfaces are on trial in the streets of London. Recently the British Wireless for the Blind Fund decided to start distributing radio recorders on a limited basis and this proposal originated from another resolution of a few years ago. These are the achievements of the Federation at a national level.

Local branches can list their own successes. For example, the Cleveland branch of the Federation recently had a successful road safety campaign. The branch was concerned with the state of the environment for the blind and so they invited several councillors and representatives from the police and public utilities to a meeting. The branch let it be known that only if the pavements are clear can the blind and elderly disabled people walk in safety and freedom. As a result of the meeting the Federation has obtained seats on road safety committees and local police liaison committees in the Cleveland area. In this way the Federation can influence environment policy in Cleveland.

It has been suggested that the campaigning work of the Federation could be carried out more effectively by the local voluntary societies for the blind, but the members of the Federation would deny this. For example, Brian Proctor believes that a voluntary organisation would quickly find itself

'with a conflict of interests between fund-raising and campaigning and if anyone studies the history of these charities they will soon discover that the campaigning will very quickly cease. Many associations have to work very closely with local authorities and if they were to pursue their campaigning role conscientiously they could find themselves campaigning against the local authority which could damage a working relationship or put the association under pressure to drop the campaign; neither alternative would be good for the blind.'²⁷

The structure of the Federation and a critique of its work

The Federation is the largest independent organisation in Britain solely for the visually handicapped and it has no formal links with any trade union, political party or religious body. The Federation is run and controlled entirely by the visually handicapped and full membership, with full voting rights, is available only to those people on the blind and partially sighted registers. The relatives and friends of the ordinary members can join as associate members. The membership is taken from all sections of the community. Some members are employed in open industry and others work in sheltered workshops. Some are self employed or retired or, all too often, unemployed. Some are students and some are housewives. Most of the membership is composed of young and middle aged visually handicapped people. In 1973 an analysis of 150 replies to a questionnaire revealed that some 40 different kinds of occupation, trade or profession were being followed by members of the Federation.

Today the Federation has approximately 30 branches spread throughout Britain. In addition, there is a central branch used by members who do not live near enough to a local branch, and these members are kept in touch with Federation business through correspondence. For many years there were criticisms that the Federation's central efficiency could be improved and that the organisation needed a central office and a paid staff. In April 1984 a permanent office of the Federation was opened in Wakefield and this will allow the Federation to streamline and expand its activities.

The policy of the Federation is determined by an Annual Delegate Conference to which branches elect delegates in proportion to their membership strength.

The implementation of conference decisions is the responsibility of the Executive Council, most of whose members are elected annually. None of these officers are paid and the Federation depends almost entirely on the voluntary contributions of its members and friends. The members are kept informed through the Federation's quarterly journal Viewpoint, which is published in ink print and in braille and on tape. Most of the Federation's literature is produced in these three ways in order to meet the varying needs of its blind and sighted members.

The size of the membership of the Federation is a constant cause of anxiety and the organisation depends on a small core of loyal supporters. In the past few years, several branches have closed, including the Esmet branch and the Blackpool and Fylde Branch and some branches are losing members. However, people do want to join, albeit in small numbers, and some new branches have been opened, including one in the Darlington area. The current national membership stands between 750 and 800 and that number is up, because previously it had been below 650. Each year at the Delegate Conference the Federation presents a block and gavel to the branch which has recruited most new members. In 1985 it went as it has in the past to the London branch. In 1984-1985 the London branch recruited 52 new members and it continues to be the Federation's biggest branch.

The Federation is good at national pressurising and operates well as a cabinet, but there have been criticisms that the Federation is too introverted and spends too much time contemplating its own navel. For example, at the Federation Delegate Conference at Hereford in 1985 the delegates spent an hour debating a motion with no fewer than 11 amendments dealing with the annual subscription, which is now £3. There was also a long internal discussion between the north west area council and the north east area council on who should represent the Federation on the North Regional Association for the Blind. Several people have argued that the energies directed inward could be more usefully channelled outwards into one of the Federation's many campaigns. Colin Low has often said at conferences that the members should spend less time on debating the policies and should spend more time on campaigning for them. A dynamic approach can do as much as any number of resolutions or committees. Indeed there have been criticisms that the Federation is not a very good political party and could do with much more contact with blind people to build a mass movement. The Federation could direct more energy into its recruitment campaign. Many blind people have never been approached to join the Federation and some have never even heard of it. Fortunately the Federation is now adopting a more ambitious and dynamic recruitment policy. It is now considering radical measures to increase membership by cutting subscription rates and by encouraging affiliation from special interest groups of the blind. In 1985 Doreen Chaney was elected as Public

Relations Officer for the Federation and she is adopting an energetic recruitment policy. She visits clubs and social activities where the blind and partially sighted are involved and explains the work of the Federation. Her direct appeal to the blind is having some positive results and more middle aged blind people are starting to join the Federation. Some people have claimed that the Federation has little to offer to young people. Chaney is trying to improve this by improving the social life of the Federation. If the recruitment drive is successful then the Federation will become a stronger voice for blind people.

In conclusion: The history and the significance of organisations of the blind

In Britain the emergence of organisations of the blind is correlated with the emerging hierarchy of class. In the mid 19th century a minority of skilled workers had developed their own unions. By the late 19th century there was also a significant number of unskilled manual workers employed in the large towns and cities and they in turn formed their own organisations. Between the 1880's and the 1930's the dockers, miners, transport workers, agricultural labourers and others began to organise to defend their interests, turning a sectional pressure group into a mass social movement. The National League of the Blind was one of these 'new unions' and represented a working class development. The employees in the sheltered workshops for the blind were directly inspired by the success of the London dock strike of 1889 and set out to improve their

own wages and conditions. The League had all the classic features of the new trade unionism. In political terms it was closely linked to socialist ideals and the strike weapon and was a strong critic of exploitation and philanthropy. When the League was formed most of the blind were in sheltered workshops or the workhouse. But in the 20th century there have been increasing opportunities for the blind in open employment and in the professions and by 1945 over two thousand blind people were engaged in open industry. This was a new and a significant social stratum of blind people. Some of these people formed the National Federation of the Blind, which represented a middle class development. In political terms, the Federation was more moderate than the League. The Federation did not campaign for major new welfare legislation for the blind and preferred to work with the organisations for the blind rather than to openly criticise them. However, in the mid 1960's a new group of young blind intellectuals emerged who crystallised the feeling that the blind should speak for themselves and not let others speak for them. The new leaders of the Federation were part of a new radical intelligentsia in the middle class who were openly critical of existing institutions and customs. They have done much to develop the concepts of participation and integration and under their leadership the Federation has become a very much more articulate and listened to voice of the blind than it was before.

Some people feel that the voice of the blind would be more loudly heard if there was only one organisation of the blind. Tom

Parker, for example, has argued that:

'When there was only one National Organisation of the Blind in this country, namely the National League of the Blind, we achieved the passing of two Acts of Parliament for the adult blind of this country . . . Since the blind people divided themselves into at least twelve National Organisations, we have not achieved a single Act of Parliament for the adult blind. This is unfortunate, and is I think mainly responsible for the fact that blind people are beginning to fall behind as far as provision by the State is concerned. There is no doubt that we constitute too small a world to be divided. '28

Many blind people agree with Parker and hope that in the future, the League and the Federation will become a single organisation. The two organisations already cooperate on a number of campaigns and the social consciousness of each organisation is now similar. A single blind movement would constitute a formidable pressure group in the political arena. It should be emphasised that in the 1940's the League and the Federation were both to blame for the split in the blind movement. Then the leaders of the Federation were elitist and had a different consciousness to those of the League. But the League had no arrangements to deal with the new social stratum of the blind that had been created by the development of open employment. In the 1940's the League should have made a category for white collar groups, but it failed to do this.

Historians of blind welfare tend to neglect organisations of the blind. For example, June Rose in her well known analysis, briefly mentions the League and the Federation, but does not examine in sufficient detail the contribution they have made to the development of blind welfare.²⁹ This omission is important because some major

advances in blind welfare in this century have been achieved through the campaigning of the two organisations. This point should be emphasised. For example, with the assistance of the Labour Party and the Trades Union Congress, the League in 1914 persuaded the government to establish an Inter-Departmental committee of enquiry into blind welfare. The League helped to shape the recommendations of the committee in 1917 and, in turn, this led to the establishment of a special department in the Ministry of Health for the blind. In 1914 the League persuaded the Local Government Board to make ophthalmia neonatorum a notifiable disease and over time this helped to reduce the incidence of blindness. The Blind Persons Act of 1920 was brought about as the result of a march to London organised by the League. Later the League successfully persuaded several local authorities to properly enforce the Act and then in 1938 successfully campaigned for another Act of Parliament. It was because of these campaigns by the League that the provisions for the blind soared ahead of the provisions made to other disabled people. In the field of sheltered employment the League's own workshops in the Rhondda set new standards for all the other blind workshops to follow. After a long campaign by the League the municipal rate of wages was gradually introduced into all the workshops. The achievements of the Federation have been less spectacular, but still impressive. In particular the participation campaign of the Federation has democratised the Royal National Institute for the Blind and blind people now have real influence within the Institute. David Mann,

the former President of the Federation, has observed that any pressure group such as the Federation. 'speaks for far more people than formally belong to it',³⁰ and the Federation's six campaigns have led to a range of improvements in services for all the blind.

Notes and References

1. For an analysis of one of these small interest groups see Lynda Drummond Walker, 'British Retinitis Pigmentosa Society', Regional Review, Number 66, Winter 1979, pages 7-10.
2. Jacobus tenBroek quoted in The Braille Monitor, March 1982, page 84.
3. R. Milband, 'Politics and Poverty', in D. Wedderburn (ed.) Poverty, Inequality and Class Structure (Cambridge University Press, London, 1974) page 191.
4. See Sidney and Beatrice Webb, History of Trade Unions (Longman, London, 1896)
5. There are several good studies of the history of early trade union development. The most succinct is A. E. Musson, British Trade Unions, 1800-1875 (Macmillan, 1972). Also see J. Stevenson, 'Early trade unionism: radicalism and respectability 1750-1870' in B. Pimlott and C. Cook, Trade Unions in British Politics (Longman, London and New York, 1982) and H. Pelling, A History of British Trade Unionism (Penguin, Harmondsworth, 1971).
6. Michael P. Jackson, Trade Unions (Longman, London and New York, 1982) page 11.
7. In 1886 a Royal Commission had been appointed to investigate the condition of the blind and in 1889 the Royal Commission issued its report. The report gave details about the wages and conditions in the workshops.
8. F. Le Gros Clark, Blinded in War. A model for the welfare of all handicapped people (Priory Press, Royston, Hertfordshire, 1969) page 74.
9. In 1912 the first strike organised by the League took place in Bristol.
10. See Hansard, 11 March 1914, Volume LIX, Cols. 1313-55.
11. Madeline Roof, Voluntary Societies and Social Policy (Routledge and Kegan Paul, London, 1957) page 199.
12. The National League of the Blind, Golden Jubilee Souvenir Brochure (National League of the Blind, London, 1949) page 23.
13. See The Labour Party, The Blind Persons Charter (Labour Publications Department, London, 1937, second edition).

14. Tom Parker has had an extraordinary career spanning over 60 years and he is widely regarded as one of the most notable members of the League. Parker became chairman of the Rhondda branch of the League when he was 19 and representative of the south west on the National Executive of the League in 1926, when he was 23. Between April 1936 and January 1969 he was the Organiser of the London and Home Counties Area of the League. He was also General Secretary and Treasurer of the League between January 1969 and September 1979. Parker is a good example of a blind person who is well integrated into the community. He has had an impressive career in mainstream politics. In 1946 he was the first Labour Councillor in one of the two Uxbridge divisions of the old Middlesex County Council and he led the Labour group on it between 1949 and 1965. He persuaded the council to create the Uxbridge Old People's Welfare Association and promoted services for the blind in the area. In 1951 he fought his first Parliamentary seat as Labour and Co-op candidate for Ruislip-Northwood. He got the highest Labour vote ever recorded for the constituency, but was not elected as the MP. In 1964 he came within 600 votes of being a Member of Parliament, when he narrowly lost to the Tory Charles Curran in Uxbridge.
15. Tom Parker, 'Changes I have seen', Regional Review, Number 66, Winter 1979, page 29.
16. Tom Parker, 'Changes I have seen', Regional Review, Number 66, Winter 1979, page 29.
17. Madeline Roof, Voluntary Societies and Social Policy (Routledge and Kegan Paul, London, 1957) page 218.
18. See the National League of the Blind and Disabled, Report submitted by the National Executive Council to the 28th National Triennial Delegate Conference 11, 12, 13 May 1985, the section entitled Membership.
19. In 1969 Milligan was the delegate of the West Yorkshire branch to the Federation conference.
20. See Colin Low, In Our Own Affairs (National Federation of the Blind, 1972). This six page document launched the participation campaign.
21. Fred Reid quoted by Anne Lapping, 'How do we treat the blind as people?', New Society, 14 March 1968, page 374.
22. The Policy and Resources Committee was formerly known as the Policy and Selection Committee.

23. National Federation of the Blind, About the National Federation of the Blind (National Federation of the Blind, 1985) page 26.
24. Charles Taylor speaking to the Federation Delegate Conference in 1977. Taylor was then the President of the Federation. See The New Beacon, July 1977, Volume LXI, Number 723, page 179.
25. See Donald Jackson, 'The National Federation of the Blind', Regional Review, Number 66, Winter 1979, pages 31-33.
26. National Federation of the Blind, About the National Federation of the Blind (National Federation of the Blind, 1985) page 3.
27. Ben Proctor, 'Why do we need the NFB?', Viewpoint, Winter 1985, page 31.
28. Tom Parker, 'Changes I have seen', Regional Review, Number 66, Winter 1979, page 30.
29. See June Rose, Changing Focus The Development of Blind Welfare in Britain (Hutchinson of London, 1970).
30. David Mann, 'Foreward', National Federation of the Blind Annual Report 1983-84, page 7.

CHAPTER SEVEN

SOCIAL SERVICES AND REHABILITATION

In this chapter I intend to examine some issues relating to the social services, and the rehabilitation of the visually handicapped.

The role of the ophthalmologist in the rehabilitation of visually handicapped patients

Cholden and Firestone and several other writers have described several working principles to be used in informing a patient of the threat of blindness.¹ Both Cholden and Firestone emphasised that the ophthalmologist has an important part to play in initiating the rehabilitation of the visually handicapped. Clearly, exactly what and when the ophthalmologist tells the patient about his deteriorating eye condition which will lead or had led to registration as blind or partially sighted, affects the patient's perception and understanding of his condition, and his acceptance of the need to adjust to visual impairment as an important condition of life.

In his work Cholden stressed that the ophthalmologist needed to clarify the medical situation with the patient so that he might be psychologically prepared to receive help. Reluctance to bring the patient to an understanding of his visual impairment and the need to rearrange his life around the existence of the handicap is an obstacle standing in the way of rehabilitation. The ophthalmologist can help the patient accept his disability and learn to live with it.

Early timing of information facilitates rehabilitation efforts by the patient. When the established condition of irreversible

blindness exists, leaving false hope for return of vision is unwise in that rehabilitation efforts are impeded. Hope should be encouraged for a useful and fulfilling life, in spite of blindness. Cholden pointed out that it is considered kinder not to hold out hope when only a small chance exists for improvement. The patient should be told clearly and decisively but not abruptly. Where blindness has not yet occurred, but is expected, Cholden recommends that the patient be informed of the possibility of blindness, and that a period of time be then allowed for the patient to adjust to the possibility. Then blindness should be discussed as a possibility, and after another interval as a certainty. In this way, Cholden believes that the patient may begin his adjustment to blindness even before he becomes blind.

Cholden then went on to say that the patient sensed and reacted to the expressed and unexpressed attitudes of the ophthalmologist. Therefore, the doctor's influence as a source of authority at a time of crisis may contribute significantly to the patient's future rehabilitation efforts, and the interest of the doctor in planning will be very significant to the patient.

While these canons of practice are sound, there is a need for systematic investigation and discussion of agreed principles of rehabilitation. Firestone points out that, although it might be doubted that a long period of delay in informing the patient would be helpful, the exact timing of the information might be less crucial than the clearness and sensitivity with which it was presented. This may be an important focus for discussion in ophthalmological training and practice.

The psycho-social and practical problems created by visual loss and how they can be alleviated by rehabilitation

First of all it is important to consider the grief syndrome - the gradual process of the realisation of the fact and the implications of loss. The majority of the literature that is available in the field of psychological adjustment to visual loss is emotive, based on value judgements or individual experience, or lacks a firm scientific foundation for understanding the intrinsic nature of adaptive reactions. It is important to examine the literature on loss, bereavement, terminal illness, crisis, stress, and therapeutic intervention, to find a firmer scientific foundation for the understanding of this process.

This section embodies a conceptualisation of 'the grief syndrome' - the gradual process of the realisation of the fact and the implications of loss. It is the condensation of the theoretical frameworks supported by empirical material of a number of prominent authors who have written on grief reactions to various losses. Three particularly important writers in this field are Fitzgerald, who established the applicability of the loss model to visual loss, Parkes and Marris.² Among these writers the work of Parkes is particularly important.

It is important to examine the nature of grief. Grief is the psychological reaction to loss - the gradual process of the realisation of the fact and implications of a major loss or change. The phases and features of the grief syndrome, or loss model, have been well described in studies of bereavement, terminal illness, loss of a limb, loss of a home, and other major losses and crises. Fitzgerald demonstrated that the loss model is applicable to visual loss in a study

of sixty-six recently registered blind adults aged between 21 and 65, with visual acuities ranging from absolute blindness to 20/200, and from very gradual to very sudden loss of vision.³ In Fitzgerald's study the intensity of the initial reactions to the loss seemed unaffected by either the rapidity of the loss or the amount of previous sight in all but a small number of persons. No systematic study is presently available on the reactions to visual loss of elderly visually handicapped people for whom visual impairment is but one aspect of the ageing process and of multiple losses.

Quite clearly, the grief syndrome of adjustment is a dynamically unfolding process, and not a fixed state of depression. Its features and phases appear, disappear and reappear, or may be apparently absent. Grief must be worked through to a resolution, and it cannot be avoided, only postponed, and it cannot be rushed.

'Grief work' is the process of learning by which change resulting from the loss is progressively realised and a fresh set of assumptions about the world is established. Parkes points out that anything that continually allows the person to avoid or suppress this pain can be expected to prolong the period of mourning.⁴

According to Parkes and Rosenblatt, Walsh and Jackson, grief work involves the following seven processes:⁵

1. Preoccupation with thoughts of the loss.
2. A painful, repetitious recollection of the loss which must occur if the loss is not fully accepted as permanent.
3. An attempt to make sense of the loss and fit it into assumptions about the world, or to modify those assumptions if necessary.

4. An acceptance of the fact and the implications of the loss.
5. Extinction of non-adaptive behaviour.
6. Acquisition of new behaviour and relationships.
7. Dissipation of disruptive emotions.

Bowlby and Parkes have pointed out that grief may have a biological basis.⁶

The essence of psychological adjustment to loss and change lies in the difficult process of examining, unconditioning and reconditioning learned patterns of behaviour and learned assumptions about one's place in the world. Parkes points out that the basis of grief is resistance to change, reluctance to give up expectations, status and familiar patterns of life when the order and the predictability of life are disrupted and the change is unwanted. The impulse to defend the predictability of life is a universal principle of human psychology expressed by Marris as 'the conservative impulse' to assimilate social reality into an existing structure,⁷ and to avoid or reorganise parts of the social environment which cannot be assimilated.

The intensity of grief reaction or adjustment difficulty is directly proportional to the degree of involvement with that which is lost; the degree of disrupted habitual behaviour, including the number of changes and secondary losses involved; and the extent to which the gradual process of realisation of the fact and implications of the loss can be assimilated into an individual's self-concept and learned 'assumptive world'. Therefore, the intensity of grief depends on the degree of disruption. Rosenblatt, Walsh and Jackson point out that:

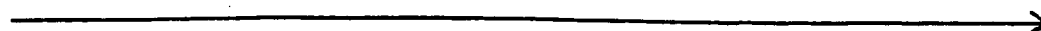
'The greater the amount of patterned activity disrupted (as calculated perhaps on a minutes per day basis) the more likely one is to experience grief and the greater the grief experienced . . . Strong grief reactions may be a sign of broken habitual patterns. '8

Marris and Parkes point out in their writings that grief is a conflict which must be resolved between retaining old purposes, habits and understandings and acquiring new ones. These two contradictory impulses, that is, the return to the past and to a state before the loss contrasting with the need to move forwards in the future to reach a state where the crisis is resolved, make the present almost unbearably painful.

Therefore, the less radical the changes required in one's lifestyle, expectations, assumptions and abilities, the less difficult would be the adjustment process.

It is important to consider the phases and the features of grief. Several writers have described the phases of the grief syndrome, and by amalgamating their descriptions one can devise the following table of seven phases of the progression of the grief syndrome, which is the gradual process of psychological adjustment to loss over a period of time, beginning with the state of the person before the loss and continuing through the resolution of grief.

Table 1 - The grief syndrome: the gradual process of realisation of the fact and implications of loss and change

I	II	III	IV	V	VI	VII
Pre-loss	Anticipation	Awareness/ Confrontation	Initial reactions	Denial/ depression/ acceptance	Reorgan- isation	Resol- ution
Time 						

I now intend to examine the seven phases in turn.

Phase one is pre-loss. Important events or critical factors just before or concurrent with visual loss may influence the magnitude and the nature of the person's reaction to the stress of visual loss. Previous loss reactions or excessive depression or grief prognosticate poor outcome, as may the inability to discharge emotional tension. Personality factors deriving from genetic make-up and the individual's previous life experience are important determinants of the magnitude of grief. The capacity to bear anxiety and stress is developed in childhood experiences of physical care and well-being, which establish the individual's basic personal and physical security.⁹ When visual loss occurs with or shortly after other accidental or developmental crises, which Parkes calls 'psycho-social transitions',¹⁰ the cumulative stress may create a crisis of major proportions or contribute towards a poor overall adjustment. The accidental crises include the loss of a job; illness or accident; loss of a loved one through death, separation or divorce; and natural causes. Developmental crises include marriage, childbirth, starting school, adolescence, leaving school and seeking employment, the marriage of children, moving house or entering a residential home, and immigration. Other stresses include demoralisation before the crisis, problems within the family, poor housing conditions, work problems and worry about children.¹¹ Parkes argues that reliable indices are required to help us to predict who will be at risk of suffering a severe grief reaction so that scarce resources may be available when and for whom they are most needed.¹²

Phase two of grief is anticipation. In this phase the person moves from a fear or suspicion of the possibility of loss to probability and then to certainty of loss. Timeliness and expectations of loss affect this period. During this phase the individual has an opportunity to engage in what Janis calls 'worry work',¹³ which is defined as 'anticipation before misfortune'. According to Janis, worry work involves several processes, including the following:

1. Attention is focused on possible danger.
2. There is opportunity for appropriate planning.
3. Assumptions and expectations may be modified.
4. Appropriate emotions may be experienced.
5. Relearning may occur without excessive stress.

In his studies, Fitzgerald found that five patients had no reaction to the loss of sight because at an early stage they had acknowledged the certainty of ultimate blindness and organised their domestic and occupational activities around the anticipation of the loss to be minimally affected. But Fitzgerald also found that twenty-one patients with gradual loss of vision who could have similarly anticipated blindness did not do so, and became anxious and depressed at the onset of visual loss.¹⁴

Phase three of grief is awareness or confrontation. Whether the patient is informed or realises without being told, the phase of awareness is the first turning point to the gradual process of realisation of the fact and the implications of the loss. For individuals with an acquired visual loss, there is always a turning point at

which point the patient is confronted with or becomes aware of the fact of visual impairment or blindness. The timing of this response to the loss of sight varies: when sight begins to deteriorate, at the onset of sudden blindness, after consultation and at registration. The procedure of examination - certification - registration is a crucial period on which to focus. Fitzgerald found that these events, with their implications of irrevocability, together with the ritual of recognition of a new identity as a registered blind person, were more important for some in defining the onset of blindness than the actual loss of sight itself.

Phase four of grief is comprised of initial reactions to the individual's situation. The short-term emotional reactions to the loss need to be distinguished from the long-term adjustments as the fact and the implications of the loss of sight are progressively realised by the individual.

'Psyche defence' is the function of many initial reactions to the awareness of loss, even in cases in which the confrontation is a confirmation of one's fears, rather than unexpected news. Parkes argues that no one can take in at once the fact or the implications of a major psychic trauma. Psychic defence allows the gradual acceptance of the implications of the loss. Numbness and shock, disbelief, initial denial, and a sense of unreality, even anger, are adaptive responses in the early stages of the grief reaction, although they are maladaptive in the later stages, when they become fixated. Feelings of panic, desperation and guilt are commonplace. Fitzgerald

observes that despair and hopelessness may lead to thoughts of suicide, but not many attempts are actually made.¹⁵ A prominent characteristic of this initial emotional reaction is the fluidity and intensity of some reactions. The physical and the mental symptoms of distress or grief reactions have been well documented by Lindemann,¹⁶ and all the prominent writers on grief reactions note an increase in physical and mental illness after major losses. Physical manifestations include symptoms of physiological reactions of alarm,¹⁷ being sympathetic stimulation and parasympathetic inhibition; physical and mental signs of reactive depression; and psychosomatic disorders, including psychosomatic visual phenomena.¹⁸

Phase five of grief is the gradual process of realisation, which includes denial, depression and then acceptance. With the increasing realisation of the discrepancy between the world that was and the world as it now is, struggle and an initial denial give way to despair and depression, or letting go, and the patient moves on from initial to full acceptance of his circumstances. This cycle takes place each time another implication of the loss is discovered and examined, and assumptions and behaviour must be unlearned and relearned. Until an individual has acknowledged that a loss has occurred, there is no possibility of resuming a normal life without that which was lost. The ophthalmologist is in a unique position to move the patient out of uncertainty and denial into a state of acknowledgement, realisation and acceptance of his visual loss.

Mitchell points out that depression during the process of adaptation to loss or change can be considered normal and potentially

healing.¹⁹ It can lower responsiveness and act as a protective screen; it can act as a cut-out when basic survival is threatened so that the adaptation can follow afterwards; it can have a cathartic effect of releasing pent-up emotional tension by weeping; and it can be thought of as a period of inward diversion of energy while the person adapts to external traumatic events.

The sixth phase of grief is that of reorganisation and relearning. Indeed, the turning point in the process of recovery is that of reorganisation and relearning, which is a concomitant of the move from denial to acceptance. Fitzgerald found that this turning point was associated with increased self-esteem from attempting and mastering acts of self-sufficiency. During this period of reorganisation, Caplan and Parad described the following patterns of adaptive coping:²⁰

1. Task-oriented activity: which includes breaking the problem down into separate elements and then dealing with each aspect;
2. Correct understanding of the situation: which includes seeking new knowledge and keeping the problem in consciousness;
3. The management of feelings and emotions: which includes the awareness of feelings, appropriate verbalisation, discharging tension and mastering emotions;
4. Seeking and using help with actual tasks and feelings: which includes using interpersonal and institutional resources.

The final phase of grief is resolution. Finally, the individual reaches a state of resolution in which he has a full acceptance of the

fact of the loss and has acquired new behaviour and relationships, has extinguished non-adaptive behaviour, and is rid of disruptive emotions.

However, it should be stressed that, although an individual can achieve full acceptance of the fact and the implications of the loss, visual handicap demands continuous adjustment throughout life as one encounters each new situation.

Pathological reactions to grief include delayed, inhibited or chronic grief. In their work, Parkes and Lindemann indicate that pathological reactions can be transformed into normal grief by making it possible for the patient with delayed or inhibited grief to begin to do 'grief work', and to overcome flaxations or blocks to realisation which at last allow him to 'unlearn' his attachment to that which was lost.²¹ Success of rehabilitation with chronically grieving individuals who are socially isolated and unable to find anything in life to look forward to may depend on helping the patient to discover a new place in society.

It is important to realise that each member of the immediate family in which there is a visual loss will experience a process of adjustment, and role and status changes, and that the behaviour and expectations of others have major effects on the individual's acceptance of and adjustment to the loss. Therefore, for the sake of comprehensive assessment and rehabilitation it is vital for members of the family to be included.

A number of other factors affect the adjustment to visual loss. Several studies indicate that partial and unstabilised loss is more

difficult to adjust to than total or stable loss. Presumably, the strong element of ambiguity, of marginality, and the inability to make a final adjustment is particularly stressful. It has been said that a totally blind person spends all of his time explaining what he can do, while a partially sighted person spends his time explaining what he cannot do. It has also been suggested that recovery of vision can be as traumatic as the loss of vision. This is possibly because of increased sensory bombardment, and once again because of ambiguity.

In the grief syndrome the time of confrontation may be considered a period of crisis for the patient. The 'crisis theory' of Caplan²² and the social work concept of 'crisis intervention'²³ are based on the principle that help given at a time of crisis, when pathological patterns of thought and behaviour are developing, is more likely to be acceptable and more effective than help given long after these pathological patterns have become established. The initial emotional reaction, understanding and attitudes towards the reality of the disability are most important for determining the frame of mind for future adjustment. Appropriate help at this crucial time of confrontation, awareness and initial emotional reaction - whether in anticipation of severe visual loss before it occurs or at the onset of relatively sudden visual loss - can perhaps make the difference between making the most of what one has left or sitting back and giving up.

There is the opportunity for a most effective crisis-intervention support team at the eye clinic or the hospital when the patient is

confronted with the diagnosis of irreversible visual impairment.

The ophthalmologist is in a particularly strong position to influence adjustment and rehabilitation, and if rehabilitation were initiated as an extension of medical treatment rather than by the social services, misunderstood by many, particularly the elderly, as 'the welfare', it would be more acceptable and more effective.

The guidelines of Parkes can be adapted for anticipatory guidance to apply to visual loss.²⁴ Nine important points can be mentioned:

1. Give a clear explanation of the nature of the situation.
2. Discuss any fears which the patient or his family have and give reassurance wherever possible without giving false hope for the return of sight.
3. Warn the patient about the after-effects he can expect to encounter.
4. Give instructions for action to mitigate unpleasant symptoms.
5. Outline the rehabilitation which will follow and the part the family and the patient can play to ensure a successful outcome.
6. Give assurance about further support throughout the period of adjustment.
7. Predict the final result he can reasonably aim for, including the types of limitations he can expect.
8. Encourage appropriate emotional expression and give reassurance about the normality of painful feelings.
9. Finally, reinforce these steps with printed information explaining the condition and the help available. A particularly

valuable source of information is the In Touch handbook, by Margaret Ford and Thena Heshel.²⁵

These guidelines can be given to a visually handicapped individual by a number of people, but it is important to decide who will be the 'key person' with overall responsibility for the patient (this may vary for each patient) and who will be responsible for undertaking each of the tasks.

The provision of help to the visually handicapped

Clearly, it is important that the ophthalmologist understands how the system of provision of services for the visually handicapped operates, so that if he recognises that a patient needs particularly quick or urgent attention from specialist staff he will indicate this when referring the patient to the social services.

The judgement of the ophthalmologist is crucial as to when he sends in the BD8 registration form and why, to ensure that the visually handicapped patient is referred to the rehabilitation staff of the social services department as early as possible after the visual loss which will create problems of daily living, has been diagnosed.

Before the reorganisation of the social services in 1971, the welfare department's partially sighted and blind population were the responsibility of one type of specialist worker - a one-year qualified social welfare officer for the blind, or SWOB, previously referred to as a home teacher for the blind.²⁶ The social welfare officer for the blind made the first contact with the newly-registered blind or

partially sighted person in his own home within several days of registration. This practice of home visiting distinguished between the newly blind and the physically handicapped, who would be rehabilitated in a hospital before going home. The social welfare officer for the blind also organised social activities, taught braille and craftwork, and was only concerned with the social welfare of the blind and the partially sighted.

The strengths of the pre-1971 system may be said to have lain in the following.

First of all, as the Younghusband Report pointed out in 1959, there was a system of regular visiting²⁷ - the majority of visually handicapped people being visited every 7 to 12 weeks, and the very lonely being visited weekly or twice a month. Secondly, there was a significant number of reliable, knowledgeable, and trained workers who were dedicated and who had a sense of urgency about their client's needs and a preventive approach to their problems. Thirdly, there was a continuity of the relationship between the worker and the client. Fourthly, a specialist service existed in which staff had a current knowledge of the needs and situations of the visually handicapped people on their caseloads, making it easier to identify any need for new types of services. Fifthly, the visually handicapped did not have to compete for relative priority with every other potential kind of client group. Finally, the cessation of this service served to emphasise its achievement. That is to say, as the number of workers with specialist knowledge decreased, so correspondingly did the

knowledge about the visually handicapped population, and problems in the delivery of services to the visually handicapped increased.

The weaknesses of the previous system of blind welfare are alleged to have been that the blind were segregated, and that home teachers or social welfare officers for the blind tended to be too possessive and rigid about their visually handicapped clients. They encouraged dependence on the worker and the blind welfare system, they were too symptom-centered on blindness, and took an approach that was too narrow. In the pre-1971 system the visually handicapped were over-visited and over-pampered, there was too much 'hand-holding' and visits were often unplanned and indiscriminate. The types of services that were offered were focused on keeping the blind occupied, which was judged to be inferior to the contemporary approach which is oriented towards rehabilitation.

As a matter of fact, three-quarters of the registered blind and partially sighted at that time were over sixty-five years of age, and by our present knowledge would have limited the need for rehabilitation. Indeed, regular visiting and hand-holding were perhaps exactly what the very lonely and very old visually handicapped people wanted, although one can question whether the time of scarce specialist staff which was spent in regular visiting to detect a possibly deteriorating condition which would have been overlooked by a non-specialist was most efficiently spent.

Finally, there was deemed to be inadequate 'casework' skill taught in the social welfare officer for the blind's course compared

to that taught on generic social work courses. This was perhaps the most decisive factor which caused the Central Council for Education and Training in Social Work to discontinue the training of social welfare officers for the blind in 1972.

In 1965, in response to mounting criticism concerning the multiple and fragmented nature of social work organisation and practice, an enquiry was begun into the organisation and the responsibilities of the local authority personal social services in England and Wales, to consider what changes were desirable to secure an effective family service. The Seebohm Report of 1968²⁸ resulted in the Local Authority Social Services Act of 1970, which brought about the reorganisation of the social services, and the present day situation.

The present trends in the provision of specialist social services to the visually handicapped in local authorities in England

In a discussion of the present trends in the provision of specialist social services to the visually handicapped in English local authorities the obvious starting point is the Seebohm Report. The recommendations of the Seebohm Report and their impact on social work training and practice, legislation and other major reorganisations have had a profound effect upon the present provision of specialist services for the visually handicapped. The quality and the quantity of services provided varies enormously from one local authority to another.

The Seebohm report affected services to the visually handicapped in four major ways. First of all, a unified social services department

was created by the amalgamation of separate social work departments (that is, the child care, welfare, mental health and other departments).

Secondly, social work specialisation by traditional client groups was no longer favoured, and the generic concepts of common social work training, mixed caseloads, and one family to one worker received official support. Thirdly, the Central Council for Education and Training in Social Work (CCETSW) was established to organise training for the social services. Fourthly, the traditional training of social welfare officers for the blind or home teachers was abolished by the Central Council for Education and Training in Social Work, and a distinction was made between the social work and the teaching aspects of rehabilitation. The social welfare officers for the blind course was replaced by an interim training for technical officers for the blind to teach communication and daily living skills, in addition to mobility officers for the blind who teach orientation and mobility. Technical officers and mobility officers are still in existence.

In addition to the Seebohm report, since 1969 four other factors have had an important influence on the care of the visually handicapped. First, legislation increased the responsibilities of the statutory authorities and there were increased public demands on the new department, but there was no corresponding increase in resources. The Children and Young Persons Act of 1969 and the Chronically Sick and Disabled Persons Act of 1970 brought a disproportion of child care problems to the social services department, as pressure from the public increased for social workers to prevent non-accidental

injury to children, and they also increased the expectations and the rights of all groups of handicapped people. Second, major structural reorganisations in local government and the National Health Service, as well as the incorporation of hospital social workers into the realm of the social services department caused a large amount of disruption for some local authorities at a time when they were starting to recover from the reorganisation of the social services. Third, periods of economic difficulties and shortage force value judgements about the relative priority between different types of social problems and relative need. This perception of relative priority and the orientation of an individual social worker's caseload are influenced by previous social work training and experience. The majority of social workers in Britain have no training or experience in visual impairment. Most qualified social workers in managerial positions of decision-making have qualifications in generic social work, child care, or mental health. Fourthly, most of the social work with the visually handicapped is done by unqualified social workers with limited training or none in social work or visual handicap and with inappropriate supervision.

As a result of these variety of factors, the visually handicapped are generally perceived as a low-priority group.

In the 1980's there are basically three models of local authority structure for providing social services to the visually handicapped. These are the specialist model, in which only specialist staff with knowledge and experience of visual handicap carry the visually

handicapped on their caseloads; the mixed model, in which some specialist staff work in conjunction with generic social workers, usually unqualified with mixed caseloads, although some social work area teams have no specialist staff in that area; and thirdly, the generic model, in which no specialist workers with knowledge and experience of visual handicap are engaged in contact with clients.

The essential difference between these three models is the relative priority given to other client groups for which the social service department is responsible, as manifested in the numbers and the types of specialists employed, and the question of whether visual handicap is perceived as the client's most identifying characteristic when the BD8 registration form reaches the department's intake and referral section.

The three models of provision of social services to the visually handicapped will now be considered in more detail.

In the specialist model, all social work and rehabilitation teaching for the visually handicapped population are provided only by specialist staff with knowledge and experience of visual handicap, and no generic workers without competence in visual handicap deal with the problems relating to visual handicap. It follows that in this model new registrations would be immediately referred to specialist staff located in a central team or in social work area teams, to assess and meet the needs of the client which related to visual handicap first. Other problems not directly related to visual handicap would then also be undertaken by these specialists or referred on to generic

social workers and other staff who provide support. In this model, direct referral to the specialist staff allows the visually handicapped individual to bypass the generic social work team, thus avoiding competition at a relatively low priority with other client groups, especially child-care related work which takes up the bulk of the time of qualified social workers. In the specialist model of service delivery, either the local authority has never changed its pre-Seebohm blind welfare practice by not distributing the caseloads of social welfare officers for the blind to generic social workers or the local authority originally did so, but returned to social work specialisation (albeit usually unqualified) based on visual handicap.

In the mixed model, which tends to be found in most local authorities, either there is some specialist knowledge in some social work area teams but not in others or technical officers and mobility officers work with usually unqualified generic social workers who may or may not have a knowledge of visual handicap. In the local authorities where the mixed model is used, all the registered cases of visual handicap which are referred to the department may be passed on to workers with some specialist knowledge. Demands are made upon the specialists to meet all the rehabilitation needs without adequate training. Caseloads tend to be unmanageably large, and the most simple problems to the most complex problems may be handed on to them.

Finally, in the case of the generic model, some local authorities have no specialist workers at all in direct contact with clients, and

because of financial constraints have no prospects of improving the situation in the near future. These particular local authorities are forced to resort to other workers' skills and knowledge, such as home helps, occupational therapists and the staff of residential homes and day centres, without adequate training to modify their existing skills to the needs of the visually handicapped.

Whatever the local authority he lives in, the visually handicapped patient tends to go through the following twelve stages of provision of social services as he moves from the health services and through the social services. First, the individual's visual handicap is detected; second, he is referred to an ophthalmologist; third, he is examined and if necessary re-examined; fourth, the individual is certificated as blind or as partially sighted; fifth, he is registered with the social services department; sixth, an assessment is made of his need; seventh, plans are made with the client for his rehabilitation or treatment; eighth, there is a mobilisation of resources to meet the individual's needs; ninth, there tends to be a wait for services and training; tenth, there is the provision of services, aids and training; eleventh, there is a programme of after-care and finally, a long-term follow up programme, in which the individual's progress is reviewed. Quite clearly, the speed with which an individual can pass through the system and emerge as a rehabilitated person depends greatly on the local authority model of provision of services and the length of the wait lists of specialist workers. The ophthalmologist has an important part to play in this process, and might speed the process by early

referral, where this is possible, and by indicating that a person should receive priority treatment.

Those specialist staff for the visually handicapped who are employed in local authorities at the present time can occupy a post at a managerial level or at a field work level. At a managerial level a member of the specialist staff can be an adviser in visual handicap. At a field work level, the specialist staff for the visually handicapped include a variety of workers - social welfare officers for the blind or home teachers, orientation and mobility officers for the blind, technical officers for the blind, qualified or unqualified social workers with some knowledge and experience of visual handicap, perhaps acquired through in-service training, occupational therapists with a special interest in visual handicap and additional skills in non-visual or low-visual methods, and finally sessional workers, including competent visually handicapped people; who teach braille, moon, craftwork, typing, cooking, and so on.

The only training courses in the United Kingdom which qualify staff for work with the visually handicapped are a qualification in technical work with the blind which produces technical officers and one in orientation and mobility which produces mobility officers. Both of these courses last for six months, and are generally considered to be inadequate in length and in scope to prepare specialist workers for the demands which are made on them, especially if they purport to meet the needs of all the subgroups of the visually handicapped population.

The present training of technical officers and mobility officers is designed to make them teachers and not social workers. For this reason, they are deprived of any real working knowledge of psycho-social aspects of human relations on their training courses, as if that element alone constituted social work. Therefore, the specialists who are in the closest contact with the visually handicapped, often at times of crisis, are not competent to deal with their clients', or clients' families' problems in psycho-social adjustment to visual loss. It is often in the strain of learning new skills that emotional reactions to newly-acquired visual handicap are most acutely realised and erupt. For the protection of vulnerable clients as well as vulnerable staff, this weakness in the present training programmes should be immediately rectified.

There are five particular problems associated with specialist staffing. First of all, as there is no longer a qualification for social work - as distinct from rehabilitation teaching - with the visually handicapped, local authorities face the problem of replacing social welfare officers for the blind or home teachers who retire or become qualified as generic social workers to improve their career prospects. Secondly, it is difficult to acquire or maintain an adequate number of different types of specialists. Cutbacks and freezes on posts mean that mobility officers and technical officers may not be employed or replaced. Thirdly, there is no higher-grade specialist training for work with the visually handicapped than the two types of course which last for six months. Therefore, clients with particularly

difficult problems have only basic grade specialist teachers and unqualified social workers. Fourth, there is little adequate supervision or support for many specialists working in local authorities. Finally, there are indications to suggest that specialist workers with the visually handicapped have very low status in social services departments, often inadequate remuneration, and no career structure. These workers have to compete with social workers with a two-year qualification, often at a post-graduate level, who constitute the largest number of staff in departments, and with occupational therapists who have three years' training. There is evidence to suggest that many of the specialist workers with the visually handicapped are frustrated, preoccupied with achieving professional recognition, and concerned about the value of their qualifications when a new form of training is introduced.

I now intend to examine the results of two important and recent surveys, namely the Southern and Western Regional Association for the Blind's survey of the ratio between clients and specialists and Biggs' analysis of the provision of mobility services, which both show that there are too few specialist workers for the visually handicapped spread throughout the country.

The Southern and Western Regional Association for the Blind's survey of the ratio between clients and specialists

Between 1979 and 1980 the Southern and Western Regional Association for the Blind collected together a series of figures concerning the ratio between clients and specialists in different parts

of the country. The first set of figures that were published concerned the local authority areas within the Southern and Western regions. I will examine this first set of figures in some detail since they reveal some important trends.²⁹ The figures are set out in tables 2, 3 and 4.

The figures can be interpreted in different ways: but, in any way that one may care to look at them, they provide the facts against which to judge the assertion that the service for the visually handicapped is not as good as it used to be.

When the Southern and Western Regional Association presented the figures they pointed out that to lay down a hard and fast rule about the size of case loads takes no account of the complexities of particular cases, although it is reasonable to argue that all the complex cases cannot be concentrated in one area. It also appears to take no account of the intention of many local authorities to run a generic service, where no ratio between specialists and clients as direct as a specifically specialist case load can be worked out. It is, however, reasonable to relate the need for specialist knowledge to the total number of visually impaired people in a local authority and to suggest that an average rural case load should be of a particular maximum size and an average urban case load should be of a slightly larger maximum size. How that need for specialist knowledge is satisfied is the problem of the local authority. But there is no denying that the need exists. It is then appropriate to look at areas where according to the findings of the survey a good service has been maintained - like

Key for tables 2, 3 and 4Categories

- A Qualified workers devoting 50 per cent or more time to the visually handicapped.
- B Unqualified workers devoting 50 per cent or more time to the visually handicapped.
- C Qualified workers devoting less than 50 per cent time to the visually handicapped.
- D Qualified workers but not spending time with the visually handicapped - available to advise.
- E Total population of registered blind and partially sighted people (DHSS figures for the year ended 31 March 1979).
- F Average number of people registered blind or partially sighted to the number of workers, qualified or unqualified, devoting 50 per cent or more time to the visually handicapped.

Note

- a) Registration total for Tower Hamlets for year ended 31 March, 1978.
- b) The City of London is covered by neighbouring local authorities.
- c) The situation in Hackney and the City of Westminster is better than the figures suggest: both boroughs have four qualified workers each one of whom devotes less than 50 per cent of the time to the visually handicapped.
- d) Details for Leicestershire supplied by voluntary association.
- e) Details for Staffordshire supplied by voluntary associations, do not include Burton on Trent.

Table 2 - Metropolitan district areas

Area	A	B	C	D	E	F
Birmingham	10	3	0	4	3188	245.2
Coventry	3	0	0	2	1029	343
Dudley	2	4	0	0	793	132.2
Sandwell	Six people are employed but details as to qualifi- cations were not given				892	
Solihull	1	0	1	0	339	339
Walsall	4	2	0	0	822	137
Wolverhampton	2	0	1	1	804	402

Table 3 - London Boroughs

Area	A	B	C	D	E	F
Barking	0	1	0	0	458	458
Barnet	2	0	1	0	1221	610.5
Bexley	2	0	1	0	510	255
Brent	3	0	5	0	881	293.6
Bromley	1	0	1	0	1294	1294
Camden	1	0	0	0	552	552
City of London	0	0	0	0	7	infinity
Croydon	8	0	0	0	924	115.5
Ealing	2	1	1	0	974	324.6
Enfield	5	0	0	0	1009	201.8
Greenwich	2	0	0	1	555	277.5
Hackney	0	0	4	0	1052	infinity
Hammersmith	2	0	1	0	634	317
Haringey	1	0	0	6	963	963
Harrow	3	2	0	0	639	127.8
Havering	1	0	0	0	544	544
Hillingdon	4	2	2	0	656	109.3
Hounslow	1	0	0	0	572	572
Islington	1	0	0	0	550	550
Kensington and Chelsea	1	0	0	0	439	439
Kingston	1	0	0	0	346	346
Lambeth	3	1	0	0	1045	261.3
Lewisham	4	7	0	0	883	80.3
Merton	2	0	0	0	689	344.5
Newham	1	2	0	0	846	282
Redbridge	1	0	1	0	755	755
Richmond	0	1	0	0	626	626
Southwark	2	0	2	0	893	446.5
Sutton	2	0	0	0	620	310
Tower Hamlets	1	0	1	0	684	684
Waltham Forest	2	0	1	0	870	435
Wandsworth	6	0	0	0	1152	192
Westminster	0	0	4	0	656	infinity

Table 4 - County Councils

Area	A	B	C	D	E	F
Avon	12	4	0	0	2601	162.6
Bedfordshire	3	0	0	4	1623	541
Berkshire	3	1	0	1	1786	446.5
Buckinghamshire	1	1	1	0	1428	714
Cambridgeshire	4	0	0	11	1236	309
Cornwall	5	1	1	0	1301	216.8
Derbyshire	15	1	0	5	2969	185.6
Devon	5	0	0	0	3366	673.2
Dorset	9	0	0	2	2882	320.2
East Sussex	12	3	1	0	3443	229.5
Essex	13	0	6	0	4854	373.4
Gloucestershire	5	2	1	0	1511	215.9
Hampshire	2	2	2	2	4760	1190
Hereford and Worcester	3	1	1	3	1620	405
Hertfordshire	4	0	0	0	2576	644
Isle of Wight	2	1	0	0	437	145.7
Kent	17	1	0	4	4031	223.9
Leicestershire	13	4	2	0	2998	176.3
Lincolnshire	7	2	2	3	1367	151.8
Norfolk	4	2	1	0	2009	334.8
Northamptonshire	2	0	1	1	1277	638.5
Nottinghamshire	10	6	0	0	3238	202.4
Oxfordshire	7	0	0	0	1909	272.7
Salop	8	1	0	0	992	110.2
Somerset	10	0	0	1	1469	146.9
Staffordshire	4	2	3	0	2315	385.8
Suffolk	7	0	2	5	1765	252.1
Surrey	8	0	3	0	2686	335.8
Warwickshire	4	2	0	0	1382	230.3
West Sussex	8	2	0	3	2710	271
Wiltshire	1	0	0	0	1320	1320

Derbyshire or Somerset, Croydon or Harrow, Birmingham or Walsall - to work out what the ratio should be.

However, the difficulties of doing so do not stop there. For, it is necessary to bear two further points in mind. First, as Cullinan has emphasised, the under-estimate in the total number of those registered as blind may be as much as twenty five per cent among elderly people.³⁰ Secondly, the partially sighted register is almost certainly undersubscribed because there is little or no benefit to be derived from being on it. However, if the local authorities are performing properly the four tasks³¹ which they were directed to perform by section 29 of the 1948 National Assistance Act, as amended by virtue of the 1972 Local Government Act, then both registers should be kept up to the full.

In commenting on the figures, the Southern and Western Regional Association for the Blind pointed out that the statistics seem to suggest that as a general rule the ratio in a rural area should be 200 clients to each specialist: on that reckoning an urban ratio might run up to 250 clients to each specialist. The Southern and Western Regional Association for the Blind pointed out that this tallies with the rule of thumb that sometimes used to be applied when assessing the number of home teachers required throughout the United Kingdom.

Regarding the figures for the county councils, the Southern and Western Regional Association for the Blind pointed out that they should not be interpreted as condoning the practice whereby unqualified people are considered as adequate to deal with the problems of the

visually impaired. But it would also be equally wrong to condemn the efforts of unqualified people as inevitably inadequate. However, it is clear that the averages do reveal a breadth of discrepancy between a ratio of approximately 100 registered visually impaired people to each specialist to a ratio of approximately 1,000 registered people to each specialist. The Department of Health and Social Security has said that the decision about the provision of specialists is one that must be taken by each individual local authority. But the Southern and Western Regional Association for the Blind and several other organisations and individuals have maintained that the Department is under some obligation to ensure that the mandatory requirements consequent upon the Local Government Act are complied with in all local authorities. Is it possible that they are complied with throughout the country, when the discrepancy is so big?

In looking at the figures, allowance needs to be given for transfers and retirements during 1979 and 1980, while the figures were being sent to the Southern and Western Regional Association for the Blind. The average in the first column was worked out by the Southern and Western Regional Association on the basis of workers, qualified or unqualified in work with the visually handicapped, spending at least fifty per cent of their time on work with the visually handicapped. It is an average figure of the work done rather than of qualification to do it. It was based on returns which local authorities themselves supplied to the Southern and Western Regional Association, except where a note to the contrary offers an explanation.

In the next section I intend to do two things: first, I intend to examine the historic development of personal mobility training based on the long cane system, and then I intend to discuss Biggs' disturbing findings concerning the distribution of mobility officers in English local authorities.

The development of the long cane movement and Biggs' findings concerning blind mobility training services

It is clear that blindness is a severe handicap to personal independent mobility, but this has never prevented some blind people from overcoming their problems and in some cases displaying a degree of independence that compares well with that of the average sighted individual. Although nowadays people tend to associate blind mobility with guide dogs,³² historically, successful blind mobility techniques have usually involved the use of sticks or canes. Even nowadays, evidence points to guide dog users being a minority among blind travellers, and a survey conducted in Nottingham in 1981 confirmed this.³³

It was not until the Second World War that a successful attempt was made to systematise cane-based mobility when Richard Hoover developed the long cane system in the United States. The long cane consists of an aluminium shaft about 130 cm. long (the exact length varies with each individual) and about 225 g. in weight. It has a crook and a rubber grip at the upper end and a renewable nylon tip at the lower end. It is used to scan the ground a pace ahead of the user. Not only is it used to detect obstacles and sudden drops such

as stairs and kerbs, but also its lightness permits the average user to detect different surface textures. To a properly trained user it should give almost total security from injury (head-high obstacles are the major exception), allowing the individual to concentrate his other senses on other things, such as the flow of traffic going on around him, and to use them to improve the safety and the speed of his journey. The survey conducted by Clark-Carter, Howarth, Heyes, Dodds and Armstrong of the visually handicapped in Nottingham in 1981 revealed that although long cane users tended to have poorer vision than other visually handicapped people,

'those trained with the long cane make significantly more journeys in a normal week and are significantly more able to cross roads alone.'³⁴

After he had evolved the system, Hoover then developed a carefully structured learning programme and trained sighted instructors to pass on the skills and the training without which the long cane can prove dangerous, both to the general public and to the user. Although the long cane system was only slowly accepted in the United States, it was well established by the time British interest was aroused in the mid 1960's. In 1966, the Midlands Mobility Centre was established in Birmingham by Dr Alfred Leonard and Walter Thornton, who had both visited the United States and had become convinced in their different ways of the superiority of the long cane system over any cane mobility techniques then available in Britain. A two-year Nuffield Foundation research grant was obtained, which was later extended for a further year, and an American instructor, Stanley

Suterko, was invited to Britain to initiate the programme. When he returned to the United States in 1967, another American instructor came over for two years until the Centre was firmly established. In 1969, the Centre was put on a permanent and sound financial basis with support from the Royal National Institute for the Blind, the Birmingham Royal Institution for the Blind and St Dunstan's. At the same time, in recognition of its position as the only establishment in Britain for training mobility instructors for the blind, its name was changed to the National Mobility Centre, and it retains this title today. ³⁵

The central objective of the National Mobility Centre is to make personal mobility training based on the long cane system available to as many blind people as need it. The Centre has a staff of only six, four lecturers, a research assistant and the Principal, and about twenty five students, who must all be fully sighted, pass through the Centre every year. A great deal of emphasis is placed on training the students under a blindfold in the skills that they will be expected to teach when they qualify. Although it is appreciated by members of the Centre that blindfold work does not show what it is like to be visually handicapped, it does demonstrate vividly to the student both the problems and the potential of learning the long cane system.

However, the training does not stop there, because one of the great strengths of the long cane system is its versatility. Students at the National Mobility Centre are trained to apply the techniques they learn to different situations, selecting or adapting them to suit the requirements of each individual blind person. This may involve

consideration of people who have a certain amount of useful vision, prescribing a different type of cane or, increasingly nowadays, the special problems of people with handicaps additional to their sight problem. The intention of the National Mobility Centre is that, by the time they qualify, mobility instructors will be able to provide suitable instruction in personal mobility to most of the visually handicapped individuals for whom they will be responsible.

By the terms of section 29 of the 1948 National Assistance Act, local authorities are empowered to make arrangements for disabled and handicapped people who are ordinarily resident within the authority to receive instruction in the methods of overcoming the effects of their disabilities. The 1970 Chronically Sick and Disabled Persons Act goes further and makes it

'the duty of every local authority having functions under section 29 of the National Assistance Act 1948, to inform themselves of the number of persons to whom that section applies within their area and of the need for the making by the authority of arrangements under that section for such persons.'

The staff at the National Mobility Centre have interpreted this to mean that all local authorities should have available for blind people in their area some form of home-based mobility training. Guide dog training takes place in residential centres and cane-based training is available in residential rehabilitation centres such as those run by the Royal National Institute for the Blind in Torquay. However, Geoffrey W. Biggs of the National Mobility Centre has pointed out that these do not, however, necessarily equip the blind individual to cope with his own home area. Therefore, Biggs and the other members of staff at the

National Mobility Centre consider

'that all local authorities should, except in exceptional circumstances, employ a person qualified to teach the long cane system, often known as a mobility officer for the blind.'³⁶

By 1 May 1982, 314 students had qualified as mobility instructors at the National Mobility Centre, of whom 240 were still working, 64 abroad and 176 with various British local authorities, voluntary organisations and schools for the blind. Another 6 instructors trained elsewhere also to work in Britain. In April 1982, a survey was initiated by Geoffrey W. Biggs to assess what this meant in terms of the extent to which local authority cane-based mobility instruction was available in Britain. The results of the survey were published in September 1982.³⁷ In the survey, National Mobility Centre figures on the employment of mobility officers for the blind correct at 1 May 1982, were compared with figures produced by the Department of Health and Social Security on the numbers of registered blind and partially sighted persons in England, correct at 31 March 1980. The disparity in the dates was not felt to have any major effect on the results.

The situation in Wales, Scotland and Northern Ireland was not considered in Biggs' survey, partly because the relevant figures were not immediately available and partly to keep the survey to manageable proportions. Biggs' impression was that the situation in those parts is worse than in England. The numbers of registered partially sighted were also not considered in the survey. This was partly to simplify the calculations and partly because the accuracy

of the register of partially sighted individuals varies even more widely than that of the register of blind persons. Biggs' early work on the survey did take account of the numbers of partially sighted, but they made little difference to the general pattern that was uncovered by the survey.

Biggs' research revealed that, of the 109 local authorities in England with the power to appoint a mobility officer for the blind, 70 had done so, employing a total of 104 trained mobility instructors. Biggs found that the 39 local authorities that had not appointed a mobility officer comprised 6 of the 40 shire counties, 15 of the 33 London boroughs and 18 of the 36 metropolitan districts. In all, 23,597 blind people, or twenty two per cent of the 107,765 registered blind people in England, lived in authorities without a mobility officer, twenty five per cent of them in the 6 shire counties, twenty nine per cent in the 15 London boroughs and forty six per cent in the 18 metropolitan districts.

The local authorities were then ranked by Biggs according to the number of registered blind in their area. This revealed that no fewer than 30 of the 39 local authorities without a mobility officer were to be found among the 50 authorities with 651 or less registered blind. This compared with the national average of 989 registered blind per local authority. These authorities were 2 of the 6 shire counties, 13 of the 15 London boroughs and 15 of the 18 metropolitan districts.

Next, a ratio of blind people per mobility officer was worked out by Biggs for areas with a mobility officer or officers. It was

not possible in Biggs' study to make an allowance for part-time employees or to eliminate those instructors who, although employed by a local authority, no longer provided mobility instruction. Consequently, the figures that Biggs produced were slightly optimistic at times, but he did not feel that this invalidated the exercise. Nationally, the ratio worked out at 809 : 1, but a very wide variation in workload was revealed, ranging from 235 : 1 in one London borough to 2389 : 1 in one of the shire counties.

Biggs felt that the ratio of 468 : 1 for the London boroughs was impressive compared with the national average, but felt that this is a reflection of their comparatively small numbers of blind people. The largest London borough, with 783 blind people, fell well short of the national average of 989 blind people per authority. Most of the metropolitan districts also have small numbers of blind people, but their overall ratio of 794 : 1 reflects the existence of the larger authorities such as Birmingham, Leeds and Manchester. Biggs felt that the overall ratio for the shire counties, 930 : 1, was something of a disappointment. Obviously, this is partly the consequence of the larger numbers of blind people in the counties - 37 of the 40 counties are to be found among the 59 largest authorities. However, not only do they have more blind people than other types of authority but also they are larger in area, which can have the effect of increasing the proportion of time spent travelling from client to client during the mobility officer's working day.

Biggs' survey shows that there is still considerable room for improvement in the provision of mobility services for visually

handicapped people. The survey showed that even in 1982, fifteen years after the introduction of long cane training, at least twenty two per cent of England's blind people did not have the services of a local authority mobility officer. Biggs pointed out that obviously some of the authorities without a mobility officer on 1 May 1982 were only temporarily in that position but, on the other hand, in many large local authorities the mobility officer or officers are only responsible for part of the area, leaving blind people in other parts of the authority just as lacking in home-based mobility training as if there were no mobility officer at all. Biggs noted that at present there is no way of knowing how many people are affected by this situation, but the numbers will almost certainly exceed considerably the number only temporarily deprived of a mobility service.

It is possible for local authorities to provide some kind of mobility training without actually employing a mobility officer, by buying in expertise, by sub-contracting to a voluntary agency or by sending the blind person to a residential rehabilitation centre. In practice, the first option is very rarely available since most active qualified mobility instructors are already fully committed. The second option does occur from time to time, but there are very few voluntary bodies employing their own mobility officer and they do not really have the resources to provide a substitute for a local authority mobility service. The last option has much to recommend it for general rehabilitation, but mobility instructors working at these centres would be the first to point out that the training they give can be next to worthless if there

is no local mobility officer to complete the training in the blind person's home area.

Although it is clearly nonsensical for very small authorities to employ a full time mobility officer, the question of the level at which the employment of a full time specialist mobility officer becomes viable is yet to be answered. An American study by Welsh and Blasch in 1974 calculated, on the basis of estimates from the directors of a sample of agencies, that about sixty per cent more mobility instructors were needed in the United States, but no attempt was made to relate this to the numbers of blind people.³⁸ In 1976 two surveys by the mobility officer of a London borough, Astrid Klemz, reported that, of the blind people under 70 in that borough, 25.5 per cent wanted mobility training and 52 per cent needed it, while 15 per cent of the over-seventy age group needed some form of mobility training.³⁹ Averaged out over the whole blind population, this would indicate that at least 15 to 20 per cent of the registered blind would profit from receiving some mobility training. The survey carried out by Clark-Carter, Howarth, Heyes, Dodds and Armstrong in Nottingham in 1981, in an area of the country with a tradition of good services to the blind, found that, although at least 30 per cent of the blind people surveyed would profit from mobility training, only 12 per cent had done so.⁴⁰

Because of the individual basis of the training (for safety) and the length of time sometimes required to complete the course (up to three months on a daily basis), a mobility officer's caseload is small

compared with most social workers'. For example, James, who was a typical mobility officer, reported that she had dealt with twenty seven cases in the previous year, eighteen of which involved actually giving some element of mobility training.⁴¹ Biggs points out that a very rough calculation based on these figures and the proportion of new registrations (11.7 per cent in 1980) seems to indicate that a ratio of between 500 : 1 and 700 : 1 may be needed merely to keep pace with new registrations. However, this is little better than a hypothesis, and further research is necessary in this area.

Biggs' figures are all based on the assumption that the mobility officer provides mobility training and no other service. In practice, this is rarely the case, and many local authority mobility officers have additional qualifications and provide other rehabilitation and social services to the visually handicapped people for whom they are responsible. This has the effect of reducing the number of blind people necessary to make employment of such a specialist worthwhile. A more flexible worker such as this would obviously be of more interest to a small authority.

Some general observations concerning the ratio of clients to specialists

The variation in provision for the visually handicapped between local authorities is likely to be attributable to a number of factors, including the differing views that local authorities have of the importance of the respective services that they have responsibility to provide, the shortage of funds created by the cut backs in public spending, and the different ways in which workers in the field of visual

handicap are deployed and supervised. Demographic and regional factors are also likely to influence the provisions of service. Local authority provision could be improved if local authorities employed more specialist technical officers and mobility officers for the visually handicapped, assured that these staff were deployed in the most effective way, and if senior staff in social services departments kept themselves informed of the requirements of visually handicapped people living in their areas, through an appropriate line management structure linking senior staff with specialist skilled workers for the visually handicapped. Local authorities could also take greater account of the facilities provided by other agencies, for example by the Royal National Institute for the Blind and the regional associations, and assure that where appropriate visually handicapped people in their areas have the opportunity to make use of these services. Local authorities should also ensure that the visually handicapped people who live in their areas are fully informed of the services that are available to them, both locally, regionally, and nationally.

The survey that was undertaken by the Southern and Western Regional Association for the Blind concerning the ratio between clients and specialists demonstrated that a good service has been maintained in Birmingham. The Birmingham Social Services Department has provided a valuable service for its visually handicapped clients by establishing a rehabilitation unit for them. I now intend to examine the work of this unit because it provides an important example of a particular type of service delivery to the visually handicapped.

The Birmingham Social Services Department Assessment and Rehabilitation Unit

To lose one's sight is a personal tragedy so complex that the total reality of the experience can never be fully shared by any other person. However, to lose one's sight and not have the opportunity to obtain help from those professionally trained to give it is an additional tragedy which must inevitably reflect upon the quality of local authority social service. As local authorities have a mandatory responsibility to provide services for the visually handicapped, it is crucial that these services are designed to meet the real needs of this client group. It can be suggested that within this context four major needs can easily be defined. First, there is a need to provide a social work service which will enable visually handicapped people and their families and friends to cope with the psychological, emotional and social impact of blindness. Second, there is a need to provide a social work service which will ensure that visually handicapped people are aware of and receive the full range of welfare benefits, both statutory and local, to which they are entitled. Third, there is a need to provide a rehabilitation service which will enable visually handicapped people to cope more effectively with the practical problems of loss of sight. Fourthly, and finally, there is a social need to provide a variety of recreational and therapeutic activities which will help to enrich the lives of visually handicapped people.

Therefore, in developing a service strategy, planners must be prepared to recognise that those who lose their sight are entitled to

the help of understanding and informed counsellors, committed and skilled teachers, and relevant and practical facilities. As was pointed out earlier, there is little doubt that the reorganisation of both the national and the local personal social services in the early 1970's resulted in a diminution of services to the visually handicapped in many parts of the country.⁴² Cliff Vawda is the Senior Assistant for Services for the Blind in the City of Birmingham Social Services Department, and in an article that was recently published in The British Journal of Visual Impairment, Vawda pointed out that in Birmingham, two major difficulties became apparent:⁴³ With the implementation of a generic social work policy social workers became responsible for the care of all client groups. Although their training should have prepared them to deal with the psychological and the social needs of visually handicapped people, the social workers were obviously not equipped to help with the practical problems of blindness. Indeed, in Birmingham it was established that some of them had a very poor understanding of the implications of sight loss. Vawda points out in his article that although it was originally planned to have a social worker for the blind based in each area office, this was not possible due to lack of specialist staff within the Department and the scarcity of appropriately trained people seeking employment. In addition, the blind and partially sighted population was increasing every year. Consequently, services for visually handicapped people were certainly limited. In particular, great concern was expressed over those who had just lost their sight for it transpired that many

of them were not being identified early enough and therefore did not receive help when it was most needed.

Vawda points out in his article that in order to overcome these problems the Social Services Department considered three options. First, it could adopt a policy to expand the specialism in area offices. To do this it would have to recruit staff and second them for either technical officer or mobility officer training. This would have meant that the service for visually handicapped people would be based upon the home teacher model - that is, a specialist worker being totally responsible for the visually handicapped population within a defined area. Second, the few specialist workers already employed by the Department could be gathered into a centrally-based section and work as a specialist team covering the whole city of Birmingham, regardless of area boundaries. This would have meant a departure from the existing policy of an area-based social work service. The third and final option was that the Department could set up a rehabilitation unit which would provide a rehabilitation service for visually handicapped people throughout Birmingham. This resource could then be used as a centre of excellence in knowledge and skill from which services for this client group could be developed.

After discussion it was decided to adopt the third option and to establish an Assessment and Rehabilitation Unit. It was thought that such a Unit would provide a specialist facility which the Department lacked, and a professional foundation upon which other services designed to meet the needs of visually handicapped people could be developed.

Before actually planning the operation and the location of the new unit a great deal of thought had to be given to its main objectives. Initially, two major issues required to be settled - who exactly would the unit serve and how would it serve them?

The Social Services Department decided that the Unit would provide a service for all the visually handicapped in the city of Birmingham. That is to say, those registered blind, those registered partially sighted, and those not registered as either but with a substantial loss of sight.

Vawda points out in his article that to meet the identified needs, four main objectives of the Unit were determined. First, to stimulate within the visually handicapped client the motivation and determination to learn a range of skills which would help to improve the quality of life which blindness can so easily disrupt. Second, to provide visually handicapped people with relevant facilities which would enable them, their families and friends to understand, accept and adjust to the implications and the problems of blindness. Third, to provide social work staff with the opportunity to acquire a realistic understanding of blindness, and through this knowledge to work more effectively with visually handicapped clients. Fourthly, and finally, to provide a focal point within the city where anyone who is involved with the problems of sight loss could seek constructive advice, help and understanding.

It is clear that these objectives were very broad, but nevertheless they created the framework within which the Unit was to be planned.

The question of accommodation was of great importance, because the Department believed that if the Unit were to be set up in unsuitable premises in the wrong location the consequences would be all too familiar - disillusioned clients, dissatisfied staff, and disappointing results. To create an atmosphere in which the first two objectives could effectively be met meant that the actual premises would have to provide no feeling of formality or institutionalisation. The Department decided that the Unit would not be placed in a multi-purpose centre for the handicapped, because it was believed that this type of environment, instead of helping the visually handicapped person, could often add to their stress and confusion. It was agreed that the emphasis should be upon finding a building which was small and could be related to the type of accommodation in which many people live. A variety of properties were looked at, and the Housing Department agreed to allocate two adjoining four-bedroomed town houses, situated near the centre of the city, and close to shops and excellent local bus and train services.

In December 1978 work started on the adaptations and alterations within the premises. It had been agreed that structural alterations should be made downstairs which involved creating a corridor and widening all the doorways to allow wheelchairs to pass through. In addition, two existing toilets downstairs were enlarged so that those in a wheelchair would be able to make use of them. The kitchen was fitted with a range of units designed for use by handicapped people and the equipment included electric and gas cookers and an automatic

washing machine. Apart from a shower being fitted in an upstairs bathroom no other structural alterations were made.

A great deal of importance was placed upon the installation of appropriate lighting, which is very important if visually handicapped people are to make the maximum use of what sight they have. However, none of the staff with the responsibility for building projects had any specialised knowledge of lighting. Consequently, enquiries were made outside the Department, and assistance was given by a constructional engineer in London who had an interest in lighting for the visually handicapped. The Department found that it was not possible to provide a lighting system which could meet the needs of every visually handicapped individual, but it was found that the lighting in the Unit helped the majority of the students with residual vision.

The third very important aspect which was considered by the Department when planning the interior of the building was the importance of colour contrasts and the texture of furnishings. To encourage those with even the smallest degree of vision to use it, it was agreed that the environment should provide the maximum stimulation through decoration and furnishing. The preparation of the scheme took much longer than was anticipated, for it involved reading and evaluating articles, papers and pamphlets on the subject, planning the decoration for the whole building, and selecting suitable furniture, carpeting and curtaining.

When the work on the premises was completed the accommodation consisted of four workrooms - three downstairs and one upstairs, each

with a different colour scheme; a kitchen, a students' lounge, a low vision room, a conference room and an interview/rest room. In addition to this there were two bathrooms upstairs and two toilets downstairs, and four staff offices which double as workrooms for individual study. The thinking behind the interior design of the premises was an attempt to create an informal environment in which visually handicapped people would feel comfortable and relaxed.

While planning the actual function of the Unit much thought was given to interpreting the term Assessment and Rehabilitation. It was considered to be crucial at this stage to define clearly the rehabilitation approach. It was envisaged that the Unit would not provide a formalised programme with every client undertaking the same course over the same period of time. It was recognised that the needs of each client would be different and, therefore, programmes would have to be designed to meet individual needs. In addition, it was appreciated that the client's needs should not be seen in isolation, for within this context the needs of those surrounding the client are equally important. Accordingly, the concept of a rehabilitation partnership was adopted in Birmingham - a partnership between the client, the family and friends, consultants and advisers, teachers and support workers, and the environment. To understand this concept more fully it is worth considering the way in which the rehabilitation partnership was envisaged in Birmingham.

Regarding the clients, the rehabilitation needs of each visually handicapped person will always differ. Therefore, it was recognised

that in preparing the rehabilitation programme these specific needs must be taken into consideration. It was recognised that emphasis must be placed upon those aspects of understanding and skill which will enable clients to accept their loss of sight, and so be encouraged to achieve their maximum potential.

Regarding family and friends, it is important to recognise that the impact of blindness may often affect family and friends as much as the visually handicapped individual. Consequently all rehabilitation programmes must offer an opportunity for the family and friends to receive any necessary help and support. Indeed, the programme at the Unit sometimes includes activities which involve many personal relationships surrounding the visually handicapped person.

Regarding consultants and advisers, in this context these terms refer to the range of professional people which a newly visually handicapped person might encounter. These will include doctors, opticians, psychologists, social workers and employment officers. However, it was recognised in Birmingham that to ensure maximum benefit for the client, each consultant or adviser must be willing to recognise that those in other professions may have an important contribution to make to the rehabilitation programme.

Regarding teachers and support workers, if rehabilitation is defined as the key to independent living, then the role of the teacher is that of teaching the skills required to achieve this. Within this context the word 'teacher' means rehabilitation officer for the blind.

Although they may originate from different professional backgrounds, including technical officer, mobility officer and occupational therapist, each will have a valuable contribution to make. In addition, a great deal of help may be given by the support worker - home help, district nurse, voluntary visitor, and so on. In some situations it is only through the continuous support of these workers that the visually handicapped person is able to stay at home whilst undertaking a programme of rehabilitation.

Regarding the environment, perhaps the most ideal environment in which to undertake a rehabilitation programme is to be living at home whilst attending a specialist unit on a daily basis. In these circumstances, rehabilitation skills can be taught in a controlled environment, and then under supervision they can be put into practice in the client's own home.

It was within this formula of the professional partnership that the basis for individual programme planning was established in Birmingham. The major factor in planning programmes was that consideration would be given to using a variety of specialists outside the Unit itself. The philosophy behind the rehabilitation approach which the Department has adopted is to utilise any possible professional or other support which may enable the individual visually handicapped person to live a fuller and a more independent life.

The Birmingham Social Services Department Assessment and Rehabilitation Unit in Edgbaston in Birmingham became operational in September 1979 under the direction of Cliff Vawda, who is the Senior

Assistant for Services for the Blind. Although Vawda is based in Central Office, he is responsible for the overall development of the project. It had been agreed that there should be four professionally trained staff - a senior and three rehabilitation officers for the blind. In fact the Unit opened with three staff - the senior and two rehabilitation officers for the blind. Although the staff are trained in rehabilitation techniques relating to visual handicap, it is recognised that they will not necessarily have all the skills to deal with certain problems. In this situation it has been possible in Birmingham to put into practice the theory of the professional partnership. This means that the rehabilitation approach provides a more comprehensive programme than might be anticipated.

At the Unit it was accepted that rehabilitation, to be efficient, could not be taught in a group situation, and therefore it was decided to adopt a ratio of three students to one member of staff. However, it has been found that it is not always possible to adhere to this ratio, for it has been found that there are times when students with additional problems or disabilities require a great deal of individual attention. Under these circumstances it is necessary to reduce the number of students attending.

Vawda points out in his article on the Unit that the effectiveness of the one-to-one teaching approach has proved to be extremely beneficial, both to the student and the staff. It enables the student to settle very quickly and to build up an immediate positive relationship with each member of the staff. When social workers refer

students to the Unit they then become outside members of the rehabilitation team. The practice of referring clients to a day centre and then forgetting them for six or seven weeks is totally alien to the whole rehabilitation approach. Therefore each student is brought to the Unit for an introductory visit by his or her social worker. If it is felt appropriate, the student is encouraged to bring any member of the family, or a friend, on this visit. The introductory visit is considered a crucial part of the rehabilitation process, because it enables the member of staff who has been delegated as the key worker to make an early assessment of the student's needs. It also enables the potential student to see the Unit and to decide whether it would help him.

In planning the Unit, it was recognised that the Social Services Department would have to provide transport. Consequently, all students are initially transported by taxi. If they are able they are taught during their programme to travel independently to and from the Unit by public transport. Originally, students attended the Unit on a full-time basis five days a week, but in the early 1980's this was changed to four and a half days. Although the students' working day is from 10 am until 4 pm the staff found that there was not sufficient time to evaluate and plan their work before the students arrived or after they left. Therefore it was decided to set aside one afternoon a week during which the staff could discuss new referrals, evaluate and plan students' programmes and consider other issues relating to the operation of the Unit. At these weekly meetings, the individual

nature of the work is highlighted, for the staff are able to consider in detail the progress of each student, and adjust the programme accordingly.

Vawda notes that the average length of the programme at the Unit has turned out to be five weeks, although no time limit is placed upon a student. As individuals have their own pace in coming to terms and coping with blindness, it is felt at the Unit that flexibility in the amount of rehabilitation which they receive can mean the difference between failure and success. One of the main objectives of rehabilitation should be to give the student a feeling of worth rather than deficiency. Every student has at least one case conference arranged during his or her programme. At this case conference the Unit staff, the student's social worker and any other person directly involved with the student's future, discuss the student's progress. The student is always invited to attend at some point during the conference to become involved in the discussion. These conferences allow those involved to assess the value of the rehabilitation programme and to set realistic goals for the student's future.

The model which Birmingham Social Services Department has adopted has proved to be very successful since it was introduced in 1979. It enables visually handicapped people to receive a rehabilitation service within the continuity of their lives. It also involves their families and friends in the adjustment process that is required to cope with visual handicap, and by so doing has increased

their understanding of the frustrations and difficulties that are caused by sight loss.

The success of the project in Birmingham can largely be attributed to the quality of the staff who are committed to the concept of such a rehabilitation model. The main problem which has arisen has been caused by limitations on the number of staff. Vawda has pointed out in his article on the Unit that between 1979 and 1983 there were over four hundred referrals to the Unit, and a waiting list has inevitably developed. As a result, it is not always possible to take a student at the most appropriate time.

In the original concept it was intended that the Unit should provide an information service on all aspects of visual handicap for staff within the Birmingham Social Services Department and for those who are interested in blindness. However, because of the staffing situation it has not been possible to set up this service, but it is hoped that in the future the Unit will be able to extend its activities to meet this particular need.

The Birmingham Social Services Department Assessment and Rehabilitation Unit has proved that it is possible for a local authority to provide a rehabilitation service which can both enrich and improve the lives of the visually handicapped. This has been its central contribution.

Penelope Shore's recent study of local authority social rehabilitation services to visually handicapped people

Dr Penelope Shore's report, Local Authority Social Rehabilitation Services to Visually Handicapped People,⁴⁴ was commissioned by the

Study Group on Rehabilitation, which was set up under the Chairmanship of Fred Reid by the Royal National Institute for the Blind in 1982. The survey on which the report was based covered nineteen local authorities in England and Wales responsible for the provision of social services to visually handicapped people. These nineteen authorities were chosen as a stratified random sample.

Dr Shore's report, which was published on 3 June 1985, deserves the closest attention by all those engaged in determining policies for the social rehabilitation of visually handicapped people. There are two reasons for attaching importance to it.

First of all, it offers the most authoritative picture to date of the enormous variation in standards of provision of social rehabilitation for visually handicapped people, and it proposes a theory, based on the statements of those managing the services, which attempts to explain why these variations exist. Since the creation of generic Social Service Departments in the wake of the Seebohm Report of 1968, evidence has been accumulating on the inadequacy of rehabilitation services for the visually handicapped in many areas and the unacceptable variation in standards of provision. Dr Shore's report provides authoritative corroboration for this evidence. It points to unacceptable delays in the registration procedures which are the essential preliminaries to the initiation of rehabilitation services. It substantiates existing evidence of wide variation in the numbers and calibre of Social Services Department staff responsible for assessing the needs of

visually handicapped people and providing rehabilitation services for them. Most strikingly perhaps, it identifies a very low level of provision for people over the age of sixty-five, and suggests that ageist attitudes result in discrimination against elderly visually handicapped people in respect of the quality of the rehabilitation service they receive. Only 21 per cent of the local authorities surveyed by Dr Shore appeared to have reached an acceptable standard of rehabilitation service, and the evidence presented to Dr Shore on future plans suggests that in areas where provision is already poor, the situation is likely to deteriorate further.

Dr Shore's report does not stop short at description - it offers a theory, based on the statements of Social Services Department management and fieldworkers, which attempts to explain why these variations exist. It suggests that Social Services Department staff often attach a low priority to visually handicapped people compared with other disadvantaged groups for whom they are responsible. That visually handicapped people should be perceived in this way may stem from uncertainty as to the precise obligations laid on local authorities by legislation, as well as from the absence of effective pressure by and on behalf of visually handicapped people. It may also be that deficiencies in the training of specialist workers for the visually handicapped, and especially the lack of a unified national training programme, lead to these specialist workers being perceived as having a lower status than other Social Service personnel with other qualifications. But

Dr Shore's report also points to the existence of managerial deficiencies which compound these shortcomings. Many areas are not only woefully lacking in specialist workers for the visually handicapped but also possess no strategy for remedying this deficiency. In all too many areas there are no arrangements for the effective monitoring of rehabilitation services by Social Services senior management, and in many cases there is no clear line of managerial responsibility for services to the visually handicapped from the Director of Social Services to the Social Worker in the field.

The second reason for paying close attention to Dr Shore's report is that it recommends the Royal National Institute for the Blind to take action to improve the quality and the availability of rehabilitation services to visually handicapped people at a local and regional level. This recommendation, which has been accepted by the RNIB's Rehabilitation Study Group, would represent a major re-orientation of the RNIB's services. Evidence accumulated by Dr Shore shows that Social Services departments and visually handicapped people themselves prefer to see rehabilitation services provided, as far as possible, in or within reach of the client's own home. The widespread existence of this preference accounts, no doubt, for the very low take-up of places on the residential social rehabilitation course offered by the RNIB at Clifton Spinny until 1983. Dr Shore urges, and the RNIB's Rehabilitation Study Group has recommended, that the RNIB's future role in social rehabilitation should lie chiefly in helping local authorities, regional associations

for the blind, local voluntary bodies, and National Health Service staff, as well as the Department of Health and Social Security, to bring local services for the visually handicapped up to an acceptable standard.

Dr Shore's report contains a number of specific recommendations concerning the way in which the RNIB might try to bring this improvement about. The most important of these is the setting up of a pilot project in two or three local authority areas, to be called a Rehabilitation Consultancy Service. This service, provided by trained RNIB staff, would aim at assessing existing services and assisting the local authorities to improve them by providing appropriate information and advice, and by co-ordinating voluntary and statutory bodies, both at a local and national level. However, the Rehabilitation Consultancy Service will be intended to support and in not in any sense to replace the roles of these bodies.

If successful, the proposed pilot project should yield important short term and long term results. In the short term it should foster the improvement of staffing levels of specialist workers, increase and improve the quality of services to elderly visually handicapped people and speed up registration procedures by fostering co-ordination between various professional groups. In the longer term the RNIB might envisage the establishment of national minimum standards for the provision of social rehabilitation services to visually handicapped people, offering each newly registered person a rehabilitation plan, drawn up in the light of his or her individual needs and delivered

as appropriate in his or her own home, at a day centre or, in some cases, at a residential unit within reasonable reach of his or her place of residence.

The Royal National Institute for the Blind has accepted the recommendations of Dr Shore's report and in October 1985 Ian Bruce, the Director-General of the RNIB, announced that the proposal for the establishment of an RNIB Rehabilitation Consultancy Service is being widely welcomed among local authority departments and the idea will be tested in two or three pilot areas prior to a national launch. The new consultancy service is being given a high priority by the RNIB, and it is one of the thirty-three projects recently approved under the RNIB's new £25 million development programme.⁴⁵

The importance of self-help and peer-counselling

In her study of the social rehabilitation services that are offered by local authorities, Dr Penelope Shore found some evidence of self-help among the visually handicapped. She found that self-help groups had come into being as a result of peripatetic rehabilitation courses in one rural authority (E), though in the other comparable authority (D) the specialist fieldworker's proposal that members of a particular course should form their own self-help group had met with no tangible response. Dr Shore found that in one of the urban authorities providing day centre rehabilitation (N), particular efforts had been made to instigate a self-help group for younger visually handicapped people, but the initiative had failed, apparently through lack of interest amongst the younger people themselves. The

challenge posed by the question 'what happens after rehabilitation?', had received a positive response from one urban authority providing day centre rehabilitation. In this authority (R) the establishment of specialist workers in visual handicap had been extended by the appointment of an Activities Organiser, whose responsibilities included the initiation of self-help groups.⁴⁶

Overall, however, Shore's survey revealed little evidence to suggest that local statutory rehabilitation services in Britain had been influenced by the recognition given in the United States to self-help and peer-counselling as integral aspects of rehabilitation. It may be that the work of agencies such as the American Foundation for the Blind, the Vision Foundation, the Santa Monica Centre for the Partially Sighted, and the Arkansas Rehabilitation Research and Training Centre had not become sufficiently well known in this country when the fieldwork for Shore's survey was carried out in 1983. The appearance of a number of articles and publications relating to the role of self-help and peer-counselling in rehabilitation may by now have stimulated greater awareness of these issues.⁴⁷

Two well established self-help rehabilitation groups do exist in the south east of England, at King's College Hospital in south London and in Chelmsford, and they provide good examples of the value of self-help which other parts of the country could emulate.

Mary Todd, a counsellor, E. W. G. Davies, a consultant ophthalmic surgeon, and I. S. Kreeger, a consultant psychiatrist, have established a self-help group for visually handicapped people

in the Ophthalmology Department within King's College Hospital, London.⁴⁸ Since 1979 they have been studying the needs of patients in work which has evolved from both patients' action and emotional, psychological and intellectual needs. The study combines professional intimate knowledge with practical experience in counselling and group work. Todd, Davies and Kreeger are concerned with the care and counsel of newly registered patients, particularly diabetics. Many of these patients are moving towards the end of life. In April 1983, at the request of the Ophthalmic Surgeons, with the approval of the District Health Authority, King's Edward's Fund for London gave recognition to this work. They agreed to fund the appointment of Mary Todd as co-ordinator in order to authenticate for general use a self-help project for visually handicapped patients, initially for three years. Todd hopes to show that rehabilitation of newly registered patients is improved and accelerated in group work where patients help each other to overcome depression and move towards a forward look in coping with loss of vision. During 1983 there were seminars and talks with consultants, clinicians, nurses and medical staff within the hospital. As a result of patients' communication with social workers, an exploratory training group for the visually handicapped has been running since November 1983. Todd hopes that the development and growth of the work will be evaluated as time goes on. She believes that benefits to patients, families and professional workers includes an improvement in the care and understanding of a visually handicapped patient; the relief

of suffering and isolation; the restoration of self esteem, and patient participation; an improvement in rehabilitation, reeducation and the flow of information to the visually handicapped participants, and the innovation of new methods of communication. The work at King's College Hospital is a pioneering venture, and there is no other similar work within the National Health Service. In the future more self-help projects for visually handicapped patients in other hospitals should be established, because the participants can gain much from being members of such a group.

In August 1985 Guideline, the weekly programme for the visually handicapped on Radio London, reported on the self-help group in Chelmsford. In Chelmsford the visually handicapped have received little assistance over the past few years from the statutory authorities and so they have set up their own rehabilitation centre, where they now teach each other braille, handicrafts and touch typing, and discuss any other problems associated with visual handicap. The group have been lent a room by Age Concern, where they meet once a week from ten o'clock in the morning until four o'clock in the afternoon. What is amazing is that the social services throughout the country do not make use of the blind in the community to teach the newly blind. If the social services provided a room and facilities then a blind person could more easily teach a newly blind person all the skills that they need to know. As well as the educational aspect, such groups would also provide a suitable forum where visually handicapped people could help each other to overcome their depression and move towards a forward look in coping with the loss of vision.

Elderly people and visual handicap: Some issues for social service provision

This section begins with a familiar statement, which does not need elaborating but which is of great concern - that many elderly people with visual impairment receive little help from social service departments and are often not well looked after by the health services. It is also widely acknowledged that the relevant voluntary organisations for visual handicap did not, until recently, focus sufficiently upon the needs of elderly people although there are some welcome signs that this is now changing.

About three quarters of the registered blind in the United Kingdom were in 1980 over the age of 64 and more than half are aged 75 or over. According to estimates of prevalence, there are between 1 to 2 elderly people registered blind per thousand of population. This, however, takes no account of two factors; first, that many elderly people with substantial visual impairment, may be as many as two thirds, will not be registered as blind and secondly, that the distribution of the problem is uneven across the country for reasons which are not fully understood. In Dr Shore's study on local authority services to visually handicapped people, it is pointed out that elderly people with visual impairment are over-represented in areas of urban deprivation and in those with high numbers of black people. The relationship between these factors is not clearly understood and further research is needed. It illustrates, however, one of the central dilemmas for service provision, namely the balance which is needed, and difficult to achieve, between special

concentration on visual impairment as such, on the one hand, and, on the other, an awareness of the elderly person as a whole person, physically, emotionally and socially. For example, put bluntly, if an elderly person is blind, black, living in an inner city, alone, that conjunction will have significant implications for what help is needed.

This association of factors is further and crucially illustrated by the fact that so many visually impaired old people have other major disabilities. In her study, Dr Shore found some 78 per cent of her respondents were affected by one or more disabilities in addition to blindness, although, interestingly, 91 per cent considered sight loss to be their major handicap. This finding is slightly at variance with comments made by Cullinan, who suggests that a substantial proportion perceive other disabilities to be more significant in affecting their quality of life.⁴⁹ Be that as it may, a glance at Dr Shore's table gives the familiar picture of these disabling diseases; arthritis and rheumatism top the list, with diabetes, heart disease and hypertension making up the next largest groups. The interaction of disabilities as it affects the life style of elderly people and limits what can be done to help them is clearly crucial, and a fascinating area for further study. Dr Shore's survey did not include those visually impaired elderly people with a substantial degree of mental frailty. This was because the study depended on the respondent's own views. However, since 1 in 4 elderly people over 80 can be expected to have a substantial degree of mental

frailty, the interaction of this disability with visual impairment is clearly another major issue.

Two further points about the population which is the focus of this section: about one third of all visually impaired people live alone. It is obviously likely that living alone will be over-represented in the elderly population so it is not unreasonable to suppose that probably half of those elderly people who are visually impaired live alone. That has major implications for service provision, whether practical, psychological or social. Secondly, large numbers of the elderly visually impaired will be women. This has a range of implications, from the fact that women have traditionally been less assertive about their rights and their needs, to the evidence from the Equal Opportunities Commission that where middle-aged women (as distinct from men) are looking after frail elderly people, the authorities are less likely to provide a range of supporting services.⁵⁰

When all this is added up, plus the fact that the visual impairment in question is often of a gradual and insidious kind, the case for viewing the position of these elderly people as a whole rather than primarily focussing on visual impairment seems strong. In so many ways they form part of a large, growing population about whom health and social services are rightly so concerned. That is not, however, to suggest that their well-being cannot be substantially enhanced by help in the area of visual impairment.

What, then, are some of the issues which need to be addressed if we are to be more effective in helping this group of people?

First, and quite fundamental, must be a consideration of our attitudes to, and expectations of, elderly people. In her report Dr Shore refers to agism; that process by which, by categorising and labelling people, we develop negative stereotypes. It is very important to acknowledge this and combat it. There is a sense in which no amount of professional and organisational effort will succeed if basic values and beliefs about ageing are not tackled. Agism is expressed through such awful words as 'what can you expect at your age?', a phrase beloved of some doctors, which can in effect be a cover for medical incompetence. Indeed, Dr Shore found that many elderly people colluded with this, assuming their degenerative eye disease to be in some way just a consequence of their old age.

Secondly, assumptions about ageing pervade the whole of our approach to rehabilitation and to programmes of treatment. Of course, it would be foolish and counter-productive to ignore the limitations which old age, and some associated disabilities, impose on some individuals' capacity to respond to such programmes. That, however, is an entirely different matter from a blanket assumption that the opportunities to learn and to adapt offered to younger people are inappropriate for the old. Much, much more needs to be learnt about the capacities of elderly people to benefit from such help.

The attitudes of the helpers will be crucial in such attempts. In this connection, one notes with regret that in Dr Shore's description of innovatory work in the field of visual impairment generally, there was only one example specifically concerned with elderly people in a survey of 19 local authorities. Clearly, we have a long way to go.

Before leaving the issue of attitudes to ageing, one must distinguish between agism and more subtle complex fears and anxieties. It is not agist to acknowledge that there are unresolved ambiguities in the position of elderly people in British society today. It is more difficult for elderly people to find their place in a society in the midst of rapid technological change and with a high degree of geographical and social dislocation. It may well be that some of the reluctance amongst professionals to engage fully with the needs and the problems of elderly people reflects their own anxiety about the process of ageing as it may affect themselves. Certainly, it is not uncommon to hear social workers describe work with elderly people as 'depressing'. This may on occasion be so and it would be foolish to deny it. Yet it may also reflect a lack of imaginative grasp on what it is like to be old because the workers have not been there themselves.

All these matters have profound implications for education and training. Simply to increase teaching on gerontology and the social aspects of ageing without examining further the attitudes of society, including the helpers, towards old people, will not produce the climate of realistic optimism desirable for the future development of services. It is to those aspects of service provision most relevant to elderly people with visual impairment that we now turn.

It is important to consider the relationship between health and personal social service provision. Of the structural division between health and personal social services, most of us would have to say, with the Irishman when asked the way, 'if I were you I wouldn't start

from here'. The structure that we have is in many ways incompatible with the development of comprehensive services appropriate to elderly people's needs. The divisions are particularly unfortunate for the elderly visually impaired; for example, they bedevil the whole process of registration which is so contentious. However, we are saddled with this structural division for the foreseeable future. Rather than bemoan it, one can point to some critical points in the system for which improvements should be earnestly sought which are not unrealistic.

The first concerns primary health care and the creation of age/sex registers by general practitioners. It is hard to over-emphasise the importance of this development, which is still highly variable and which, of course, general practitioners cannot be obliged to set up. Without these registers, access to preventive health care for the elderly population is extremely difficult. The implications for elderly people with developing visual impairment are obvious. The existence of the register does not in itself ensure appropriate help but it is a prerequisite to it. The appointment of nurses in some practices with a specific remit to follow up elderly people on the register is to be welcomed. So are 'pensioners health groups' which are springing up in various parts of the country. The evidence of undetected remediable health problems is overwhelming and preventive activity of this kind has great potential both for the well-being of elderly people and for the reduction of dependency in later years.

Another illustration of the possibility of a more constructive relationship between health and social welfare than has existed in the past concerns the beginnings of comprehensive assessment, undertaken jointly by health and social services. This is important at certain critical times. For example, when applications are made for day or residential care, an opportunity is presented to review the strengths and needs of elderly people as a whole. It is likely that at this point remediable health problems will sometimes emerge which, once treated, will substantially alter the prognosis for that person. This notion of joint assessment is far from general but at least it is under discussion. So also is the possibility of having a more systematic and extensive input from health services into day and residential care provision by social service departments. However, one must add a word of caution; it is obviously important to keep these health matters in proportion so that we do not 'medicalise' old people. Indeed, the very fact that the provisions are separate may perform a useful corrective function in this respect. A view of elderly people, however, which ignores the mounting evidence of undetected health problems does little to help them sustain their dignity and independence in old age.

It is important to consider the organisation of services within the personal social services. It is well known that provision between local authorities is highly variable in quality and quantity, that there are different patterns of service delivery across the country and that in general a low priority has been accorded to work with the visually

handicapped and with elderly people. In fairness it must, however, be said that there has been a welcome change with respect to the last, since the study which Parsloe and Stevenson undertook in the mid 1970's, which drew attention to the neglect of social work with elderly people.⁵¹ Despite many competing pressures and priorities, there are indications that social workers are wanting to redress this balance.

This client group, the elderly visually impaired, offers an excellent illustration of issues surrounding the specialist/generic debate. Given the characteristics outlined earlier, it would be quite inappropriate to isolate their visual impairment as the main focus of attention. Hence it is probably sensible to envisage a partnership between locally based social service teams, whether patch or specialist, and a centralised specialised input concerned with visual disability. At present, the position across the country is, however, highly confused because of the variations in patterns of delivery and uncertainty as to their relative merits. Although much has been written about patch teams, it is not always realised that quantitatively this has been matched by developments in specialist teams. Many local authorities have, almost secretively, formed specialist teams, sometimes for the elderly alone, sometimes for the elderly and the handicapped. This is not an appropriate place to embark on a debate about the relative merits of the different models. It is important that the expertise in visual impairment is located strategically within the departments and can be readily

identified by the teams serving elderly people. The experience of the past fifteen years shows quite clearly that a degree of specialisation is essential if needs for particular services are to withstand competing pressures and priorities.

We await, with rumour and counter-rumour, a Green Paper on the future of the personal social services. Whether this emerges, as had been anticipated, within the next few months is now less certain. However, the Secretary of State's address to the Association of Directors of Social Services in 1984 indicated in what ways his mind was working. In that speech, reference was made to strategic planning as a future role for social services departments. The implication was that departments would offer much less direct service and be more concerned with ensuring that services were provided, whether by themselves, the voluntary or the private sector. If these ideas were to be followed through, the role of local authority departments would be dramatically changed and there would be major implications for staffing. The matter cannot be fully explored here. In particular the development of the private sector raises complex and contentious issues. These are already becoming apparant in the rapid growth in private residential care for elderly people. So far as the voluntary sector is concerned, the past history of provision for the visually impaired has, of course, depended heavily on the contribution of the voluntary organisations. In this sense, the Secretary of State's ideas may not be unwelcome. Nonetheless, it is necessary to think out carefully the distinction

between voluntary activity as a pressure group, with perhaps some limited service provision, and as a major provider of services contracted out by local authorities to voluntary organisations. It is arguable that such a trend would accord ill with policies of 'packages' of community care, carefully planned and monitored, which lie at the heart of service provision for this client group. One can distinguish the elderly visually impaired and their multiple needs from those traumatically blinded who may well be served by small, highly specialist local organisations who are interested in specific disabling conditions. It is important that, in the debates which will follow the Green Paper, if it is published, workers with the visually impaired, especially those in the voluntary sector, consider carefully the merits of a radical change in structures such as has been mooted.

As has already been suggested, structures and systems without adequate education and training are fruitless. The outcome of CCETSW's proposals that there shall be 'one qualifying award in social work' is not yet known. If we assume, however, that the distinction between CQSW and CSS will before long disappear (most people agreeing that the present distinction was not sustainable) this leaves for another stage in the debate the critically important question - what additional or different training is needed which cannot be reasonably defined as social work?

Whatever is done about basic or formal postqualifying training, there will be a continuing need for staff development

programmes. In the present staffing stringency, the availability of key specialist staff for consultation, to advise and develop programmes for staff is obviously crucial. For example, one would like to see such key staff regularly visiting old people's homes and day care establishments, both of which are bound to have a proportion of elderly clients with poor vision. This is an area in which it is easy to see a contractual arrangement by a local authority with a voluntary organisation being of particular value.

This section of this chapter has ranged over a number of areas widely and somewhat superficially in an attempt to show how both the needs and the problems of visually impaired people and the services which seek to help them interact in a variety of complex ways. Even so, it is a blinkered view since the well-being of such people is bound up with social provision generally, of which health and social care are just a part. Thus, housing and transport policies will be of significance in all these matters. Above all, social security provision stands as an essential background to all other services. It is to be hoped therefore that all those who work with and for elderly people will take a keen interest in the present proposals for change in the social security system, in particular in the debate about pensions, the outcome of which will affect fundamentally the security of future generations of old people.

The problems arising from visual impairment have to be considered in relation to the position of elderly people both in general and in individual cases. The personal social services

which are offered to such people cannot be effectively planned in isolation. They are critically affected by overall departmental strategies which, in turn, interact with other social services, notably health and with other sectors of welfare, voluntary and private. Progress will only be made if these links, boundaries and relationships are further explored.

Some important points concerning the need for services among the visually handicapped

About the fact that services are needed, there can be no dispute: the dispute is about how one quantifies and qualifies that need. It is a dispute which is difficult to resolve, because it requires an intimate professional knowledge to do so. That means a degree of knowledge which is likely to go hand in hand with what some people would regard as an entrenched, possibly prejudiced, view as to how the need should be quantified and qualified.

The Department of Health and Social Security absolves itself from any responsibility in this task by saying, to quote a former Junior Minister, that

'our view has always been that it must be for local authorities themselves to determine need and to decide what provision of services would best meet that need.'

However, in addition to declining to quantify and qualify the need, the DHSS has also refused in the recent past to offer any guidance as to how the task should be done. In 1983, the DHSS undertook an exercise to try to fill gaps in its knowledge about service provision and current practice around the country, hoping

'to learn about examples of good services and especially about effective co-operation and co-ordination among these services and between them and other services.'

In the letter from which this passage is quoted, the DHSS is referring to the services provided by

'primary health care, community health services, low vision services, local authority social services, voluntary services for visually handicapped people (and) ... the hospital ophthalmology service and general ophthalmic services.'

For this purpose the DHSS arranged visits in 1983 to a few selected areas to get the views of people working there about effective co-operation and co-ordination. It is understood that this is to be the basis of a DHSS report to its ministers.

But, what is considered to be good practice by the practitioners is not necessarily what the clients need.

Let us take as an example the recent situation in London - the nation's capital. In 1983 the London Broadcasting Corporation, a local commercial radio station for the London area, reported on the provision of services for the visually handicapped there. 30,000 registered blind people live in the London Boroughs. That is 30 per cent of the total number for England. In round figures there are 60 specialist workers (mobility officers, technical officers or former home teachers) in the London Boroughs, which amounts to one specialist for every 500 registered blind people. However, some London Boroughs have no specialists at all while one at least (at the last count) had one specialist for every 200 registered blind people. Where there is such a wide discrepancy, can it truthfully

be said that the need is being correctly determined by all the local authorities?

In nearly every case the truth probably is that the needs of individual clients have not been assessed and determined.

The assessment of the different needs of individuals - or for practical purposes groups of them in so far as they can be grouped - is fundamental to the development of a proper training programme. It was hoped that the Independent Special Option in Visual Handicap would provide Social Services Departments with the sort of trained specialists that they require. The disappointing take-up of the option - one or two likely candidates a year until the end of the 1980's - suggest that the Social Services Departments wanted something else, for they perceive that the needs of visually impaired people will not be met by fitting current training into one option of the CSS.

But what local authorities want and for whom, is still uncertain.

Take, for example, the teaching of people to teach braille.

A recent survey, conducted on the inspiration of the Association for the Education and Welfare of the Visually Handicapped, showed that few of the people trained to teach braille to adults spent any long period of time subsequently doing so. It should be possible, as the end result of any training plan, for any individual anywhere to learn braille; but it should not be necessary to train every specialist everywhere to teach it. When seventy-five per cent of the registered blind are 'old old', braille tutors, like mobility instructors, are highly specialised people who are unlikely to be frequently used.

Even so, mobility and the use of braille are important minority needs which must not be overlooked.

The needs exist but they must be got into proportion.

Other minority needs exist. Two are worth mentioning because they have begun to be realised after many years of apparent neglect. The first is the need of multi-handicapped blind people in hospitals for the mentally handicapped. The Southern and Western Regional Association for the Blind's Committee on the Multi-Handicapped Blind established some years ago that there were visually impaired people in mental handicap hospitals who should never have been admitted in the first place. They are not mentally handicapped: they are just visually impaired. But in addition there are others who, were it not for their visual disability, would be qualifying now to leave hospital and to be cared for in the community. The Royal College of Nursing has decided to see what training should be given to hospital staff, at all levels, to ensure that visually impaired people can profit from the government's policy of 'Care in the Community'. The second need is affected by the training that the Guide Dogs for the Blind Association provides for future owners. That training has, in the past, been regarded as isolated from main stream rehabilitation and mobility training. It looks as if an attempt will soon be made to bring it in from the cold - to link it in with the training that is being done elsewhere and with the total education experience from the cradle to the grave.

For education never stops, although its intensity may vary.

Margaret Ford, who is well known for the part which she plays in

the BBC radio programme In Touch and who also works for the Social Services Department in East Sussex, has remarked that in her patch more than half the registrations occur in the last three years of life. That is a frightening observation. However, it is one which underlines the issue of need. As the participants at a conference on visual impairment in old age pointed out in 1983, it is not necessary to employ an individual fully qualified in every aspect of work with the visually impaired to deal with the need of such old old clients.⁵² But it is necessary that anyone working with them should know something about visual impairment and as much again, or more, about old age.

Given such knowledge on the part of the worker, there is some hope that the individual's needs will be met.

From the cradle to the grave there is a great variety of needs, to meet which training in every aspect of work with the visually handicapped should be both available and taken up. The previous 'all-or-nothing' attitude of the trainers has prevented an effective and comprehensive take-up of training opportunities. It is to be hoped that the organisations for the visually handicapped are about to break this mould and to share their skills amongst all those who can use them to satisfy the client's needs.

In conclusion: Some implications of Paper 20.3

In July 1984 the Central Council for Education and Training in Social Work made the decision that 'there would eventually be a unified system of qualifying awards in social work'. Since then, at the

beginning of 1985, CCETSW published in paper 20.3 its propositions for qualifying training towards this end. This marks the conclusion of an attempt to persuade people that the CQSW and the CSS were qualifications which were different but equal, for paper 20.3 implies as much when it talks of the 'frustrations and problems posed by the distinctions between CCETSW's existing qualifying awards'. Although in many areas of work local authorities seemed inclined to accept that the practical nature of CSS training made it more valuable to them than CQSW training, CQSW holders were sufficiently influential to ensure that theirs was regarded as a superior qualification. The Council has set itself the task of redressing this imbalance 'eventually'.

The three training bodies working in the area of visual handicap have during the last decade provided at Leeds or in London training, which was always considered to be of a temporary nature, for technical officers and at Birmingham training, which is considered worldwide to be of an exceptional standard, for mobility officers. In April 1981, as an attempt to combine these two strands, they published an independent special option which could be grafted on to the CSS. It was longer than other special options; it did not fit in with what local authorities wanted; the question of costs was not settled; it did not take off. But, more importantly, it was linked with the CSS rather than providing an integral part of it. Local authorities which wanted their employees to study certain aspects of the specialism as part of their CSS found that the independent special option allowed for them to study all or nothing. For example, a day care worker

who did not need to study braille would have been obliged to do so. Just as CCETSW has come to realise that there should be a single qualifying award in social work, the training bodies in the area of visual handicap must accept that their contribution to that qualifying award should be an integral part of it.

Paper 20.3 is searching for the way to provide a qualifying training system,

'sufficiently flexible to adapt to changing demands while maintaining its basic integrity as professional education.'

That is to say that, although demands on the individual employee will be varied depending on his exact job, in field or residential work, in day care, in domiciliary work, in community care, for a local authority, a voluntary agency, in probation services or the private sector, the reaction to them should have a common basis. Moreover, whatever the area of work, there will be a demand (more limited in some areas than others) for some employees to have an expertise in visual handicap.

It is not suggested that all qualifying training should contain an element of training to work with visually handicapped people. CCETSW is maintaining that, if there is one qualifying award in social work, employers and the public will be able to assume a minimum level of knowledge and competence in all holders of that award, but not that they have identical areas of skill. It is the task of the three training bodies working in the area of visual handicap to provide the element of special expertise in visual handicap expected of the

worker wherever his workplace, if that element is required. Its exact form will vary to suit the worker and the workplace.

Nor is it meant to suggest that the only thing the three training bodies have to do is to contribute to the CCETSW qualifying award. They must still train specialists to a more elaborate extent than CCETSW qualification would require, because local authorities will want it. They should be prepared to arrange suitable training at any level on any aspect of work with visually handicapped people.

The training that the three training bodies working in the area of visual handicap have provided in the past has been too inflexible. The same would have applied to the independent special option which was just the sum of past specialist training. It was an attempt to ensure that one individual could react appropriately to a range of clients, some of whom might have been totally blind from birth, whereas others might have suffered a sight impairment at any stage of life thereafter. There is still a need for such an omni-competent specialist. However, there is an equally important need that the training bodies should provide those elements of special expertise, whenever they are required in the future qualifying training of social workers.

Before they do so all three of the training bodies working in the area of visual handicap must get their own acts together. In the period that led up to the publication by CCETSW of paper 20.3, the National Mobility Centre, the North Regional Association for the Blind and the South Regional Association for the Blind reached

agreement about the closer integration of the specialist training that each one is providing. This was very timely in that it coincided with CCETSW's publication of its propositions about policies for qualifying training. The three training bodies working in the area of visual handicap should reap the advantage of that coincidence by providing as and when required the element of special expertise which the Council's future qualifying courses may require. The three training bodies working in the area of visual handicap cannot afford to remain out in the cold. Moreover, the three training bodies working in the area of visual handicap do an injustice to the people whom they train and those for whom they train them by not allowing themselves to swim in the mainstream of social work.

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- a) a social work service ... for people living in their own homes, at centres or elsewhere
 - b) facilities for social rehabilitation ... including assistance in overcoming limitations of mobility and communication
 - c) ... facilities for occupational, social, cultural and recreational activities ...
 - d) for keeping of registers ...
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CHAPTER EIGHTTHE ELDERLY PERSON WITH
FAILING VISION¹

Failing sight and hearing are two of the central problems faced by people in retirement. This point is sometimes emphasised by pensioners when they discuss the personal problems that confront them in their daily lives. For example, Mary Stott, a retired newspaper journalist in her seventies, has observed that: 'It is the deterioration of ... sight and hearing that is the major problem for most of us.' She notes that the decline of sight and hearing is often very gradual and recalls that

'at first you find yourself leaning forwards to catch what people are saying, choosing the front rows of the meeting hall or the church, saying to the telephone caller "Please speak up; this is a very bad line." Then, perhaps you transfer the receiver from the left hand to the right, and discover that it is not the line that is faulty, but the left ear. You find it increasingly difficult to read street names and bus numbers and to recognise acquaintances until they are practically within hand shaking distance.'²

Prevalence and consultation

Empirical research has shown that many elderly people in Britain have failing vision. In 1976 an investigation into some aspects of visual handicap by Abel indicated that 60.5 per cent of the registered population with visual impairments were over 65 years of age while 37 per cent of these people had at least one additional handicap.³ More recently, Goldacre showed that, of all new patients referred to out-patient departments in the Oxfordshire Regional Health Authority area, 14 per cent between the ages of 65 and 74 and 29 per cent over 75 years were sent to eye departments.⁴

In 1946, before the foundation of the National Health Service, Dr. Sheldon had shown in a random population survey of elderly people that failing vision was a serious problem and 30 per cent of those surveyed had unsatisfactory spectacles, 82.5 per cent of the glasses had come from hospital ophthalmic departments, 17.5 per cent had been obtained otherwise from Woolworths, or inherited. A husband and wife often shared the same pair of glasses. When questioned, people might say 'the glasses are all right but my eyes are weak.' Twenty years later Cartwright found that nearly one person in five had chronic eye trouble while two out of three of these had never sought consultation at any level.⁵ Williamson, following an examination of elderly people registered with general practitioners in Edinburgh, pointed out that 37 per cent of the studied population had visual impairments, which were often unknown to the general practitioners concerned.⁶ Therefore, actual records of visual handicap amongst elderly people show the prevalence to be high while research indicates that the true prevalence is probably even higher. One can conclude that a large amount of visual defect exists in the population which is unknown to the medical services. Furthermore, the added importance of whole person medicine is stressed through the knowledge that one hundred and twenty drugs now in current use by elderly people can produce visual side effects.⁷

A recent study of the prevalence of eye disease in the elderly in an English community

I now want to consider a recent and important study by Gibson, Rosenthal and Lavery of the prevalence of eye disease in the elderly

in an English community and compare their findings with the results of other surveys.⁸ Before giving an account of the study I will make a number of introductory comments.

The increasing number of elderly people in the United Kingdom raises important issues to those concerned with the provision of health care to this age group. In Leicestershire, for example, it has been estimated that between 1978 and 1987 the numbers of those people over 75 years of age will increase by 21 per cent.⁹

This is particularly important in ophthalmology since much of the work of eye departments is concerned with the treatment of cataract, senile macular degeneration and open angle glaucoma. According to Sorsby these are the three major causes of blindness in the elderly.¹⁰ Recent advances in the treatment of these three conditions suggests that this workload can only increase further.

However, despite these predictions Gibson, Rosenthal and Lavery have observed that very little information is presently available concerning the prevalence of eye disease amongst the elderly population in Britain.¹¹ The analysis of blind registrations,¹² hospital eye clinic attendances and admissions,¹³ and data from ophthalmic operations¹⁴ have yielded some important information. However, it is important to point out that the usefulness of the information from these sources has been limited by a lack of uniformity in disease definition and by the selection of the population sampled, and these problems have been well described by Cullinan.¹⁵

The most comprehensive ophthalmic prevalence survey carried out to date has been the Framingham Eye Study.¹⁶ In the period from 1973

until 1975 2,675 members of the population of Framingham in Massachusetts were examined by an ophthalmic team. The study population had been under investigation since 1948 for coronary heart disease risk factors and were aged between 52 and 85 years. An overall response rate of 67 per cent was achieved, which included 84 per cent of those still living in the immediate environs of Framingham. A careful design of the study protocol, strict disease definition and criteria for diagnosis were used to achieve accuracy and standardisation of observations. The ophthalmic team allowed little individual clinical interpretation and so interobserver variation was reduced to a minimum. The Framingham Eye Study permitted the prevalence rates of cataract, senile macular degeneration, open angle glaucoma and diabetic retinopathy to be obtained.

Gibson, Rosenthal and Lavery of the Department of Ophthalmology at Leicester University School of Medicine were interested in undertaking a similar study in Britain and the study they carried out has been based as far as possible on the definitions and the criteria used in the Framingham Eye Study.

Gibson, Rosenthal and Lavery's study was undertaken over a period of two years in Melton Mowbray, a market town that is situated midway between Nottingham and Leicester in the county of Leicestershire. An unusual situation exists in Melton Mowbray in that virtually all the town and most of the surrounding countryside is served by a single twelve doctor general practice. The entire population of 32,000 persons registered with this practice were established on a computerised

age-sex register by the Department of Community Health at Leicester University. Melton Mowbray was chosen for this register because of the similarity in terms of age, sex and social class composition to England and Wales as a whole.

From this register a population sample of those aged 75 years and over on December 31, 1980 was compiled and this contained 1,329 subjects. This sample has been the target of a comprehensive health and social services study by the Department of Community Health at Leicester University. Those members of this original population still living in the Melton Mowbray district on April 1 1982 formed the basis of the eye study. A total of 990 subjects were traced and these were listed in random order and from this 854 names were called over a two year period. 159 persons had died and 18 persons moved before they were first called and consequently 677 persons were available for examination, of which 484 were actually seen, a response rate of 71.5 per cent to date. Gibson, Rosenthal and Lavery carefully compared the 193 non-attenders to those that attended the survey, to ensure that the responders were representative of the whole sample. (See table I). There was no statistically significant difference between the two groups in the sex ratios, ages and in whether they lived in a town or village. The mean age of the non-responders was greater than the responders but this was not statistically significant.

However, the prevalence rates were calculated by Gibson, Rosenthal and Lavery by two methods to make an allowance for any discrepancy between the attenders and the non-attenders, in terms of eye disease.

Method one assumes that the non-attenders have the same amount of eye disease as those that attended the survey. Method two assumes that those who did not attend the survey had no eye disease and this allowed a minimum prevalence rate to be calculated. Similar calculations were carried out for the Framingham Eye Study.¹⁷

Table I - Attenders and non-attenders

Attenders		484
Non-attenders		193
Total		677
By sexes	Males	Females
Attenders	147	337
Non-attenders	58	135
No significant difference (χ^2 test at $p = 0.05$ level)		
By place of dwelling	Town	Village
Attenders	373	111
Non-attenders	145	48
No significant difference (χ^2 test at $p = 0.05$ level)		
By age		
Attenders	Mean age = 81.7 (SD 3.9)	
Non-attenders	Mean age = 83.0 (SD 4.3)	

The subjects who attended Gibson, Rosenthal and Lavery's survey were examined by an ophthalmologist and an ophthalmic optician and a questionnaire was completed for each attender. The examination was composed of visual acuity for near and distance, full refraction, slit-lamp biomicroscopy, applanation tonometry and fundus examination with direct and binocular indirect ophthalmoscopy

after pupillary dilatation. Where it was possible fundus photography was performed of the optic disc and macula.

Gibson, Rosenthal and Lavery tested visual acuity at six metres using the Shellen test types and was recorded with and without usual distance correction and after refraction a best visual acuity was obtained. The last complete line that the patient was able to read was recorded. Near vision was tested using the Faculty of Ophthalmologists approved test-types with near correction if worn.

Examination for senile cataract was carried out with mydriasis, direct ophthalmoscopy, direct and retroillumination with the slit-lamp. Senile cataract was said to be present when the best corrected visual acuity was 6/9 or worse in the affected eye and this was attributable to lens opacities. Subjects with aphakia were included in this group, but all cataracts that could be ascribed to congenital or secondary causes were excluded.

For the purposes of Gibson, Rosenthal and Lavery's study the macula was defined as in the Framingham Eye Study (that is, the area of clinically apparent pigmentation, surrounding the foveola). Senile macular degeneration was diagnosed by an exclusion category as in the Framingham Eye Study. Degenerative changes were divided into those of the dry type, such as drusen formation or pigment disturbance and those of the exudative type with elevation of the retinal pigment or neurosensory epithelium. If these were detected then senile macular degeneration was diagnosed, as long as the best corrected visual acuity was 6/9 or worse. A history of secondary or congenital causes

of macular disease excluded the diagnosis of senile macular degeneration.

In the Framingham Eye Study the examination for open angle glaucoma included a screening examination. Gibson, Rosenthal and Lavery did not perform such an examination and so they used different definitions and criteria to make this diagnosis. In their study, a person was considered to be suffering from open angle glaucoma if all of the following four conditions were met:

- (a) Glaucomatous cupping of the optic disc, defined as a cup-disc ratio equal to or greater than 0.5 or the presence of notching of the neural rim, or asymmetry of the optic discs.
- (b) Intraocular pressure by applanation tonometry above 21 mm Hg. Included in this group were those subjects whose intraocular pressure were known to have been in this range when they attended hospital.
- (c) An open anterior chamber angle as judged by the method developed by van Herick and Shaffer.¹⁸
- (d) If these three criteria were met then the person was asked to attend an eye clinic at Leicester, where a repeat ophthalmic examination including Goldman perimetry was performed. Glaucomatous field defects were considered as baring of the blind spot, arcuate scotoma, paracentral scotoma, nasal step and advanced field loss. Enlargement of the blind spot was also included in this category.

A diagnosis of low-tension glaucoma was made if (a), (c), and (d) but not (b) were present. Persons who had already had a diagnosis

of open angle glaucoma made were not asked to reattend for perimetry as it was not felt justifiable to do so in view of the long journey involved. Those who attended the eye department at Leicester were assessed through their case records.

In the study the criteria for the diagnosis of diabetic retinopathy were the presence of microaneurysms, dot haemorrhages, hard exudates, microvascular abnormalities or neovascularisation. In the survey a history of diabetes was obtained from the subjects.

Tables II, III and IV summarise the key results of the survey. Table II provides a summary of the association between senile cataract with age and sex. Gibson, Rosenthal and Lavery found that the overall prevalence of senile cataract was 46.1 per cent and this increased with age and there was a statistically significant increase between the 76-84 age group and those over 85 years of age. The odds of having senile cataract in the 85 year old group compared to the 76-84 age group was found to be 2.6 (1.6, 4.3) with 95 per cent confidence limits in brackets. No significant difference between the sexes was found. Gibson, Rosenthal and Lavery found that the overall prevalence of senile macular degeneration was 41.5 per cent and this is shown in table III. They found that there was no significant difference between the two sexes but the odds of having senile macular degeneration in those people aged 85 years and over compared to the 76 to 84 age group was 1.8 (1.1, 2.9) with the 95 per cent confidence limits in brackets.

Table IV shows the prevalence of open angle glaucoma. Gibson, Rosenthal and Lavery found that the overall rate was 6.6 per cent, a

Table II - Prevalence of senile cataract by age and sex

Age in years and sex	Number examinable (a)	Number examined (b)	Positive in one or both eyes (c)	Prevalence per cent (c/b)	Minimum per cent prevalence (c/a)
Age 76-84					
Men	183	132	49	37.1	26.8
Women	356	260	114	43.8	32.0
Total	539	392	163	41.6	30.2
Age 85 and over					
Men	24	15	9	60.0	37.5
Women	114	77	51	66.2	44.7
Total	138	92	60	65.2	43.5
Total all ages	677	484	223	46.1	33.0

Table III - Prevalence of senile macular degeneration by age and sex

Age in years and sex	Number examinable (a)	Number examined (b)	Positive in one or both eyes (c)	Prevalence per cent (c/b)	Minimum per cent prevalence (c/a)
Age 76-84					
Men	183	132	54	40.9	29.5
Women	356	260	98	37.7	27.5
Total	539	392	152	38.8	28.2
Age 85 and over					
Men	24	15	6	40.0	25.0
Women	114	77	43	55.8	37.7
Total	138	92	49	53.3	35.5
Total all ages	677	484	201	41.5	29.7

Table IV - Prevalence of open angle glaucoma by age and sex

Age in years and sex	Number examinable (a)	Number examined (b)	Positive in one or both eyes (c)	Prevalence per cent (c/b)	Minimum per cent prevalence (c/a)
Age 76-84					
Men	183	132	13	9.8	7.1
Women	356	260	15	5.8	4.2
Total	539	392	28	7.1	5.2
Age 85 and over					
Men	24	15	1	6.7	4.2
Women	114	77	3	3.9	2.6
Total	138	92	4	4.3	2.9
Total all ages	677	484	32	6.6	4.7

minimum rate of 4.7 per cent, with no statistically significant difference between the sex and age groups. Previously undiagnosed cases amounted to ten out of the total of thirty two.

Gibson, Rosenthal and Lavery only found two cases of diabetic retinopathy and this number is too small to draw any conclusion regarding the effect of age and sex in the prevalence.

I will now compare these results with the findings of other epidemiological surveys of the elderly.

It is apparent that an inherent problem of surveys involving elderly subjects is that of obtaining an adequate response rate to ensure that the sample studied is representative of the population being investigated. This problem is particularly relevant in surveys dealing with eye disease because of the equipment needed to undertake an adequate ophthalmic examination. In practice it is usually easier and more efficient to request the subject of the study to attend a clinic for ophthalmic assessment, as Gibson, Rosenthal and Lavery did in their study, rather than attempt to transport expensive and heavy equipment to the subject's home. Due to the problems of mobility that exist in the elderly, Gibson, Rosenthal and Lavery considered the response rate of 71.5 per cent to be acceptable. Higher rates of response in the elderly age group have been obtained by other investigators, including by Martinez, Campbell, Reinken and Allan.¹⁹ Gibson, Rosenthal and Lavery have carefully analysed the attenders and the non-attenders and they consider that for the parameters given the sample of attenders are representative of the elderly population of

Melton Mowbray. (See table I). By assuming that the non-attenders have chosen not to take part because they have no eye disease, Gibson, Rosenthal and Lavery were able to calculate a 'minimum' prevalence rate.

A second major problem in research concerned with the epidemiology of eye disease is that there is no universal agreement on the definitions and the criteria for diagnosis of senile cataract, senile macular degeneration and glaucoma.²⁰ For this reason direct comparison between survey results is often impossible since much of the assessment is necessarily subjective and prone to error by the observer.²¹ Where it was possible Gibson, Rosenthal and Lavery used the same procedures and definitions as the Framingham Eye Study. However, in the Framingham Eye Study the upper age limit was 85 years and only a small proportion of the total sample were in the 75 to 85 year old age group, which amounted to 431 persons of which 397 lived in the 'local' area. The Melton Mowbray study had 76 years as the lower age limit.

The prevalence rates from several surveys for senile cataract, senile macular degeneration and open angle glaucoma are presented in tables V, VI and VII.

The information concerning the prevalence of senile cataract has in the past been derived from statistics of registration of blindness, population survey and data about cataract operations. Sorsby analysed registrations of blindness in England and Wales and showed that 22 per cent of registrations between 1955 and 1962 were caused by cataract.²²

Table V - Comparative prevalence rates for senile cataract

Survey	Age group	Number screened	Prevalence (per cent)	
Framingham, 1973-1975	75-85	397	46.1	Male 41.5 Female 48.9
Gisborne, N. Z., 1982	75-85	300	38.2	Male 57.8 Female 38.4
Melton Mowbray, 1982-1984	76-84	392	41.6	Male 37.1 Female 43.8
Edinburgh, 1972	70 and over	149	40.7	Male 33.0 Female 46.0
East Kilbride, 1975	65-74	4,300 eyes	14	
New York, 1957	65-79		31	

Table VI - Comparative prevalence rates for senile macular degeneration

Survey	Age group	Number screened	Prevalence (per cent)	
Framingham, 1973-1975	75-85	397	27.9	Male 24.4 Female 30.1
Gisborne, N. Z., 1982	75-85	300	9.1	Male 6.1 Female 10.9
Melton Mowbray, 1982-1984	76-84	392	38.8	Male 40.9 Female 37.7

Table VII - Comparative prevalence rates for open angle glaucoma

Survey	Age group	Number screened	Prevalence (per cent)	
Framingham, 1973-1975	75-85	397	7.2	Male 9.9 Female 4.9
Gisborne, N. Z., 1982	75-85	300	2.2	Male 2.2 Female 2.8
Melton Mowbray, 1982-1984	76-84	392	7.1	Male 9.8 Female 5.8
Ferndale, 1966	40-74	4,231	0.47	
Bedford, 1968	40 and over	5,941	0.76	
	80 and over	70	10.0	

He also found that the proportion grew with increasing age and that there was a greater frequency in women than in men.

In population surveys for cataract the usual definition of cataract includes a deficit in visual acuity. The survey carried out by Martinez, Campbell, Reinken and Allan in Gisborne in New Zealand in 1982 involved a randomly selected sample of 481 subjects aged 65 years and over.²³ This study used the same visual acuity level in the definition of cataract as in the Framingham and Melton Mowbray studies. The prevalence of senile cataract is very similar from these three surveys for the age groups compared (see table V). They show that about two-fifths of the age group 75 to 85 or equivalent have cataract. All three surveys demonstrate an increasing prevalence with age and a higher prevalence for women than men, although the latter was not statistically significant in the Melton Mowbray study.

Milne and Williamson studied a random sample of 487 people living in Edinburgh, aged 62 years and over, which included 149 persons aged 70 years and over, and their study shows a cataract prevalence of 22 per cent for ages 62 to 79 years, a prevalence of 40 per cent for those aged 70 years and over and a higher prevalence of cataract for women than for men.²⁴

The geriatric assessment survey carried out in East Kilbride by McWilliam was carried out on a non-randomised sample of 2,600 persons who were aged 65 years and over.²⁵ The prevalence for cataract for those aged 65 to 74 years was 14 per cent although the examination and the selection of subjects was different to the aforementioned surveys.

The survey carried out by Kornzweig, Feldstein and Schneider in New York in 1957 also cannot be compared directly to the other studies.²⁶ The study in New York was based on a selected group of 1,100 residents of a Jewish home for the aged and infirm. The overall prevalence of cataract was 31 per cent for the 65 to 79 year old age group.

Data obtained from cataract extractions in Britain have shown that an operation for cataract is commoner for women than for men and that between the ages 60 to 90 years senile cataract extraction increased by ninefold.²⁷

Epidemiological information regarding the prevalence of senile macular degeneration is not so readily available. Sorsby found that twenty three per cent of those registered as blind in England and Wales between 1955 and 1962 was attributable to senile macular degeneration.²⁸ The Framingham study showed a prevalence of 27.9 per cent for ages 75 to 85, with a higher rate for women than for men. The survey carried out by Gibson, Rosenthal and Lavery in Melton Mowbray showed a much higher prevalence of senile macular degeneration of 38.8 per cent for people aged between 76 and 84 and this increases significantly with age. The survey conducted in Gisborne in New Zealand has a much lower prevalence than the other two surveys and this may be wholly or partly due to the different definitions used for the diagnosis of this condition. Further analysis by Gibson, Rosenthal and Lavery of the results they have obtained from Melton Mowbray in relation to different variables will hopefully enable them to make further comparisons with these other studies.

Chronic open angle glaucoma is probably the ophthalmic disease on which most epidemiological work has been undertaken. Leske has observed that the classic diagnostic triad consists of characteristic nerve-fibre bundle visual field defects, cupping of the optic disc and raised intraocular pressure.²⁹ Often only one or two of these criteria have been used in diagnosis which limits the comparability of the results with other studies.

One of the most comprehensive glaucoma studies yet conducted was in Ferndale by Hollows and Graham.³⁰ In Hollows and Graham's study 92 per cent of the residents of three Welsh villages in the Rhondda valley were examined. A strict definition of open angle glaucoma was used and 4,231 people were examined between the ages of 40 and 75 and only 20 people (or 0.47 per cent) met the study definition of open angle glaucoma.

Another large British study is the Bedford Glaucoma survey.³¹ The sample of 5,941 people were volunteers and therefore self selected and this does not meet the criteria for a population study of prevalence. The new cases of open angle glaucoma amounted to 45 cases (0.76 per cent) and just over half of these were found in those aged 70 years and older, despite the fact that this age group represented only 10.7 per cent of the total study. The incidence of open angle glaucoma for those of 80 years and over is calculated by Bankes and his colleagues as 10 per cent.

The Melton Mowbray study found very similar prevalence rates for open angle glaucoma to the work at Framingham, although Gibson,

Rosenthal and Lavery's examination was necessarily different since they did not use a screening examination. The prevalence of 7.0 per cent for those aged 75 to 85 or equivalent is much higher than would be expected from the Ferndale study, even though this survey dealt with a younger age group. Gibson, Rosenthal and Lavery also found a much higher prevalence in this age group for men than women although it was not statistically significant because of the small numbers involved. The Gisborne study found a lower prevalence for men than Framingham, although there was no significant difference between the sexes.

Direct comparison of the prevalence of open angle glaucoma between different surveys may be misleading because of the different criteria for diagnosis used. Leske and Rosenthal have shown that if those cases in the Framingham Eye Study with isolated blind spot field defect are excluded from the figures, the prevalence for open angle glaucoma in the 75 to 85 year old age group would fall to 3.5 per cent.³² Although the prevalence studies may not be directly comparable, the overall picture suggests that for the 75 to 85 age group the prevalence of open angle glaucoma is up to 7.0 per cent, that this rises dramatically with age and that there is a higher risk for men than women of having glaucoma.

It is important to point out that most of the epidemiology of glaucoma has been confined to samples of the population in North America and in Western Europe. More work still remains to be carried out in other continents and to explain the apparent high prevalence in some races with the apparent absence in others, such

as the Australian aborigine.³³ In Britain it is hoped that the Melton Mowbray study will be used to form the basis of cohort studies of senile cataract, senile macular degeneration and open angle glaucoma in the elderly population. In conjunction with the health and social services survey carried out on this same sample by the Department of Community Health at Leicester University, it will hopefully be possible to gain further information regarding these three conditions and the social and the visual status of the elderly.

A closer examination of cataract and glaucoma

Professor Arnold Sorsby has pointed out that the three major causes of blindness in the elderly in Britain are cataract, glaucoma and senile macular degeneration.³⁴ Of these three cataract and glaucoma are the most significant and so each of these will be examined in more detail.

I first want to say several things about cataracts in general. Cataracts are generally, although not exclusively, the problem of older people. There are two main types of cataract. The commonest form is some degree of Nuclear sclerosis of the lens of the eye. The lens inside the eye goes on growing throughout life, even when an individual has reached a great age. Gradually, the middle of the lens becomes hard, dark and compressed, rather like the heart wood of a tree, and over the age of sixty five the cataract this causes is almost universal, in varying degrees. If an individual just has Nuclear sclerosis then he or she is not usually very inconvenienced. The condition tends to make a person short sighted, but although this may affect distance

vision, and although it may make driving a car difficult, it usually has a rather agreeable compensation for close vision. For example, an elderly woman who has worn glasses all her life may find at the age of seventy that she can suddenly do without her glasses for knitting and see very well when she holds a book close to her eyes. Moreover, this is a type of cataract which usually pursues a very slow course, and does not itself generally cause very serious problems.

The other type of cataract is the Cortical cataract. In this case the outside layers of the lens undergo various changes which render them opaque. It is this sort of cataract which may progress to form the white mark that can be seen as the so called ripe cataract. Ophthalmic surgeons do not usually have to wait until the cataract is ripe to remove it because if the cataract is completely white, like a dense piece of paper, the patient will of course see absolutely nothing out of it and it is advisable to remove the cataract before that stage is reached.

Patrick Holmes Sellors is a Consultant Ophthalmic Surgeon at St. George's Hospital in London and at the Croydon Eye Unit at Croydon in Surrey, and recently he described the practice of cataract extraction and the practical results of the operation.³⁵ Sellors points out that Cortical cataracts are rather more uncertain in their effect, because it is not the total amount of the cataract that matters, but its position within the lens of the eye. Sellors may see patients who have quite marked cataract - the sort of cataract that can be seen with a torch quite easily - and yet the patients may have quite remarkable vision through this cataract. Or, on the other hand, he may see cases of another type of Cortical cataract, particularly in the back of the lens, where

the cataract is very small but in a critical place as regards the optics of the eye. In such a case, a very tiny cataract may have a disastrous effect upon vision.

Sellors points out that when he and other surgeons assess their patients there are two things they try to do. They of course look at the patients and decide what sort of cataract they have, but what they like to do most of all is try to assess the particular visual requirements of the particular patient. For example, a seventy year old woman living in a terrace house with the shops just around the corner quite clearly does not require the same standard of vision as a person who is going to regularly use a busy motorway. In fact, the visual requirements of the seventy year old woman are probably really quite modest. Probably what is important to her is that she is able to see what is on the shelves of a shop, is able to count her money and is able to see the screen of a television. If her visual acuity is 6/24 or 6/36, which by the average person's standards would be rather poor vision, this might be quite adequate for her needs. She may find crossing the roads difficult, and may even need to ask someone to help her across, but, basically she is not greatly inconvenienced. Sellors has found that the type of cataract which affects reading vision presents a more serious problem because of the real deprivation it may cause. He has found that to most patients close vision matters far more than distance vision.

I now want to consider the problems of removing cataracts. The crucial point to emphasise is that when a surgeon takes a cataract out, he is taking out the focusing lens of the eye. When the cataract is out,

the eye is completely unfocused, and the problem is how then to refocus it.

One way is to do so with a pair of spectacles. For this the patient needs a lens of approximately plus twelve dioptries. This lens will focus the light on the back of the eye and it will moreover have the advantage of slightly magnifying things, but, because the lenses are so thick, there will be quite spectacular distortions. Sellors points out that these distortions can lead to enormous problems. In the first place, nothing looks straight in these glasses, so that a straight road will appear to go round a corner. Because the glasses are so thick, they act as prisms so that anyone wearing them may look down and miss a step because of the prismatic effect. Another problem is what is known as the 'Jack in the Box' phenomenon. This is a blind area which blots out a particular part of one's vision, due to the optics of the lens. To counteract this the wearer of the glasses may have to put his hand on a doorpost while he can still see it, as it will disappear from his view as he gets nearer, to reappear afterwards. Sellors points out that this can of course be extremely disturbing and it is not surprising that people who have had a perfect cataract operation may complain bitterly because the glasses are intolerable - they cannot walk about with them, every time they look down things swim, and they are only really happy when they are sitting still, as it were on 'terra firma'. Sellors points out that mercifully this does not happen to everybody, but the important point to emphasise is that although the operation may have been a success, and the patient may have technically perfectly normal

sight, the sight is not normal to the patient. Elderly people may find this new vision very difficult indeed.

Before leaving the subject of glasses I want to consider the problems of unilateral aphakia - that is, the patient who has had a cataract removed from one eye and may have normal or reduced vision in the other eye. Sellors points out that if the patient is fitted with a thick cataract lens on the operated eye this lens is so different from the other one that constant double vision ensues. The reason for this double vision is that the cataract lens magnifies things by about thirty per cent and the brain cannot tolerate two images of such different size. This problem can be overcome by contact lenses and intra-ocular lenses, which will be mentioned shortly. Sellors finds that most patients find it very hard to understand, when they have a cataract removed from one eye that they cannot have a pair of glasses to correct the vision for both eyes. What is done normally is for the lens on the unoperated eye to be blanked out or for a thick balance lens to be put on that side, which will just blur out the vision. In Sellors' opinion very few patients enjoy this situation and he suggests that most of them would be better off with two indifferent eyes rather than one very good one which can only be focused by this thick lens. Sellors points out that this may all sound rather gloomy, but he wants to stress how vital it is to assess patients carefully, and to judge which of them will really benefit from a cataract operation. There is no point in clever surgery, if it results in disappointed patients.

There are other ways of correcting cataract vision, which have both advantages and disadvantages. The most common one is the

use of contact lenses. The contact lens worn after a cataract operation will eliminate most vision distortions, including the 'Jack in the Box' effect. Because the contact lens is closer to the eye there is much less magnification and it is possible when the cataract has been removed from one eye to put a contact lens on the operated eye, and wear the ordinary spectacles on the better unoperated eye. Through this technique the two eyes can be 'married up'. However, Sellors points out that the problem with this is how does an old person manage to cope with the contact lens. For example, does an old woman in this situation have enough vision in the other eye to see the contact lens? Are her hands so twisted with arthritis that she cannot handle the lens? Is her husband able bodied and can he put the lens in for her? These are the types of questions that have to be taken into account. There are some special soft contact lenses which can be worn for long periods at a time and they may well be the answer, but they too have their problems. Although they can be left in the eye for three months at a time, they can easily break or become infected and they are more expensive and more difficult to sterilise. However, Sellors believes that eventually there will be a very superior long wear contact lens which will be the answer to correcting most people's vision when they have had a cataract operation.

There is another method of refocusing the eye which is enjoying a great vogue at the moment and it consists of putting a little plastic lens inside the eye, when the cataract is taken out. Sellors points out that there is no doubt that if this is successful then it provides the

most normal vision that it is possible to have. The patient who has such an operation, provided the back of his or her eye is quite healthy, sees very well. It is an attractive technique, but it enormously increases the complication rate of the operation. The most serious complication is the water logging of the front of the cornea. Sellors points out that patients must be warned that in realistic terms there is a three per cent to five per cent risk of this water logging. This happens because of the foreign material inside the eye and the situation may then be as bad as the cataract itself.

From what has been said it is clear that too much must not be expected from cataract extraction. The secret of a good cataract operation is not the operation itself but the really careful selection of the patient beforehand and the really good correction of the vision afterwards.

It is a significant pointer, as Professor Arnold Sorsby has remarked, that in the first twenty five years of the National Health Service, from 1948 until 1962, new registrations of blindness caused by cataract dropped steeply by twenty five per cent.³⁶ It is a disturbing thought that before the foundation of the National Health Service hundreds of people went blind every year largely because they could not afford to see an eye specialist and because the hospital beds and services were not available to them.

In the 1980's there are over 20,000 cataract operations a year in Britain, mainly on elderly people in National Health Service hospitals, and the operations are successful in ninety five per cent of the cases.

Many of these elderly patients may know little about cataracts and the thought of eye surgery and the long wait for an operation often make them very anxious. In recent years several books have been published which attempt to provide an account of the treatment of cataract and attempt to answer the many questions elderly people have about their cataracts.³⁷

The comment by Awdry and Nicholls in their book that cataract 'should hardly be regarded as a disease; rather, it has parallels with the greying of hair' should be a comforting thought for an elderly person, and if cataract can be looked upon in this light then a far greater number of people would cease to believe that it is a step towards eventual blindness. It is also encouraging that Awdry and Nicholls state that cataract surgery can be undertaken before the cataract has ripened: 'Today a cataract is removed when the level of vision is not sufficient for the patient's everyday needs.' It is also reassuring to read their comment that 'Age is no bar to cataract surgery, either in babies or in the very elderly.'

Over the years listeners to the BBC's Radio Four programme In Touch have probably sent in more requests for information about cataracts than any other eye condition. Margaret Ford is the social work advisor to the programme and in response to these queries she has written a short book, In Touch with Cataracts.³⁸ The book is written in straightforward language and is in large print, and for these reasons it is probably the most accessible source on cataracts for elderly people that is currently available. The book is useful for all

health visitors and district nurses to carry with them to show to elderly people and their relatives. It brings together all the latest information on senile cataracts (the most common form); what they are, how they effect sight, and what can be done about them. The operation itself is described simply and the methods of correcting vision afterwards are clearly set out, with a chart which sums up the pros and cons of each method - spectacles, contact lenses or a lens implant.

I would like to mention three points of criticism concerning the book. The first point concerns cataract spectacles. Many elderly people have high expectations of the cataract operation, but they are not always made aware even in hospital of the difficulties they will experience when they are prescribed with their cataract spectacles. Very often they are not prepared for the gross magnification and for the way that objects are brought so much nearer to them than they expect. For example, old people often discover that they cannot place trays clearly on tables because they do not know where the surface is. Accidents can occur. The book could have put more emphasis on the problems associated with wearing cataract spectacles and, in particular, could have put more emphasis on the need to avoid accidents and falls. A second point concerns the early diagnosis of eye conditions. With most eye conditions early diagnosis is helpful and this requires further emphasis in Ford's book. It is very important that elderly persons with defective vision report this as quickly as possible and where someone has the early beginnings of a cataract it is very important that the ophthalmologist should be able to have a good look at the eye while

he can still see clearly through the lens. Thirdly, and finally, the book does not deal with the question of how an elderly person can get his or her glasses dispensed and the importance of that. One is afraid that elderly visually handicapped people will accept any glasses that they find in a chain store, whereas of course they must be prescribed very carefully.

I now want to consider glaucoma. When a patient is told that he has glaucoma the first question he asks is usually 'what does that mean?' and the stock answer is that the pressure inside the eye is too high and this raised pressure is damaging the optic nerve. What matters to the patient however is not this rather mysterious pressure but the fact that he is slowly and inexorably losing his field of vision. Glaucoma is a blinding disease and is widely regarded as a more serious disease than many others responsible for blind registration. Cataract, for example, is normally a reversible cause of blindness and macular degeneration does not lead to a great loss of mobility, serious though its effects are. Paradoxically a patient may be registered as blind from glaucoma in spite of normal visual acuity because, as in retinitis pigmentosa, so much of the peripheral vision has been lost that proper utilization of the fine central vision is impossible.

There are, in fact, many different types of glaucoma with a multitude of causes. Some are the result of congenital abnormalities, others the consequence of different diseases affecting the eye such as diabetes or uveitis. There is also acute glaucoma in which the eye pressure raises so high and so fast that great pain is experienced.

But the commonest type of glaucoma, primary or chronic open angle glaucoma, produces minimal symptoms until the disease is far advanced and no obvious cause for the disease can be seen, hence the designation 'primary'. The classical diagnostic triad of primary open angle glaucoma consists of characteristic nerve fibre bundle visual field defects, cupping of the optic disc and elevated intraocular pressure.³⁹ It characteristically causes bilateral optic atrophy with progressive reduction of the visual fields and, if untreated, eventually leads to blindness. What I want to discuss here is this primary open angle glaucoma which I shall subsequently refer to more simply as glaucoma.

Both the detection and the treatment of glaucoma present problems. At least 60 per cent of the glaucoma population of the United Kingdom are unaware that they have the disease and 40 per cent of patients registered blind from glaucoma have had treatment which has failed. These figures serve to underline the extent of each problem.

What makes glaucoma so difficult to detect is that it is a virtually symptomless and frequently asymmetrical disease in which one healthy eye can compensate for a gross defect in the other. It has been estimated that there are some 200,000 patients in the United Kingdom with glaucoma and of this number only one third are being treated. So there is a vast pool of perhaps 130,000 sufferers undetected.

One solution to this problem would be to screen the whole population of the United Kingdom but this solution is not as easy as it may appear. The simplest screening test is to measure the

intraocular pressure but, because glaucoma is a disease where the pressure is too high for the individual eye, a large number of false positive and false negative results are found. A better method of screening is to examine the visual field but this is time consuming and costly. The third, and perhaps the best method, examination of the optic nerve at the back of the eye where the damage occurs, requires considerable expertise on the part of the examiner and cannot be delegated to a technician.

At the present time total population screening is not a practical proposition but there are two alternatives. The first alternative is to screen the close relatives of patients with glaucoma since siblings and children run a ten fold risk of developing the disease. The other alternative is to carry out routine screening during tests for spectacles.

Glaucoma is a disease which infrequently makes an appearance below the age of forty. The majority of the population in Britain require reading glasses in their mid forties and thereafter attend their optician for regular sight tests. In the 1980's many opticians, particularly the younger ones, do measure the intraocular pressure and examine the visual field in addition to looking at the back of the eye. They detect a large number of the patients with glaucoma that the medical profession treat but perhaps many more would be found if these tests were formally incorporated into the sight testing routine.

I now want to consider the problem of treatment which may be either medical or surgical but always with the common aim of reducing the intraocular pressure. Medical treatment is by means of eye drops

or tablets and some of the medications have been used for many years. Pilocarpine, which is one of the mainstays of glaucoma treatment, has been used for just over a hundred years. Other frequently used drugs are adrenaline drops and acetazolamide tablets but the disadvantage of these medications which must be taken regularly is that they frequently produce side effects.

A common problem in medicine, and particularly in the treatment of glaucoma, is patient compliance with therapy. An interesting study was carried out in the United States in the mid 1970's. A small device was devised into which a bottle of drops could be placed. Each time a drop was instilled by the patient into his eye the device recorded the time and the date. It was found that compliance with therapy prescribed four times a day was poor - about fifty per cent or sixty per cent and, surprisingly, compliance had little to do with social status, age or sex. The less intelligent among the patients did just as well, if not better, than the most intelligent who claimed they were frequently too busy to remember to put their drops in. It was also found that compliance improved dramatically with drops taken only twice a day. The recently introduced new drug, timolol, is such a drop and it has proved to be gratifyingly free from side effects.

Advances have also been made in recent years in the surgical treatment of glaucoma, particularly since the advent of the operating microscope. The greater magnification and finer instruments have allowed more delicate operations to be carried out which, because of their greater safety, are now more readily undertaken. There has

also been a great deal of interest in the laser but at the present time this instrument has a place only in the treatment of closed angle glaucoma.

An important aspect of the management of the patient with glaucoma is the regular assessment of the field of vision. This is carried out by the ophthalmologist or by a trained technician but is time consuming and, with certain methods, prone to considerable error. Considerable advances have been made in recent years in automating visual field examination by utilising micro-processor technology. Several companies are actively engaged in this work and though there are still problems to be overcome it is hoped that within the next few years automated perimetry will be available at a reasonable price.

What does the future hold for glaucoma? For the problem of detection there is unfortunately no simple solution in sight. Glaucoma is a complicated and poorly understood disease and this is reflected in the medical profession's inability to find a single test which will accurately predict the future development of the disease. In the field of treatment new drugs and improved old ones are being developed all the time and in surgery progress is being made towards discovering why apparently uncomplicated operations sometimes fail. Our ability to manage glaucoma patients would be greatly enhanced if we were able to determine what is the safe level of pressure for each individual eye and also if we were able to monitor the intraocular pressure continuously over a twenty four hour period. No method of determining the safe level of pressure is yet on the horizon but a group of research

workers in Australia have developed a system for continuous monitoring of intraocular pressure and though this is still at an early stage this holds promise for the future.

In spite of the extensive research that has been carried out, the medical profession still does not understand the change within the eye which causes the pressure to rise or precisely how this raised pressure damages the optic nerve. When the medical profession has the answers, new avenues of detection, treatment and possibly prevention may be opened up.

I now want to consider the issue of alerting close relatives of patients with glaucoma. Over twenty years ago near relatives of people with primary open angle glaucoma were shown to be at particular risk of developing the disease. This discovery led to glaucoma family screening clinics being set up in some centres in Britain. Eye surgeons, however, currently rely on patients themselves to contact their near relatives to suggest that they too should be checked for glaucoma. In 1984 Andrew Eckington, a consultant surgeon, examined how effectively this informal system was working at the Southampton Eye Hospital and the study made several startling discoveries.⁴⁰

As part of a larger study 214 patients with glaucoma were interviewed at home by Eckington and his colleagues. All the patients lived in the Southampton area. The patients were asked the question 'Do you know what is wrong with your eyes?' Those that knew that they had glaucoma were then asked, 'Do you realise that glaucoma may run in families?' Finally, those that appreciated the relevance of

the family history were asked, 'Have you contacted any near relatives to suggest that they too should have their eyes checked?'

Clinicians at Southampton Eye Hospital had thought that they had explained the consequences of glaucoma to patients, telling them that the disease sometimes runs in families and that they should tell their relatives to have their own eyes checked. Despite this 56 (or 26.2 per cent) of the patients interviewed did not know that they had glaucoma, though they knew that something was wrong with their eyes, for all of them had attended Southampton Eye Hospital many times. All 56 had been prescribed eye drops to be instilled several times a day, sometimes over many years, and some had also undergone surgery. Because these patients did not know the name of their eye disease they could not respond to any publicity that was produced about glaucoma. Furthermore, none of these 56 patients knew that they had a disease that might have a hereditary basis.

The survey did find that one hundred and fifty eight patients knew that they suffered from glaucoma. Of them, 70 (or 44.3 per cent) did not appreciate that this disorder sometimes runs in families despite a booklet on glaucoma, in which the importance of the family history is stressed, being available free in the out-patient department of Southampton Eye Hospital. Many copies of this booklet were taken either by patients or by those relatives who brought them to the hospital. Of the 88 patients who realised that they should advise their near relatives to have their eyes checked, only 41 (or 46.5 per cent) had actually taken steps to contact any such relative, let alone all of them.

Therefore, of the 214 patients who were interviewed, only 47 (or 22 per cent) had alerted a relative that they might have a potentially blinding condition.

Nowadays, if glaucoma is diagnosed early, patients stand a good chance of retaining at least reasonable vision for the remainder of their lives. In its early stages the disease does not cause symptoms, and many patients do not present themselves until the loss of field of vision is far advanced or complications have set in. The identification of a group at high risk, in the form of near relatives, was a great advance because it pointed the way to identifying economically people with only slight damage to their eyesight, who might be expected to respond well to treatment. The findings of the recent study at Southampton Eye Hospital show that such early diagnosis will be achieved only rarely if the medical profession relies solely on the efforts of patients to contact members of their immediate family.

Glaucoma patients are usually elderly and are often badly shaken to learn that they have a potentially blinding disease. They may be confused by an explanation about the prescribed regimen of eye drops. Not surprisingly then, even if the doctor remembers to tell them to, many forget to contact their relatives. Clearly, in every eye unit, and possibly in every general practice as well, someone should take on the responsibility of helping patients with glaucoma to alert members of their family that they also may have the disease. Health visitors and community nurses could become involved in this work.

I now want to make a point concerning opticians and glaucoma. In April 1985 the International Glaucoma Association held a national

glaucoma awareness week to draw attention to the fact that glaucoma, if diagnosed early enough, can be arrested, but that it is essential to have an eye test geared to spotting the condition, since in its early stages there are no obvious signs as far as the sufferer is concerned. The presenters of In Touch, the weekly programme on Radio Four for the visually handicapped, have recognised the importance of this point for a long time. In 1983 In Touch carried out a random survey of opticians which showed that thorough testing for glaucoma was by no means universal when a client was given a standard eye test. At the time David Austin, an examiner in glaucoma for the British College of Ophthalmic Opticians, was interviewed on the programme about this matter. Austin gave his opinion that any optician not carrying out a thorough procedure was failing in his terms of contract and he suggested that perhaps there ought to be some kind of inspection service to ensure that all opticians test for glaucoma. However, since 1983 no comprehensive inspection service has been established. If an inspection service were set up then it would aid the detection and the treatment of glaucoma.

The consequences of visual disturbance for the elderly

Failing vision can have several important consequences for elderly people and the medical and social consequences will be considered in turn. There is a strong indication that failing vision increases mental confusion and a suggestion that it also leads to accidents.

Hodkinson, in a survey of mental confusion in the elderly, found

the degree of visual impairment was greater in those with severe mental confusion; those mentally normal had a much lesser degree of visual impairment.⁴¹ Professor Brocklehurst and Professor Exton-Smith have shown that a visually impaired person has an increased liability to falls.⁴² They conducted a study of people in Manchester and London with fractures of the femur, who also had more impairment of vision compared with a control group of similar age. Brocklehurst and Exton-Smith found that 44 per cent of those over 75 years of age with fractured femurs had not seen an optician in the previous five years, compared with 26 per cent of the control subjects of comparable age. Brocklehurst and Exton-Smith found that many of the falls occurred at night, although a significant number of those with impaired sight had falls during the day. They concluded that the eye plays an important role in the body's balance system and this could be affected by impaired vision. A reduction in the fracture rate may be one of the advantages of screening old people for possible visual disturbance with a probable substantial economy.

Visual handicap may have serious social implications for elderly people. Visual handicap can be a major source of a reduction in the quality of life and in the erosion of personal independence. The early manifestations of an impairment include difficulties in writing, reading and viewing television. They also include a fear of traffic, a reduction in shopping with resultant effects on nutrition and the general standard of living, a difficulty in recognising people and a gradual withdrawal from society with all the consequences of this withdrawal in demands

on the local authority and health services and, above all, on the individual concerned. Any deterioration in the medical condition increases the loss of mobility and reduces social contact even further.

The consequences of visual disturbance can also be made worse by other factors. For example, Armstrong-Esther and Hawkins have observed that visually handicapped elderly people may not respond to the light-dark cycle and this plus a change in routine, for example, admission to a hospital, can lead to confusion, incontinence and sleep disturbance.⁴³

Because of the serious medical and social consequences of visual disturbance, it is important that elderly visually handicapped people are provided with suitable glasses, aids or treatment, so that they can make the most effective use of what sight they have.

The contribution of the Disabled Living Foundation and Age Concern to the study of the elderly visually handicapped

In recent years the Disabled Living Foundation and Age Concern have made an important contribution to the study of the elderly visually handicapped. The Disabled Living Foundation is concerned with all the practical, rather than purely medical, aspects of life of people of any age with physical, mental, sensory or multiple disabilities or the infirmities of old age. The Foundation maintains that action resulting from careful analysis and study may restore some opportunities which disability has removed.

The relative neglect of the problems of partially sighted people emerged early on in the Foundation's study of visual handicap and a

group of experts, ophthalmologists, educationalists and others, were invited on 1 March 1973 to attend an exploratory meeting. At the meeting the discussion centered on the theme

'Do those who need information to cope with the problems of visual handicap, in particular those within the definition of partially sighted, - the visually handicapped individual and his or her family, and those professionally concerned - get the information they require?'

All the participants were agreed on the lack of information and on the need for a comprehensive information service with, as an important priority, the formation of a collection of aids for professional reference. Therefore, a multi-disciplinary Advisory Panel was created, which, at its first meeting, endorsed this proposal. The panel also asked that a research project should be designed to coordinate with the existing work of the Royal National Institute for the Blind, with the regional associations for the blind and with the other voluntary associations for the blind.

After the reorganisation of local authorities and the National Health Service in the early 1970's and the integration of the health and social services, the Advisory Panel recognised the need for an inter-disciplinary approach which would include the experience and skills of professional and voluntary bodies. It also noted the apparent lack of professional training and liaison to provide for the full needs of elderly people with visual impairments, and the apparent acceptance by many elderly people, their relatives and professional advisors of visual difficulties and the resulting lower standards of performance as an inevitable part of old age.

Therefore, it was agreed that, amongst other activities, there should be a series of regular seminars on a regional basis on the topic of the elderly person with failing vision. It was the Advisory Panel's intention that these seminars should initially only cover England and Wales, and so multi-disciplinary attendance from all over these countries was sought and achieved.

The first seminar was held in London on 21 October 1976 and a total of six seminars had been held by the end of 1978. In May 1979 the Disabled Living Foundation published a report which summarised the first four seminars.⁴⁴ The report emphasises the background facts and the main observations, suggestions and recommendations which emerged.

Age Concern has also maintained an interest in the topic of sensory loss in old age. On 13 June 1984 Age Concern England held a policy encounter in Birmingham on the needs of blind and partially sighted elderly people⁴⁵ and representatives from several organisations concerned with the welfare of the visually handicapped were present. These people included George Wilson of the Royal National Institute for the Blind, Brian Eccles of the Southern and Western Regional Association for the Blind, Bob Greenhalgh of the Partially Sighted Society and fourteen others. The policy encounter provided a valuable opportunity to review the progress made since the Disabled Living Foundation's seminars in the 1970's) and to put forward several recommendations to improve the lives of elderly visually handicapped people.

Since the Disabled Living Foundation and Age Concern published their reports no research has been carried out to determine if any of their recommendations have been implemented. Nevertheless, their ideas and proposals are still relevant today and so deserve to be discussed here.

I will now consider a range of issues which effect elderly visually handicapped people which have been discussed at the meetings organised by the Disabled Living Foundation and Age Concern. These issues include screening and the identification and assessment of visual handicap, the use of suitable lighting and colour contrasts in the home, the training and the work of professional staff, the potential contribution of the voluntary sector to the elderly visually handicapped and the care of elderly visually handicapped people in residential homes, and in institutional care. In each case the issue will be discussed and any proposals to improve the situation will be considered.

The benefits of screening

It is very important to regularly screen the elderly population for sight problems because research has indicated that regular screening, with subsequent provision of glasses, treatments or aids, can reduce the level of visual handicap in the community. Both Fenton,⁴⁶ who studied patients in a long stay geriatric ward in Portsmouth, and a Scottish Neighbourhood Survey of people over sixty five years of age,⁴⁷ showed that one in five patients benefited from an ophthalmic examination and treatment, although the latter survey also found that one patient in seven was still unable to see well enough to read a newspaper subsequently.

Sorsby has pointed out that the main special eye conditions in the elderly are cataract, glaucoma and macular degeneration.⁴⁸ Cataract can be treated. Glaucoma often affects one eye. Screening should detect glaucoma and the progression of the condition can be slowed down, but advanced conditions of glaucoma are often presented. Macular degeneration is a loss of central vision which impairs the ability to read and see individual features. Many elderly people suffer from this condition, particularly diabetics. Opticians can detect macular degeneration and help can be given to the sufferer of the condition, but the condition deteriorates. It is important to stress that if sight is tested on a regular basis then cataract, glaucoma, macular degeneration and other conditions can be picked up. However, the participants at Age Concern's policy encounter on the elderly visually handicapped in 1984 observed that many elderly people do not have sight tests because they may expect their sight to deteriorate, it may be thought that there is a charge for the sight test and glasses are thought to be expensive. In addition, by the age of sixty five, reading sight in many cases cannot be improved and this may discourage many elderly people not to have sight tests. Moreover, there is little publicity about the importance of sight tests and early detection.

It is important to outline several proposals to improve screening procedures among the elderly and four proposals can be mentioned briefly. Firstly, increased publicity about special conditions could lead to more people having sight tests. Secondly, elderly people should be encouraged to take advantage of the annual free National

Health Service eye sight test. Thirdly, opticians should be encouraged to make domiciliary visits. Finally, volunteers could be trained to give simple eye sight tests in order to give preliminary screening. The feasibility of this should be considered. These proposals would be relatively inexpensive to implement and would probably be quite successful.

It is important to emphasise that younger people with sight problems are likely to recognise more quickly than older people that they need help. Because older people expect to have sight loss it is difficult to define how they come to recognise that they need help. Moreover, even when they have been referred to an optician or to an ophthalmologist elderly people may still not recognise that they need help because they do not know what aids and assistance are available. Furthermore, ageist attitudes - as exemplified in the road symbol for the blind - discourage people from seeking help.

Elderly people can pass from having normal sight to a sudden deterioration and this can be very traumatic for them. Then the realisation of eligibility for and the processes of registration can be very worrying and lead elderly people to question how they have functioned until then. Large numbers of older people are reluctant to register as blind or as partially sighted because it is a recognition and a confirmation of their disability. There may be a stigmatising factor - as with deafness - which leads people to conceal their disability. Indeed, few of the people who are placed on a register are given counselling help.

Emotional problems are particularly acute when linked to the onset of other disabilities such as hearing loss, incontinence, arthritis and so on. The treatment of one disability or incapacity may be given less priority than another or be totally overlooked, so that early detection and treatment is not possible.

However, the trauma of sight loss would be overcome in part, at least, if elderly people were conditioned to have regular sight tests. Indeed, Age Concern England's policy for greater screening or sifting, the better use of age and sex registers and the use of prevention and well elderly clinics would benefit older people with sight problems.

The individual's ability to perform social functions is crucially important and determines how the public and professionals react. General practitioners mostly consider 'disease' rather than 'function' and seldom test the latter, this may be being left to social service personnel. Indeed, some elderly people may wish to put off the inevitable and so claim that they can see more than they can.

Several important points emerge from this discussion. First, counselling around sight loss, particularly at the time of registration, should be promoted. Second, the interaction between an individual's different handicaps, particularly in determining their 'ranking', should be considered. Third, screening and sifting procedures and the improved use of age and sex registers by general practitioners should be facilitated. Fourth, in addition to testing physical disability, social functioning should also be considered. A more minor proposal is that the national blind symbol on traffic signs should be changed.

This symbol contains ageist attitudes and these attitudes may discourage elderly people from seeking help.

The identification and the assessment of visual handicap among the elderly

The delegates at the Disabled Living Foundation's seminars in the 1970's reported that the existing facilities for the investigation and the assessment of visual handicap are over-stretched. They reported that many people of all ages, especially the elderly, who are experiencing visual handicaps, are not being identified and brought to the attention of their general practitioners for possible referral to an optician or hospital. If they were, facilities would be additionally over-burdened.

The delegates also pointed out that physical problems increase the difficulties of visits to opticians and clinics, and discourage attendance at appointments. A survey by Cullinan in Canterbury showed that 79 per cent of visually handicapped people in that area had additional disabilities.⁴⁹

Eight proposals were put forward by the delegates to counter these difficulties.

First, those who are in contact with the elderly housebound - including home helps and relatives as well as the caring professions - should be advised both on how to carry out simple assessments of vision and on how to check levels of lighting using household objects. The delegates believed that these tests would enable identified problems to be brought to the attention of a general practitioner.

Second, revised criteria should be laid down for the assessment

of lighting need. The importance of adequate lighting levels, both natural and artificial, was stressed by the delegates.

Third, the long waiting list for clinic appointments, which might inhibit professional action, should be reduced by additional clinics, facilities and staff. Peripheral clinics could take the load off existing hospitals and clinics, and provide more easily accessible centres for elderly people to attend. The present heavy ambulance and transport costs would thus be reduced. Possible sites include health centres, day centres and school clinics. In addition, mobile clinics could be introduced in rural or inaccessible urban areas.

Fourth, clinics should be sited to be easily accessible to the majority of elderly people.

Fifth, opticians should be encouraged by their terms of service to undertake domiciliary visits.

Sixth, the number of ophthalmologists should be increased to allow domiciliary consultations.

Seventh, the delegates proposed that health visitors and community nurses with increased training in the problems of visually handicapped people should be attached to general practitioners' surgeries. Some delegates felt that these health visitors and community nurses should be specialists in this field.

Finally, the delegates also proposed that clinics should be open on some weekday evenings and on Saturdays, when volunteers and transport were likely to be available, to carry elderly people to and from appointments.

Since the Disabled Living Foundation's report was published in

1979 no research has been carried out to determine if any of these recommendations have been implemented. However, these proposals are still relevant today and so deserve to be listed here.

Home lighting and the use of colour contrasts

A key issue concerning the elderly visually handicapped is adequate lighting in the home, so that the elderly person with failing vision can make the maximum use of what sight he or she still has. The speakers at Age Concern England's policy encounter on the elderly visually handicapped in 1984 reported that older people often have inadequate lighting and should be encouraged to make better use of their light. This point links in with Age Concern England's policies on self health care. The speakers at the policy encounter recommended that misconceptions about the cost of electric light should be overcome and to help in this process they recommended the book Lighting and Low Vision, which is produced by the Partially Sighted Society and the Electricity Council.⁵⁰

It is important to emphasise that a single central light in the ceiling is usually inadequate for reading, the use of an angle poise or standard lamp is a far more efficient way of using the available light. For those elderly people who have problems with glare, a lamp brought down over the shoulder for reading will minimise light scattering.

Even when an old person's eyesight is not failing an improvement in home lighting can dramatically improve visual performance. For example, P. A. Gardiner has described how as a young ophthalmologist

he had been asked to see two old ladies in their own home. Both the old ladies believed that their vision was failing. He was admitted to a beautiful drawing room with many shaded lamps around the room. Having examined the old ladies, he went round the room removing the lampshades and then asked the old ladies to read, which they did perfectly. Their eyesight was not failing. Their home lighting had been inadequate and the removal of the lampshades improved their visual performance.⁵¹

Local authority social services departments have the power under the Chronically Sick and Disabled Persons Act of 1970 to improve or adapt lighting in homes if they believe that there is a need for this. However, this is a permissive power which is not always implemented but one which could be made easier to adopt if clear and concise criteria for assessing lighting were laid down. The Code of the Illuminating Engineering Society does provide criteria⁵² but research by Silver, Cullinan, Gould and Irvine has indicated that these standards may be inadequate for many elderly people.⁵³

For reading, the Illuminating Engineering Society recommend levels of between 300 and 600 lux, but many visually handicapped people benefit from much higher levels of illuminance; optimum reading acuity typically requires illuminance levels of 1500 lux. Illuminance can be increased by moving the light source closer to the reading matter, but this may increase the heat to an unacceptable level. An alternative is to increase the wattage of the lamp, but it is inadvisable to exceed the manufacturer's recommended maximum

(which is typically 60 watts for a domestic reading light). Another approach is to change the lamp for one which is directional. In 1982 Dr. John Gill and Miss Janet Silver purchased a range of lamps from Woolworths and compared them for light output at 40 cm and 1 m; the table shows a comparison of two lamps fitted in an Anglepoise reading light.

Lamp	Nominal wattage	Price pence	Illuminance	
			40 cm lux	1 m lux
Pearl	60	30	550	90
Decorspot 80	60	79	3800	600

From their survey, Gill and Silver concluded that for a low cost it is possible to significantly increase the level of illuminance by changing from a conventional lamp to a Decorspot 80.⁵⁴

The use of strong colour contrasts in the home will also help the elderly visually handicapped person to make the full use of what remaining sight he or she has. The use of bright colours can help the elderly person to identify home appliances and the edge of table surfaces. Members of the In Touch team, who produce the regular weekly radio programme for the visually handicapped on Radio Four, have created a kitchen specially designed to meet the needs of the visually handicapped and the kitchen is a notable example of what can be achieved with the imaginative use of colour and lighting. The kitchen, which is the first of its kind in Britain, contains very little specialist equipment, but all the items selected have been chosen

because they are safe to use, easy to distinguish by colour or shape and simple to clean. The layout of the kitchen and the lighting have also been arranged in such a way as to provide the best possible help for a visually handicapped cook. In 1985 the kitchen was given a permanent home in the new premises of the Disabled Living Foundation in Harrow Road in London.

The use of colour also has implications for medications. Hurd and Blevins have observed that a decline in visual acuity with age may lead to a difficulty in discriminating between medications that are similar in appearance and so it is important for manufacturers to produce pills with bright and easily distinguishable colours.⁵⁵

A general examination of the training and the role of professional staff

All professional staff have a vital part to play in helping and supporting the elderly person with failing vision. However, the participants at Age Concern's policy encounter in 1984 pointed out that elderly people with failing vision tend to turn to formal sources of help only when there is a crisis and so professional staff should develop an outreach approach to their work in order to ensure that elderly people in need of help are identified at an early stage.

General practitioners and opticians have an important part to play in this process. It is not always the sight problem which brings attention to an individual and a general practitioner may be called into the home of an elderly person to treat other conditions, and then realise that help with sight is needed. General practitioners should ensure that all their elderly patients can see properly and that their

home lighting is adequate. Opticians are involved in identifying needs, but not all elderly people go to the opticians. However, some opticians will make home visits and these opticians can make a particularly valuable contribution to identifying and treating visual handicap in the community.

In the field of social work there is a shortage of trained professionals, which means that visually handicapped people are less and less well served. This shortage results from the emphasis put on the concept of the generic social worker, with a subsequent reduction in specific advice, and from the poor salaries and career prospects offered to all specialists. So much is this the case that the caring professions have seen little point in taking up any opportunities for post-experience training. It also appears that most of the caring professions neither expect nor receive much in-service training on the needs of the large numbers of elderly people with failing vision. This picture was confirmed by the report by the Disabled Living Foundation in 1979. The delegates at the Foundation's seminars reported that general practitioners receive little relevant training; nurses, occupational therapists, social workers and health visitors have insufficient relevant primary and post-experience education; the training of medical students is inadequate; district nurses principally learn by experience and ophthalmic opticians and ophthalmic nurses have a good theoretical training but insufficient time is devoted to the actual practical needs of partially sighted people. The delegates also put forward a number of recommendations to improve this situation. They recommended that

post-experience or post-graduate training for professionals deserves more emphasis and should be increased and made more attractive; professional training should be widened to provide sufficient knowledge of the roles and activities of other disciplines in addition to producing a specific expertise; training should be given to all general practitioners and hospital doctors to enable them to detect early visual disability; Ophthalmic Optics Departments at Universities, where some knowledge of how to prescribe and fit low vision aids is a requirement of undergraduates' degree courses, should provide or assist in the coordination of extra-mural multi-disciplinary courses with other selected centres such as social services departments and hospitals; team-work and liaison between all the professionals involved should be urgently increased and ophthalmic community nurses should liaise and work with community nursing staff and social services departments.

It is clear that the training of all personnel should cover the needs of elderly blind and partially sighted people and this training should be in a multi-disciplinary context wherever possible.

The participants at Age Concern's policy encounter on the elderly visually handicapped in 1984 observed that in the 1980's the training of professionals is still neglected although some voluntary agencies, for example the North Regional Association for the Blind, are involved in training medical students, nurses, general practitioners, social service staff, volunteers and others. If more resources were made available then more professionals could receive training in the needs and the problems of the elderly visually handicapped. The participants

at the policy encounter in 1984 proposed that consideration should be given to establishing guidelines on key staffing requirements against which the actual provision can be measured.

Another point concerns ophthalmologists. Ophthalmologists are limited by registration constraints - if a person is not registerable there is very little the ophthalmologist can do. The participants in the policy encounter in 1984 proposed that in the future ophthalmologists should not be constrained by registration procedures in assisting those in need.

The issue of communication between different professionals and between professionals and patients

It is in the interests of visually handicapped people that there are good lines of communication between different professionals and indeed between professionals and patients. However, the delegates at the Disabled Living Foundation's seminars in the 1970's reported that the communication between different professionals and between professionals and patients left room for improvement. These seminars highlighted the poor knowledge the professions have of each other's roles. The lack of inter-disciplinary discussion and feed back, which appeared particularly acute in the case of opticians, was frequently stressed by the delegates. The delegates then put forward six proposals to increase the lines of communication.

First, the delegates proposed that local guides to available services for visually handicapped people should be produced. These guides would be in large print if possible, and would be distributed to professionals and to the public.

Second, the delegates proposed that a liaison officer for visual handicap should be appointed. This person could be a hospital social worker or a health visitor specialising in the subject.

Third, the delegates proposed that more and better attended multi-disciplinary formal and informal meetings should be held. These meetings would include seminars, case conferences, primary health care meetings and luncheon clubs, at both regional and local levels, where members of the caring professions could increase contact and mutual understanding, learn what facilities were available and discuss problems.

Fourth, the delegates proposed that articles should be invited and/or offered by/to professionals concerned with visual handicap for the journals of professional disciplines other than their own, as little multi-disciplinary knowledge of elderly visually handicapped people is as yet widely available.

Fifth, the delegates proposed that there should be an improved understanding of the local systems of referral by all concerned.

Finally, the delegates also proposed that there should be an improved feed back of information from hospitals to opticians.

Since 1979 no research has been carried out to determine if any of these useful proposals have been implemented.

The practice of social work with elderly visually handicapped people

In 1983 the Southern and Western Regional Association for the Blind held two meetings to discuss the problems of visual impairment in old age⁵⁶ and at the meetings the speakers discussed the practice of

social work with elderly visually handicapped people, and the role of the specialist social worker in this work.

The speakers at the meetings recognised that poor sight is in many cases just one problem encountered in old age. Elderly visually handicapped people often have other health problems such as deafness, arthritis and cardiovascular disease and these difficulties can be made worse by a range of social problems, including poverty, inadequate accommodation and loneliness. Therefore, the speakers at the meetings proposed that in social work the right approach to the problems of the 'old-old' is a generic broad based one. Nevertheless, it was also felt that this approach will not be as good as it should be unless specialist advice is available to generic workers. It was felt that someone experienced in working with elderly visually handicapped should first of all make a thorough evaluation of the problem. The speakers at the meetings felt that it is important to highlight in this evaluation the skills that are present and absent in relation to daily living. Above all else, the individual should be put first - he or she is someone with sight difficulties who will explain his or her problems to the worker; the latter has nothing to work on until this explanation is given and success in recapturing a particular skill, lost because of sight difficulties, may enable the individual to develop other skills.

The speakers at the two meetings also felt that the worker must have a sound knowledge of the resources available to the particular elderly client group; he must accept his own limitations and be prepared to contact other agencies (either statutory or voluntary) as

appropriate; examples of such agencies are occupational therapists, health visitors, social workers and volunteers. Let it be remembered that the specialist worker in the field of visual handicap is a very scarce commodity whose time must be used to the maximum, displaying his own particular skills.

The speakers at the meetings argued that there should not be over populated case loads but rather small, changing case loads which generic social workers should handle under the guidance and with the help of specialist workers for the visually handicapped. Another way of making better use of specialist skills would be to ensure that specialists do not work in isolation, particularly as most of their clients have the variety of handicaps that old age is heir to. A team approach is possibly the most effective way of service provision, with the specialist worker being the primary worker when visual handicap is the primary disability: this would ensure continuity of support for the elderly visually handicapped client and effective coordination of the services.

The potential contribution of the voluntary sector to the elderly visually handicapped

It is also important to consider the contribution that could be made by volunteers and by voluntary organisations to the elderly visually handicapped. Integrated projects with volunteers providing support and advice to hard of hearing elderly people exist in several parts of the country. A notable example is the Kent Hard of Hearing Project. However, the report by the Disabled Living Foundation in

1979 noted that there was a shortage of volunteers to help in the field of visual handicap and a shortage of training and facilities.⁵⁷ The participants at the policy encounter in 1984 observed that since 1979 the situation has hardly changed.

However, in the future volunteers could make an important contribution to the welfare of elderly visually handicapped people. An integrated project for the elderly visually handicapped might recruit volunteers who would be trained to provide a variety of services which would complement those of the statutory sector. The project would seek to locate blind and partially sighted elderly people who are in need of help and could take referrals from general practitioners, health visitors, district nurses, social services, community groups, churches, relatives and individuals. One aspect of the project would also be to locate potential users whose disability is not known. The project workers might do simple screening themselves and then make referrals to the appropriate statutory agency if it is apparent that the elderly person needs help. The project would also encourage other workers, such as home helps and district nurses, to undertake screening. Relatives could also be encouraged to undertake screening. Other activities might include advice on lighting and the layout of the home, training in the use of aids, home visiting, counselling and advice and information. In the future much more use could be made of voluntary workers and voluntary projects could be set up all over the country.

Several well established voluntary organisations could assist in this work. For example, at a simple level eye sight testing could be

carried out in Age Concern clubs and day centres in association with other voluntary agencies for the visually handicapped. .

Information, publicity and the dissemination of services to elderly people with failing vision

At the seminars organised by the Disabled Living Foundation Margaret Ford, a social worker with West Sussex Social Services, pointed out that ideally the social worker who works with the visually handicapped needed to have a store of basic practical information about aids and services available - or at least ready access to such information. Yet there was, she observed, a dearth of such information, and little mention of the visually handicapped in the professional social work journals. It had been left to an outside organisation, the British Broadcasting Corporation, to attempt to fill this gap by publishing the In Touch handbook.⁵⁸ Until the handbook was published no easy and available source of information on services and aids for the elderly visually handicapped had existed.

Mrs. Ford felt that perhaps the old specialist welfare system for the visually handicapped was partly to blame for the lack of information. Knowledge had been accumulated within the partially sighted schools, the various organisations for the blind and the medical profession. She suspected that all had felt threatened and had clung to their own particular expertise.

The delegates then considered ways of increasing publicity and dispersing information about available services to elderly people and their relatives. Five recommendations were made.

First, the delegates recommended that publicity, aimed both at those elderly people with failing vision who have been identified and at those who need to be identified, is required at two separate levels, national and local. Nationally, posters, notices, large print pamphlets, the radio, television and the national press could be used, with the pamphlets perhaps being distributed by post offices when paying pensions. The same publicity would increase the knowledge of the caring professions. Locally, publicity could be aimed at the media but also specifically at schools, pre-retirement courses, old people's day centres and health centres. The delegates felt that it could be spread more widely by trained home helps, the caring professions and voluntary workers.

Second, the delegates recommended that leaflets, talking newspapers and regular newsletters, giving useful local addresses and information, should be published and circulated to the households of those visually handicapped people who had been identified.

Third, the delegates recommended that the print size and contrast of all official forms and handouts should be improved after simplification of the intended information, to enable greater assimilation and understanding.

Fourth, the delegates recommended that non-academic popular programmes on radio and television and also documentary programmes should be used to provide information.

Finally, the delegates added that the expertise and knowledge now available in a variety of places should be brought together and made available to those in need.

If all of these measures were implemented in a comprehensive way then the information on available services would be more widely available.

The Disabled Living Foundation published its report in May 1979 and since then there have been some improvements in the information and publicity that is available to elderly visually handicapped people. Since 1979 the In Touch handbook has gone through several editions and it is an invaluable source of information for elderly people with failing vision and their families and friends. It has been known for some time that many visually handicapped people are eligible for welfare benefits which they do not claim because they have no knowledge of these benefits. In an attempt to improve this situation the Royal National Institute for the Blind appointed a Benefit Rights Officer, Nigel Pegram, in 1984 and he is producing material for professional staff and others to help increase the knowledge and take up of welfare rights by visually handicapped people.⁵⁹ Practical information of this nature will help professional workers and relatives and friends to help elderly visually handicapped people. Unfortunately, however, there is still little mention of the visually handicapped in the professional social work and health care journals. If more articles were written then the problems of the elderly visually handicapped could be more widely known and discussed.

Attitudes and the difficulties of patients and relatives and proposals to improve this situation

The delegates at the Disabled Living Foundation's seminars in the 1970's reported that many elderly people do not report their visual

problems because they accept these difficulties and a lower standard of performance as an inevitable part of old age. The delegates also reported that this low level of expectancy has been shared in the past by relatives and the caring professions and sadly these low expectations confirmed the client in his view of himself.

The delegates then made some recommendations to improve this situation. First, the delegates pointed out that as so much can be done to improve visual performance, action is necessary to counteract the low level of expectancy of elderly people by publicity through the media and through the publication of information leaflets for issue to relatives and friends. The delegates also pointed out that it is important not only that the independence of elderly people should be maintained but also that they should be given the opportunity for regular outside contact with day centres and clubs. Any difficulties they were facing with their sight could be identified and discussed at such places.

The participants at the Age Concern policy encounter on the elderly visually handicapped in 1984 repeated this advice and recommended once again that publicity needs to be directed at elderly people and their relatives to promote a greater take up of available services and the earlier detection of visual impairments. Simple publicity along these lines is now being disseminated in Age Concern clubs and day centres. The participants at the policy encounter also recommended that the Health Education Council's programme on education for health in old age should take account of the needs of elderly visually handicapped people.

Residential homes and the institutional care of elderly visually handicapped people

Significant numbers of elderly visually handicapped people are in residential homes and hospitals. The participants at the Age Concern policy encounter on the elderly visually handicapped in 1984 claimed that the needs of blind and partially sighted people in homes and hospitals are often overlooked, as is shown in the reports of people having their glasses taken away and not having their glasses cleaned. The participants claimed that totally blind elderly people receive very poor treatment in hospitals. The participants also claimed that there is a widespread feeling by staff in homes that it is easier to do things for blind and partially sighted people rather than enable them to cope for themselves. Particular concern was expressed about conditions in the private residential and nursing home sector.

The participants then put forward several proposals to improve this situation. First and foremost the participants at the policy encounter wanted staff in residential homes and hospitals to encourage elderly visually handicapped people to make full use of their remaining vision. Therefore, they proposed that extra assistance should be available to keep spectacles clean. In some places, for example in geriatric units, voluntary spectacle cleaners have been found helpful. The participants also felt that under no circumstances should glasses be taken away.

Orientation and mobility are crucially important for visually handicapped people and most Mobility Officers would be very willing to

instruct elderly residents in private homes if invited. The participants at the policy encounter pointed out that training visually handicapped people to get around any building is possible and should be encouraged. The participants proposed that staff in private homes should be encouraged to learn about the needs of visually handicapped residents and the Code of Practice for Private Residential Homes should pay greater attention to the needs of blind and partially sighted elderly residents. The participants also felt that homes should be better designed to meet the needs of elderly visually handicapped people and that advice on lighting and decoration should also be given. Since 1984 no research has been carried out to determine if any of these proposals have been implemented.

Visual handicap amongst the elderly: A summary of some key points

It is important to emphasise a number of important points.

People with a visual handicap find that the activities which require clear sight are done less well, less often, less confidently and less easily. In the elderly, the handicapping effects of blindness are increased by the other impairments of advancing years. Arthritic conditions of the limbs or impairment of hearing reduces the powers of mobility. Loss of sensitivity in the fingers reduces the ability to rely on touch as a channel of information concerning the environment. Brain deterioration may lead to poor coordination, thus increasing the difficulty of doing housework. Together these problems constitute a syndrome of medical conditions, of which blindness is only a part. ⁶⁰

In the elderly the most common disorders which lead to poor

sight are chronic degenerative eye conditions such as open angle glaucoma, cataract and senile macular degeneration. These diseases are insidious in onset, slowly progressive and potentially blinding. However, because of the slow development of these disorders some adaptation to the disability can take place and this, together with the acceptance of poor vision as one of the concomitants of growing old, often means that specialist assessment of vision is not sought. For example, according to a well known survey carried out by Cullinan no more than sixty per cent of the visually handicapped population interviewed had had a specialist assessment, although most of these people suffered from a specific sight threatening disease.⁶¹

It is obvious that these elderly people pose a different challenge in terms of identification and management of visual disability from young people with impaired vision. Many of them are so overwhelmed by their other disabilities that poor sight appears to be the least of their worries. Yet, if health visitors, social workers and others can identify this visual disability within the community there are a number of ways in which these people can be helped. Their quality of life can be improved significantly either by medical help, a low vision aid, new spectacles, improved home lighting or by practical help from voluntary organisations, volunteers and self-help groups.

In a hospital setting, a patient's qualitative experience of visual deterioration is embodied in the clinical history. During a clinical examination, a level of visual handicap may be inferred from measurements of visual function, and yet there are no good grounds for

assuming that conventional vision tests are appropriate indicators of how well a person is able to function on a day to day basis. Ross' studies at Oxford Eye Hospital have shown that letter acuity correlates poorly with perceived visual disability in a number of disorders.⁶²

In the community, much greater reliance has to be placed on the patient's own reports of visual difficulty and in this case early identification of visual handicap needs to be carried out by social workers, health visitors and others who have regular contact with the elderly. These are the key personnel who can offer practical advice and help to those in need.

Unfortunately, however, there are enormous problems involved in the identification of visual handicap, especially when it is masked by physical disability and/or low expectations of life. For example, in the case of a patient with severe arthritis it can be difficult to determine whether poor mobility is mainly attributable to visual loss or to stiffness in the joints. Indeed, if pain is a prominent feature then poor sight may not be mentioned at all by the patient. It is surprisingly common to find older people who assume that poor vision is an inevitable part of ageing.

People who are registered as partially sighted or blind may be assumed to be having functional difficulties, but there are also many who are not eligible for registration but nevertheless suffer from a visual handicap. The total number of such people in the population is not known, but recent surveys by Genensky⁶³ and by Cullinan⁶⁴ suggest that there is a great deal of undiagnosed visual handicap in the community

which is causing hardship. In a survey carried out by Ross, Bron and Clarke at Oxford Eye Hospital in 1984, it was found that the degree of perceived visual handicap suffered by fifty patients with glaucoma was not reflected in their letter acuity scores, which is the main criteria for partial sight and blindness registration in Britain.⁶⁵ It is interesting to note that a more sensitive predictor of visual handicap is a test which determines how well patients can detect changes in contrast between a pattern and its background - which is the contrast sensitivity test.

Clearly it is very important that visual handicap amongst those who are not eligible for registration should be identified and that the sufferers are then given practical help and advice. But how can visual handicap be identified in these people? This is an important question to pose and is relatively easy to answer. Some disorders produce their own particular symptoms from which visual handicap can be inferred. For example, the sufferers of cataract complain of progressively blurred vision so that visual tasks such as sewing, reading and seeing distant objects becomes more difficult. Light falling on the lens may be distorted so that straight edges appear curved; yellowing of the lens can alter colour perception; and light scattering by the opacity causes glare in the presence of bright lights such as car headlamps or bright sunshine.

The sufferers of glaucoma, when the disease is well established, have increasing problems in getting about as their field of vision becomes constricted; but at a much earlier stage a more subtle and

often unrecognised visual disability can be identified. Lack of confidence and anxiety in carrying out daily activities, especially outside the home, are early features. Furthermore, as these difficulties are not easy for the patient to articulate and explain, they are not often recognised by professionals as disabling.

Macular disease causes problems with central vision and so any task requiring fine resolution of images such as reading, sewing and watching television becomes progressively more frustrating for the elderly patient. The distortion of images is symptomatic and many elderly patients experience problems with glare. Elderly patients with macular disease need special support from workers in the community because their condition may be unsuitable for treatment in an eye clinic.

Other disorders in the elderly, such as diabetic retinopathy, can produce a whole range of symptoms, and result in varied disabilities. These disabilities range from problems with the perception of colour (which is particularly important in diabetics who use a colour code to test their urine) to a relative loss of field of vision which often affects the macular area, leading to difficulty with tasks requiring good resolution.

However, not all elderly people with visual disability have eye disorders and we must not forget those whose disability has a purely optical basis, and for whom all that is required is a simple visit to the optician. In fact surprisingly few older people have a specialist assessment of their vision.

But it seems that elderly people often have difficulty in reaching and making use of specialist services such as the high street optician.

This may be as a result of physical disability, ignorance of the availability of the services, travel problems, or reluctance. However, when the reason for non-attendance has been identified it is likely that most of the difficulties can be overcome with the help of practical assistance from community health workers, voluntary workers, kind neighbours or relatives.

In a survey conducted at Oxford in 1984, Ross, Bron and Clarke found that all visually handicapped people seem to have more difficulty outside their home environment.⁶⁶ Ross, Bron and Clarke found that the visually handicapped find it hard to negotiate busy roads, to walk along uneven pavements and to get on to the right bus. Some may also stop going out because they become disorientated in crowds. One visually handicapped person who they questioned said: 'I can't really take it all in. I'm uncomfortable in the city centre, I'm afraid of bumping into someone.' Variations in weather alter the light conditions and produce additional hazards for visually handicapped people, as a further quotation from Ross, Bron and Clarke's survey demonstrates: 'I would say my biggest problem is clarity of vision and this seems to be very dependent on the kind of light that day.'

In contrast to this, Ross, Bron and Clarke found that most visually handicapped people appear to manage adequately in the home, although they may not be happy with their home circumstances. At home, it is possible to organise daily activities so that the inconvenience of poor eye sight is minimized. In addition to this many older visually handicapped people have lots of spare time which allows them to do things

more slowly, or to adapt their home to accommodate their disability.

In the same survey, Ross, Bron and Clarke found that loss of leisure activities and social interaction produced the most bitterness among the elderly visually handicapped. It is difficult to know how many of these lost abilities are due to poor sight and how many are simply a consequence of old age. For example, Ross, Bron and Clarke found that patients often defended their lack of social activities or hobbies by saying that in any case, this is not due to poor sight, but because of their 'age'. One patient told Ross, Bron and Clarke that 'I don't have much time for leisure now because I am old.' But for some, the despair of deteriorating eye sight has nothing to do with old age as such. Ross, Bron and Clarke found that one gamekeeper with glaucoma and severe visual field defects had lost his job because what he lacked was 'a good pair of eyes'.

One finding reminded Ross, Bron and Clarke of the importance we attach to appropriate social behaviour. Difficulty with recognising friends' faces prevented many of the patients Ross, Bron and Clarke interviewed from participating in and enjoying social events. A person who is not able to recognise a friend's face may nevertheless have little trouble in reading the newspaper or getting about and this apparent paradox makes it difficult for relatives and friends of such patients to empathise with their visual handicap. Clearly it is important that relatives and friends, as well as the patient himself, should recognise that visual disability can manifest itself in many ways. Too often, there are misconceptions about how a visually handicapped person should

function and this can make things worse than they are already for the person in question.

There are various ways in which professional staff and volunteers can tackle the problem of identifying and helping these elderly visually handicapped people so that their quality of life can be improved significantly. Perhaps the most important of these is to ensure that workers in the community are well informed about visual handicap and its various consequences. In elderly people visual handicap is often set against a complex background of concurrent ill health, social problems and low expectations of life. If an individual's understanding of growing old is that poor vision, deafness and limited mobility are the inevitable consequences of ageing, then he or she may not complain of poor sight at all. However, this does not mean that he or she is functioning well and sometimes careful questioning is required to elicit these problems.

If an elderly person seems to be disabled visually, then there are a number of practical questions to be considered. Three questions are particularly important.

The first important question to be considered is has specialist advice been sought? If the answer to this question is 'no' then a visit to the optician or the general practitioner is the first step to take. If eye disease is diagnosed and spectacles do not improve the elderly person's vision, then there are a number of low vision aids which are available. If the elderly patient can obtain a referral for a low vision assessment from a hospital clinic, then these aids are available on loan, and are free of charge, for as long as they are needed. Often

elderly people and their relatives do not appreciate that such a service is available. Hand held or spectacle mounted telescopic aids for distance vision can be borrowed, as well as a range of simple hand held and stand magnifiers for reading and near vision. In addition, some opticians will supply such aids privately to patients. Other simple aids can also be used in an effective way. For instance, visors or shades for patients who have glare problems can mean the difference between being mobile or housebound.

The second important question to be considered concerns lighting. Is lighting in the home adequate? Social workers, general practitioners, relatives and others should ensure that elderly visually handicapped people are making efficient use of their light.

The third and final important question to be considered is what other facilities are available? Although facilities may be well publicised it is likely that elderly people in need, for example, those who are relatively housebound, are the very ones who miss the opportunity to learn about local facilities. In several areas of the country main libraries will deliver books and cassettes. Voluntary groups all over Britain provide a range of services including shopping, collecting prescriptions or providing transport to the general practitioner or to the hospital. In addition, the local social services department should be contacted if a home help or meals on wheels are needed, and also if a more specialist assessment is required by the Technical Officer for the Blind or the Mobility Officer. At the national level the Royal National Institute for the Blind, the Disabled Living Foundation and

the Partially Sighted Society can all offer valuable information and advice to elderly visually handicapped people and their family and friends.

In conclusion, the important point to stress in this chapter is that workers in the community should actively look out for poor vision when assessing elderly individuals, particularly if there are other disabilities as well. If visual disability can be identified early in its development then much can be done to improve the quality of life for thousands of elderly men and women, and it is the workers in the community who are in the best position to offer appropriate help in the first instance.

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63. See S.M. Genensky, S.H. Berry, T.H. Bikson and T.K. Bikson, Visual environmental adaptation problems of the partially sighted: Final report. Prepared for the Department of Health, Education and Welfare, CPS, 100, HEW Santa Monica Hospital Medical Centre, 1979.
64. T.R. Cullinan, The epidemiology of visual disability studies of visually disabled people in the community, Health Services Research Unit Report, Number 28, University of Kent at Canterbury, 1977.
65. See J.E. Ross, A.J. Bron and D.D. Clarke, 'Contrast sensitivity and visual disability in chronic simple glaucoma', The British Journal of Ophthalmology, November 1984, Volume 68, Number 11, pages 821-827.
66. See J.E. Ross, A.J. Bron and D.D. Clarke, 'Contrast sensitivity and visual disability in chronic simple glaucoma', The British Journal of Ophthalmology, November 1984, Volume 68, Number 11, pages 821-827.

CHAPTER NINE

THE EDUCATION OF THE VISUALLY HANDICAPPED

In this chapter I intend to do three things: first, I intend to provide a brief history of the education of handicapped children;¹ then, I intend to examine the recent legislation for children with special needs and, finally, I intend to consider the problems associated with integrating visually handicapped children into ordinary schools.

In Britain only a small number of handicapped people suffer from a disability dating from birth or early childhood which affects their education. Official statistics show that in 1976 there were nearly 200,000 handicapped children of school age, roughly half of whom were mentally handicapped.² A national survey carried out by Harris in 1971 showed that there were then at least a million and a half disabled adults in the age range from sixteen to sixty five.³ On the basis of these figures, it is clear that disabled school children form only ten per cent of the disabled population in Britain under retirement age and less than two per cent of all school children. However, for this relatively small group the education and training received during childhood and adolescence plays a vital part in equipping them to deal with their adult life.

The acceptance of state responsibility for the education of handicapped children

State concern with educational provision generally is a relatively recent phenomenon, and the beginning of state concern for the education

of handicapped children did not lag too far behind the full acceptance in 1870 of state responsibility for the education of able bodied children. By this time a number of schools run by charities for handicapped children were in existence, but there was little state support for them.

Under the Poor Law introduced during the reign of Elizabeth I in 1601, parish justices were empowered to raise money by tithes or taxes to permit 'the puttings out . . . to be Apprentices' of the blind, lame, impotent and other such children. A similar power was vested in the Poor Law Guardians by the Poor Law Amendment Act of 1834, and they were enabled to pay the fees at charity schools for handicapped children of poor families.

When, in 1889, a Royal Commission reported on the condition of the blind, deaf, and the mentally handicapped,⁴ it was stressed that such powers had been used very sparingly indeed by the Poor Law Guardians, so that state assistance for the education of handicapped children, although in principle available, was in practice negligible. In its report the Commission recommended that the state should require local education authorities to provide for the compulsory education of blind and deaf children from the age of five to sixteen, and should also permit them to make provision for the education of mentally handicapped children who were not already accommodated in existing schools or institutions. It was intended that in discharging these responsibilities, the education authorities would use the existing voluntary school provision, but would make adequate grants to those establishments which were approved as suitable.

The Commissioners observed in their report that:

'The blind, deaf and dumb, and the educable class of imbeciles, form a distinct group, which, if left uneducated, become not only a burden to themselves, but a weighty burden to the State. It is in the interests of the State to educate them, so as to dry up as far as possible the minor streams which ultimately swell the great torrent of pauperism.'⁵

Pritchard is unable to accept an approach so openly economic and rational and bitterly declares that:

'What should have been presented as an ethical duty, they showed as a mundane necessity. What should have been revealed as an inalienable right, they concealed as an economic expedient.'⁶

Pritchard seems unaware of the fact that these same strictures could apply equally to the arguments advanced in favour of compulsory education for able-bodied children. The emphasis of the Commission was entirely consistent with the underlying principles of other welfare legislation, and was, moreover, effective.

The recommendations in the report of the Royal Commission of 1889 were promptly implemented, as far as blind, deaf and dumb children were concerned, in the Elementary Education (Blind and Deaf Children) Act of 1893.⁷ The provision for the education of mentally handicapped children was delayed for a further inquiry to be made. The Departmental Committee on Defective and Epileptic Children was required to distinguish between those mentally handicapped children who were capable and not capable of benefiting from education. The Royal Commission had made no such distinction explicit, but in restricting its recommendation for state responsibility for the education of the mentally handicapped to those who were not already cared for in

institutions, they did imply that there would be some so severely mentally disabled as to be unable to benefit from education. The Departmental Committee's report was published in 1898,⁸ and this attempted to define the educable mentally subnormal, but the distinction was woolly and not entirely satisfactory. In later years the educable were divided from the ineducable, ostensibly on the basis of intelligence test scores, but other considerations, such as home background, also formed part of the assessment.⁹ The dissatisfaction with a system which labelled some severely handicapped children as not worth any educational provision on the basis of questionable criteria led finally, in 1970, to the abandonment of the distinction between educable and ineducable.

However, the Committee's report of 1898 resulted in the introduction of the Elementary Education (Defective and Epileptic Children) Act in 1899, which gave local education authorities the power to provide special schools for the educable mentally subnormal. Local education authorities were also, by the same act, encouraged to provide special schools for the severely epileptic child, but for the mildly epileptic, and for other physically handicapped children, it was pointed out that

'physical defect alone is not sufficient cause for the admission of a child to a special class',

an assertion which would win agreement from many people today who are opposed to special schools for physically handicapped children. But in the 1980's there is more concern to ensure that there is adequate support for handicapped children in ordinary schools. In the 1890's

it was envisaged that such children would need no special help at all. They were to obtain their education in the ordinary schools, or, if absence through ill health made them backward, in special classes which were established for 'feeble-minded' children.

In fact, the Departmental Committee on Defective and Epileptic Children paid scant attention to the educational needs of the physically handicapped, although only those with sensory defects had previously been considered by the Royal Commission. In the 1890's it was estimated that the blind and deaf of school age numbered about five thousand. There was no attempt to estimate the numbers of physically or mentally handicapped children. It is possible that the Committee assumed that there would be very few children so severely physically handicapped that they could not attend ordinary schools, who would yet survive long enough to be able to receive and benefit from education. Given their awareness of medical knowledge at the time, this may have been an understandable assumption to have made, but it was not a correct one. Despite the fact that physical defects did not in themselves warrant admission to a special class, in the years following the Elementary Education (Defective and Epileptic Children) Act of 1899 several local education authorities were moved to provide special schools for physically disabled children who could not cope in the ordinary school environment. Similar schools were also run by voluntary charities, but the numbers of seriously physically disabled children who were unable to find a school place suitable for them remains unknown, as there was (and still is) no complete record of the number of handicapped children.

As for the mentally handicapped children who were deemed to be ineducable, these were left to be cared for in asylums or in other institutions, in so far as there was room for them, or, in default in the family, with no help at all. The permissive powers conferred on local education authorities in respect of the physically and mentally handicapped and epileptic children were made mandatory with the passing of the Education Act of 1918, thus bringing them into line with the education provisions for blind and deaf children, which had been mandatory since 1893.

Completing the process of state responsibility for the education of handicapped children

The provision of state educational services for handicapped children, then, developed piecemeal on the heels of educational provision for able-bodied children, with groups of defective children being singled out successively as requiring educational services. The first groups to be so recognised were those suffering from sensory defects - the blind and the deaf. Afterwards, the needs of epileptic children, and those mentally handicapped but still educable, were provided for. The more severely physically handicapped who could not be fitted into the ordinary school system were considered later. In each of these cases, educational provision had been extended by specific legislation to groups of children hitherto excluded from schooling, as the need to educate them was established. Not until the Education (Handicapped Children) Act was passed in 1970 was the education of all children of school age made the responsibility of local

authorities. Even after the Education Act of 1944, which included in the one measure normal children and all the groups specified in the various supplementary education acts mentioned earlier, there still remained one group - those certified as ineducably mentally handicapped - for which the education authorities took no responsibility.

Some units in the National Health Service for the care of severely mentally handicapped children, known as junior training centres, were transferred from the National Health Service to the education authorities under the Education (Handicapped Children) Act of 1970, taking effect in 1971. This transfer chiefly represented an administrative tidying-up process, since there was little immediate change in the educational policy or provision in respect of these children. One of the central arguments for the reorganisation was that the distinction between 'training' for the ineducable, and 'education' for those less severely handicapped, was unrealistic. Both the training and the education of mentally handicapped children included a large element of fitting the child socially for the daily activities of living, and many of the children needed treatment or therapy to improve their muscular coordination and control. The administrative division of responsibility between the health authorities on the one hand, and the education authorities on the other, was increasingly seen as meaningless.

Educationists objected that the system of certifying or refusing to certify a child as ineducable gave to a doctor the power to determine the educational, as well as the medical, treatment the child should

receive. Considerable concern was expressed that the process of medical certification was not only painful for the parents concerned, but also undermined their relationship with the doctor. The doctor was seen less as an ally in the management of their handicapped child than as a judge who was capable of condemning him as incorrigible and ineducable. The division into water tight compartments of 'training' for the 'certified' and 'education' for the non-certified was felt to be too inflexible to cater for the different, and changing, needs of the children.

Therefore, although the administrative convenience of the transfer of responsibility is perhaps the easiest aspect of the act of 1970 to demonstrate, the feelings of parents, and the needs of the children for flexibility in educational treatment, were also important considerations in making the change.

The adequacy of educational provision for handicapped children

There is now state responsibility for the education between the ages of five and sixteen of all children, including handicapped children, although this does not mean that all such children are in fact receiving an education. Many disabled children spend intermittent, and often quite long, periods in hospital and even where provision is made for such children to be visited by peripatetic teachers - which does not always happen - schooling may be severely interrupted. Furthermore, in 1976 there were over 9,000 handicapped children who were awaiting admission to a special school, more than 3,000 of whom had been waiting for periods of over a year.¹⁰

The demand for special educational provision is affected by the incidence of severe birth defects, the survival rate of these infants, and by the incidence of disabling diseases in childhood. There are marked fluctuations in these areas. For example, there has been a progressive reduction, to a point of elimination, in the numbers of children who become disabled after birth due to tuberculosis, rheumatic heart disease or malnutrition. Apart from fluctuations in the incidence of specific disabling conditions, the general trend is that, as a result of improved medical techniques and obstetric services, a larger number of multiply handicapped children are now surviving. These children are often too severely handicapped to be able to attend ordinary schools even with a good deal of assistance, and add to the pressure for places in special schools. Therefore any increase in the survival rates of multiply handicapped infants will increase the demand for special educational facilities without there necessarily being any increase in the incidence of birth defects. Another source of pressure on special school places was the growing reluctance, until the procedure was abandoned, to certify a child as ineducable. The result of this was that a greater proportion of mentally handicapped children joined the queue for education in special schools rather than attend junior training centres. Now that both types of provision come under the education authorities, it should be possible to make better use of existing facilities.

Clearly it is very difficult for education authorities planning special educational facilities for handicapped children to anticipate

the consequences of any changes in medical practice and techniques. However, the realisation of the direct influence of obstetric and paediatric medicine on the demand for special provision of educational services should prompt the closest possible consultation between the educational and medical authorities. As it is, it is clear that education authorities are not fully discharging their responsibilities to educate all school age children, whatever their degree of handicap. Indeed, it is still possible that the education authorities are unaware of the total number of handicapped children, since there has been no comprehensive national survey of disabled people under the age of sixteen. Not everyone shared the confidence of Sir Keith Joseph, who as Secretary of State for the Department of Health and Social Security in 1973 stated that such a survey was unnecessary because handicapped children's needs are 'not being overlooked'.¹¹

Desirable improvements in the education of handicapped children

Nevertheless, while the adequacy of basic educational services still needs to be assured, there is already a movement in Britain to the next stage - that of securing improvements in the quality of educational provision. History has repeated itself and the first such move concerns the blind and the partially sighted. The Vernon Report on the education of the visually handicapped, a term which includes both the blind and the partially sighted, was published in 1972.¹² The report accepted the basic educational provision for visually handicapped children as reasonable, but also went on to demand nursery schools and further educational services for the

visually handicapped. The report stressed that visually handicapped children lacked an important stimulus to their physical and mental development because they are unable to see the world around them. Therefore, the report argued that they had a greater need than most children of nursery school education to compensate for this lack and to enable them to benefit fully from the education given after the age of five. At the other end of school life, the Vernon Report noted that there was a grossly inadequate provision of further education places for the visually handicapped, particularly for the partially sighted, and urged that this deficiency should be speedily remedied. The report also emphasised that teaching any visually handicapped child required special skills and therefore urged that all teachers of the visually handicapped should undergo special training.

In accordance with Regulation 15 (2) of the Handicapped Pupils and Special School Regulations of 1959, teachers of the blind, the deaf and the partially hearing are already required to have special qualifications in addition to ordinary teaching certificates. In the case of other special school teachers, all are required to be qualified, but while special training is regarded as desirable, it has not yet been made obligatory. In practice, in 1971 just over seventy per cent of teachers in schools at which special qualifications are required had such qualifications but only 10.3 per cent of teachers in all types of special schools. It is clear that special training is a reality for only a minority of special school teachers, but at least the majority are trained teachers. The proportion of special school teachers who

were graduates, trained or untrained, was 8.9 per cent compared with 20.6 per cent of teachers in the state school system as a whole in 1971, but in special schools at which special qualifications were required, 20.3 per cent of teachers were graduates.¹³

It does appear from these figures as if those special schools which require their teachers to have additional qualifications do manage to obtain a higher proportion of specially trained teachers than those schools which only prefer it. They also appear to be more successful in attracting graduate teachers. It may be argued that graduates are not likely to be attracted to teaching in special schools for mentally handicapped children, who form a majority of the special school population, whereas teaching the blind and the deaf of normal intelligence offers as much intellectual reward as teaching sighted or hearing children. This argument assumes that all graduate teachers want to teach their own degree subject to a high academic level, but this may not always be true. Some graduates may be attracted by the opportunities offered in special schools for mentally handicapped children, especially those who are interested in child development, educational techniques and the modification of behaviour. Therefore it is quite plausible to aim at recruiting graduate teachers with special qualifications for the very demanding and crucially important work of teaching in all types of special schools, thus giving the handicapped children attending them the best possible chance of academic achievement or personal development despite their disabilities. There is a good argument in favour of extending to all special schools

the requirement that teachers who work in them be specially qualified. However, many people claim that there is an even stronger argument for ending the segregation of handicapped school children in special schools, and instead integrating them into the ordinary school environment.

The historical debate over segregated and integrated facilities

Any attempt in society to provide for the needs of the disabled is faced with the general dilemma that any form of special provision, while going some way to compensate for disability, may at the same time emphasise the isolation of the disabled. This problem has been an issue for over a century in educational provision for handicapped children. As far back as the 1880's, Moberley of the London School Board was urging the value of separate schools or classes for defective children. Moberley was especially concerned with mentally defective children, for whom several progressive school boards had begun to make special provision, but the majority of school boards argued that such a policy would be too expensive. The Elementary Education (Defective and Epileptic Children) Act of 1899 supported Moberley's views as far as mentally defective children were concerned and empowered local education authorities to establish special schools and classes for mentally subnormal but educable children. This act and the report on which it was based, did not, however, recommend special educational provision for physically defective children and as far as possible they were to be accommodated in ordinary schools.

The Royal Commission on the condition of the blind, deaf and the

mentally handicapped which reported in 1889 was reluctant to advocate special schools even for blind children, who should, the Commissioners thought, usually be taught in ordinary schools with the addition of some special instruction in braille or moon. At that time the educational techniques of ordinary schools relied heavily on note learning and oral examinations, and the Commissioners thought that blind pupils could adapt to these conditions. However, the Commissioners believed that deaf children would not be able to benefit from education in ordinary schools, but would require special classes or schools.

In fact, the education provision for the blind which existed at the time of the Commission's deliberations in the 1880's was mainly segregated, having been established privately or by charities which were expressly devoted to the welfare of the blind. Even after the assumption of state responsibility for the education of the blind, voluntary provision, aided by government grants, predominated, and still in the 1980's over half the school places for blind (but not partially sighted) children are provided by voluntary bodies. This particular situation, plus the changes in educational techniques and content, probably accounts for the fact that there has never been much attempt in Britain to educate visually handicapped children in ordinary schools.

The Vernon Report on the educational problems of visually handicapped children argued that the majority of these children do better in special schools. This argument was based on the conviction of the members of the committee conducting the inquiry that if visually

handicapped children were accommodated in ordinary schools, they would be less likely to receive the special type of teaching necessary to permit them to acquire a good general education despite their disability.

A memorandum submitted in October 1973 to the Department of Education and Science by the National Federation of the Blind and Partially Sighted Teachers and Students in response to the Vernon Report criticised the unqualified recommendation of education in special schools, and pressed instead for special classes for the visually handicapped attached to ordinary schools, or for special teachers to be appointed to ordinary schools where there were visually handicapped pupils.¹⁴ The members of the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students claim that these measures would aid the integration of visually handicapped children into ordinary schools. I will examine these proposals in more detail later in this chapter.

Parents of handicapped children seem generally pleased and even anxious for their children to be accepted into ordinary schools, although the difficulties in coping with normal school life for those with more than a minor handicap is probably very stressful. In 1970, the latest year for which this information is published, 4 per cent of physically disabled school children (other than blind and deaf) in ordinary schools were in wheel chairs, and a further 11 per cent needed some sort of walking aid. Altogether 20 per cent of the physically disabled children in ordinary schools needed some personal

assistance from teachers or other school children.¹⁵ It is clear that parents do not deliberately expose their children to adult hardships on the basis that they will one day be adults and have to face them. Neither is it a sufficient argument that because a disabled child will have to adjust to a society largely created by and for able-bodied adults, he or she should learn to do so without any protective environment or special help while still a child. The fact that parents of quite seriously physically disabled children prefer them to attend ordinary schools must reflect their conviction that educational standards and the chances of achievement are, despite all the difficulties, higher in ordinary schools than in special schools. Furthermore, the fact that the child can attend on a daily basis rather than as a weekly or termly boarder may also influence parents' decisions about schooling, although most special school pupils attend daily also. The Chief Medical Officer of the Department of Education and Science reviewed the position of handicapped children in ordinary schools in 1970 and warned that:

'For some this may be the right placement, but for others the more sheltered environment of the special schools, with smaller classes, intensive medical and nursing care, and full range of therapies available, may be more suitable.'¹⁶

However, it has been government policy for some time to encourage the inclusion of physically handicapped children in ordinary schools. The official policy in 1954 was that no handicapped child should be sent to a special school, who could be 'satisfactorily educated' in an ordinary school. In 1967 this stance was unequivocally endorsed in the Plowden Report, in which it was said that the unnecessary

segregation of the handicapped was neither good for them nor for those with whom they must associate and that they should therefore be placed in the ordinary school wherever possible.¹⁷ However, the Plowden Report did not give any real consideration to what was meant by 'satisfactorily educated'.

Many people felt that education authorities were tardy and unenthusiastic in their compliance with these injunctions, and there were also some voices raised in warning that to place a severely disabled child in a normal school without making special help available to him might be less satisfactory than placing him in a special school.

A central argument in favour of educating handicapped children in ordinary schools has been that it would facilitate their integration into society. However, it is important to point out that merely to allow disabled children to attend schools planned primarily for able-bodied children is in effect to follow the practice adopted in the 19th century, when the schools that were being established to bring elementary education to the children of the working classes also accommodated any disabled child who could be contained within the classroom. In the 19th century it was regarded as a progressive and humanitarian development when the Elementary Education (Blind and Deaf Children) Act of 1893 created special educational facilities for children suffering from sensory defects, and pressure was then mounted to extend this special consideration to all mentally and physically handicapped children. In the 19th century the argument was that unless special educational provision was made for disabled

children, they would be denied the benefits of education because their disabilities made ordinary schooling impossible or unsatisfactory.

However, in the 20th century the reverse argument is often made, namely, that ordinary schooling is preferable for practically all handicapped children, and for many mentally handicapped children as well. The Education Act of 1976 changed the emphasis of earlier Acts of Parliament, which required local authorities to provide special schooling for handicapped children with special needs, to requiring local authorities to educate handicapped children in ordinary schools unless it was quite impracticable, against the best interests of the handicapped children, or would involve an unreasonable cost.

The Warnock Report and the 1981 Education Act

The Education Act of 1976 was passed in advance of the publication of the report of an important Committee of Inquiry, established in 1974 under the chairmanship of Mrs Mary Warnock, Fellow of Lady Margaret Hall, Oxford, to consider the educational needs of handicapped children. The Warnock Report was published in May 1978¹⁸ and it was clear that, far from the Committee's findings informing official policy, the government's plans for education had guided the Committee's lines of inquiry. Their report noted that Section 10 of the Education Act of 1976 required handicapped children to be educated in ordinary schools except where this is totally impracticable, and declared that they had accordingly judged it more fruitful to concentrate on the practical requirements for the future than to continue to debate the advantages and disadvantages of integrated education.

The most important proposal of the Warnock Report was that the concept of special education for certain categories of handicapped children should be abandoned in favour of the recognition of special educational needs, whether arising as a result of mental or physical disability, or from behavioural problems or environmental disadvantages. The Warnock Report pointed out that one in every five school children might be expected to experience learning difficulties of one sort or another during his school life. The report argued that to single out for special educational treatment only those with mental or physical disability was to make an invidious distinction between learning difficulties due to these factors and those resulting from other causes, accentuating the differences between disabled and able bodied children, and depriving many children of the special educational consideration which their learning problems made desirable.

Many of the recommendations of the Warnock Report followed from the proposal for a broad definition of special educational need, and involved establishing a system of surveillance for every child and careful assessment of any child showing signs of having special educational difficulties. In order to equip teachers to recognise situations where such assessment procedures were necessary, the Warnock Report recommended that all teachers should, as part of their training, be taught to identify special educational needs. In addition, for pre-school provision for handicapped children, and better career guidance and further educational opportunities for handicapped school leavers.

Since the Warnock Report was published in 1978 it has set the terms for the general debate concerning the education of handicapped children. The Conservative Government accepted the central arguments of the Warnock Report and the report's main recommendations were implemented in the 1981 Education Act.¹⁹ This act, which came into force on April 1, 1983 brought with it some of the most important changes in the education of children with special needs since the 1944 Education Act. From April 1983, the individual categories of handicap, like maladjusted and ESN, were abolished and replaced by a single system defining children with special needs as having learning difficulties. Under the act, there is a new general duty on local education authorities to place as many children as possible who have been receiving an education in special schools, in ordinary schools. This integration must occur provided it is possible. Under the 1981 Education Act, children cannot be excluded because of the nature of their handicap, whether sensory, physical or mental, or because of its severity. Special education will not now take place just in special schools, but as support which should be available for any child who experiences difficulties, however temporary. Under the new law, most special education should take place as an everyday part of the work in schools and classrooms without the identification and labelling of children as 'special'. The act requires local education authorities to ensure that schools make special provision for all children who experience difficulties in their education. Under the act there are new duties for health authorities. If local health authorities

consider that a child under five years of age has special educational needs they must tell the parents, and also bring this to the attention of the local education authority. They must also tell parents of a relevant voluntary organisation that might help them.

Under the 1981 Education Act the needs of children with severe learning difficulties will be safeguarded by the introduction of a new 'Statement of Needs', or record, describing what their special needs are and how they will be met. Governors have a duty to ensure that ordinary schools, as well as special schools are meeting the special needs of their children. A major feature of the act is a greater parental involvement in the assessment and placement of their handicapped child. Parents are able to contribute significantly to the new 'Statement of Needs' with written representatives. All information provided to local education authorities to help them make special education decisions, must be made available to parents as part of the Statement. Under the 1981 Act, parents receive a copy of the Statement which includes all educational, medical, psychological and other reports. In addition, any discussions between parents and professionals during the process of assessment will be of 'crucial importance, according to the government's guidelines to local authorities. Local education authorities must also make arrangements for parents to appeal against the special educational provision written down in the Statement. New appeals committees have been set up under the 1980 Education Act, although their decisions are not binding on the authorities. There is also a further right of appeal to the Secretary of State.

The Labour Party's criticisms of the 1981 Education Act

The Labour Party welcomed the Warnock Report's recommendation that those children with special educational needs should be integrated into ordinary schools. However, Lady Warnock recognised that the report's objectives would require a major investment of resources, and the Labour Party has claimed that the Conservative Government has failed to provide enough resources to implement the 1981 Education Act. Therefore in 1983, the Labour Party called the act 'but a pale shadow of Warnock's positive proposals.'²⁰

In 1984 Andrew Bennett, the Member of Parliament for Denton and Reddish, developed this theme in the House of Commons and argued that:

'The Education Act was right in principle, but it was a disgrace that the government did not produce any resources to implement it. There are still no resources to implement it. Consequently, there are carefully prepared statements about the needs of those children but they only highlight the fact that there are not the resources to do the right thing. The principles of the act have been implemented, but we are denying them by failing to make the resources available. We do not have enough nursery places for handicapped children. When the legislation was going through the House (of Commons) everyone agreed that nursery education was important for all children, and that it was particularly important for handicapped children. We agreed that the education of handicapped children should begin as early as possible to help them overcome their handicaps. No money is available to train teachers in ordinary schools to teach children with special needs. As a result, integration does not work. No money is available to adapt buildings. The act places a duty on local education authorities to provide education for 16 to 19 year old handicapped youngsters. Little provision is made for that age group . . . we are still doing far too little for handicapped youngsters in our education system. If we want to make the 1981 Act work we must find the resources.'²¹

Official figures show that in 1985 eightyfour per cent of children with special needs were still in special schools. The Labour Member's

of Parliament, Michael Meacher, Alf Morris and Margaret Beckett claim that the reason for this

'is that the Education Act 1981 was an act without resources and a policy for integration is a fraud without a commitment to the expenditure it requires.²²

Clearly, the Labour Party believes that if more resources were made available for the 1981 Education Act then more handicapped children could be successfully integrated into ordinary schools, and the Labour Party has pledged that a future Labour government would make new resources available for the act, giving particular priority to in-service teacher training.²³

The issue of integrating visually handicapped children into ordinary schools

Integrated education is the process of educating children with and without special needs together for part or all of the time. In Britain a variety of schemes of integrated education have been attempted, and these schemes have been described and discussed by a large number of writers.²⁴

I now want to consider the general case for integrated education, and the problems associated with integrating visually handicapped children into ordinary schools. This exercise is worth doing for three main reasons: first it provides a microcosm of many of the opportunities and difficulties associated with the integration of handicapped children generally. In this connection, given the amount of systematic and well-directed pressure that has been brought to bear by the National Federation of the Blind and the Association of Blind and Partially

Sighted Teachers and Students and others over a considerable period of time in support of greater integration for the visually handicapped (so far with only very limited success), it vividly illustrates the kind of resistance integrationists have to face. But second, by highlighting those aspects that are peculiar to a particular handicapped group - what might be termed the 'handicap specific' as opposed to the 'common core' elements of the problem - it focuses attention on the need for a strategy which is sensitive to the needs of particular subgroups within the overall category of the handicapped as a whole. Thirdly, and finally, it is particularly worth looking at the visually handicapped at the present time since, in May 1982, the Department of Education and Science called on local authorities, in regional conferences, to carry out, as the first of a series of reviews of provision for different groups of handicapped children, a review of their provision for the visually handicapped to culminate in the promulgation of a national plan. The Vernon Report had called for this in 1972.²⁵ In 1975 regional conferences were reactivated for this purpose, but nothing much seems to have happened as a result. It is to be hoped that the stimulus of declining numbers of visually handicapped school children may possibly have injected the necessary fluidity into the situation to make a restatement of the integrationist position timely and a reorientation of educational provision possible.

The size and shape of the problem

According to official statistics of the Department of Education and Science, there were in January 1981, 975 blind and 2,098 partially

sighted children attending special schools, independent schools, hospital schools or special classes at maintained schools, receiving education otherwise than at school or awaiting admission to special school. These figures represent prevalence rates of 1.12 and 2.41 per 10,000 school population respectively. These 'officially identified' visually handicapped children are catered for mainly in thirty two inevitably small special schools - half run by local education authorities, and half (chiefly those for the blind) by voluntary bodies; twelve schools, all boarding, cater for the blind alone; sixteen schools, of which three are boarding, for the partially sighted; and four schools, all boarding, for blind and partially sighted children together.

Therefore, special educational provision of the visually handicapped in Britain overwhelmingly means separate or segregated provision. Moreover, at least so far as the blind are concerned, separate provision very largely means boarding provision as well. The figure of eighty per cent for pupils boarding at schools for the blind appears low only in comparison with the staggeringly high figure of ninety seven per cent given by the Vernon Report in the early 1970's (the comparable figures for the partially sighted are 1971, forty two per cent; 1981, thirty five per cent). Tony Booth, arguing from the dropping proportions of the total school population in special schools for the visually handicapped since 1950, has suggested that visually handicapped children appear to be less likely to attend a special school now than in the past, but Booth himself acknowledges the possibility that this might be due to a fall in the proportion of

children with sight difficulties as much as to any change of policy with regard to school placement.²⁶ This would appear to be what has happened since 1972, when the Vernon Report gave prevalence rates of 1.37 (blind) and 2.66 (partially sighted). Certainly the proportions of 'officially identified' visually handicapped children placed in special schools - ninety per cent for the blind and eighty five per cent for the partially sighted - have hardly altered at all since the publication of the Vernon Report in 1972, and this is surely the relevant statistic to take.

The Warnock Committee stated that there has been a steady increase over time in the number of handicapped children placed in designated special classes and units in ordinary schools rising from 11,027 in 1973 to 21,245 in 1977, that is, from 6.8 per cent to twelve per cent of all children ascertained as requiring separate special provision. The Warnock Committee makes it clear that the children placed in these classes and units have been mainly those with moderate rather than severe disabilities but all categories of handicap are represented.²⁷ So far as visually handicapped children are concerned, the partially sighted have felt the benefit of this trend to some extent, their numbers attending special classes in ordinary schools having risen from 81 in 1973, the first year when such statistics were given, to 205 in 1981. However, the blind have hardly been touched by this development at all: no blind children were in special classes in ordinary schools when such information first became available in 1973, and by 1981 there were still only seven.

The Warnock Report also states that placements of disabled children in ordinary classes are becoming more frequent, though statistics of these placements are not available. For several years now, it has been recognised that there is almost certainly a large number of children with a visual handicap of some sort in ordinary schools, in addition to those children recorded in the statistics as receiving special education, increasing numbers have also been coming to light in hospitals for the mentally subnormal and similar institutions. However, only in recent years have we begun to gain some idea of the size of these groups, at least so far as the educationally blind are concerned. In 1982 Colborne Brown and Tobin were able to identify at least 1,093 such children who were being educated in a variety of units and schools throughout Britain outside what might be called the 'official' blind education system.²⁸ This finding that there are as many blind children being educated outside the 'blind education system' as in it, accords with the picture derived from local authority social services statistics by Jamieson, Parlett and Pocklington.²⁹ However, it would be a mistake to regard many of these placements as representing integration in the sense of full functional integration into the ordinary activities and classes of ordinary schools. From this point of view, Colborne Brown and Tobin's description of their study as one of the 'integration of the educationally blind' is really rather misleading, and their liberal use of inverted commas round the word 'integration' does show some awareness of this. Colborne Brown and Tobin's more neutral formulation 'not attending special

schools for the visually handicapped', which they use elsewhere, would perhaps be a better description. In fact only 144 or 14.4 per cent of Colborne Brown and Tobin's discoveries were in mainstream schools or some sort of unit attached thereto. Almost all of the 114 children placed in a mainstream school directly were one-off placements. Some were sixth-formers having moved from schools for the visually handicapped. A substantial number were at infant school, so might not necessarily remain in integrated provision; and Colborne Brown and Tobin surmise that it is probable that some were placed in mainstream schools for other than strictly educational reasons. None of this bespeaks a particularly vigorous growth of integration schemes throughout Britain. The majority of the children identified by Colborne Brown and Tobin (nearly 700 or sixty nine per cent) were in schools or units for the ESN (S), ESN (M/S) or physically handicapped, or in special care, hospital or hospital school - some in residential placement, but most on a daily basis; and a closer analysis of a subsample of 411 cases showed that almost half (forty seven per cent) had a mental (as well as) a visual handicap, and three-quarters could accurately be described as multiply handicapped.

What kind of picture, then, is presented by this diversity of circumstances in which visually handicapped children are being educated? On the one hand, there is an official, comparatively self-contained, 'blind education system', in which about 3,000 visually handicapped children are being educated, very largely in special, often residential, schools specifically for the visually handicapped.

On the other hand, there is also a significant number of children with a visual handicap being educated in a variety of settings outside these schools - settings which, by virtue of being outside the officially sponsored blind education system, all too easily give rise to the misconception that the children being educated in them are in fact being integrated into the community.

So far as the partially sighted are concerned the contention of integration is probably correct. Colborne Brown and Tobin did not study the partially sighted, but Jamieson, Parlett and Pocklington, in their 1972 study, cited local authority social services figures showing that 29.8 per cent of registered partially sighted children aged between five and fifteen were in ordinary schools.³⁰ - The only questions, then, that arise concern the adequacy of the support they receive and the means of moving more of them from the comparative isolation of the closed official system towards the more open system of provision in the community. But so far as the educationally blind are concerned, there is real reason to question whether the system has not become skewed so as to make for a serious mismatch between provision and need - those who could safely take their place in the ordinary school, were the requisite systems of support to exist, being educated away from the community in the official blindness system, and those who need the services that system has to offer being cut off from it with inadequate support, at least so far as their visual handicap is concerned.

In the rest of this chapter, bearing in mind that it is the education

of the blind as opposed to the partially sighted that is usually thought to give rise to problems of such an intractable nature that the only thing to do with them is to educate them in special schools, I shall concentrate largely on the problems of the self-contained blindness system, on the rigidity in the system which gives it so much staying power, despite those problems, and in particular on what is needed to make the official 'blind education system' more open-ended, capable of releasing young people into the community at one end, while at the other end it draws in those who can best benefit from the particular resources that it has to offer.

Further dimensions of the problem

The general case for integrated education has two aspects. The first, which is often insufficiently stressed, is expressive or symbolic in character. Unnecessary segregation from the community represents a derogation from full humanity and citizenship. Secondly, integration also has an instrumental purpose. Socialisation in separate institutions breeds attitudes of prejudice, intolerance and self-denigration; and integration, particularly at the formative stages of personal development, can do much to sweep away the barriers of ignorance and misunderstanding that keep the handicapped and the unhandicapped apart, and ultimately lead to discrimination, dependency and an inability to cope.

These considerations apply in full measure to the visually handicapped. Going to an ordinary school helps a visually handicapped child to grow up and learn to cope with life as a member of a sighted

and not a self-enclosed 'blind' world in the most practical way possible - by living in it. It also fosters in the sighted an appreciation of visual handicap as a wholly normal incident of human diversity instead of something alien, to be at best uneasy about or at worst to reject.

Ann Shearer quotes a twenty eight year old blind woman who looks back with dissatisfaction on her schooldays in a special boarding school for blind girls. The woman recalls that:

'I learnt to read braille, do geometry in braille, and mostly academic things, except for deportment, which was, in fact, a skill we needed to learn. But practical things such as cooking, using make-up and even mobility were hardly covered at all. I think I could have learned those things with specialist help in an ordinary school. As it was, most of us were completely ignorant and unprepared for what the outside world was going to be like, particularly in terms of the attitudes we were likely to encounter.'³¹

Quite clearly this woman believes that integrated education would have prepared her for life in the outside world.

But integration also holds several other quite specific advantages - indeed imperatives - so far as visually handicapped children are concerned. The chronically small numbers concerned inevitably mean that the self-contained 'blind education system' has a number of important and inherent limitations: it is forced to operate at a regional or even a national level. It has already been demonstrated that this entails an extremely high proportion of children having to board away from their home for the whole of their schooling. Even so, many of the schools involved, especially those for the partially sighted, still have to cover the entire age range to attain viability; and in order to mobilize the resources necessary for more advanced

work, a rigorous system of 11+ selection is more or less obligatory. The very fact of being a self-contained education system also has serious drawbacks; as the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students have shown, the special school, especially the residential special school, has major drawbacks as a setting for the co-education of the sexes, for educating blind and partially sighted children together and for educating visually handicapped children in conjunction with children suffering from other kinds of handicap.³²

Much of this is often thought to be unavoidable on account of the extremely small numbers involved - it is often argued that there simply are not enough children to make viable primary, let alone comprehensive schools on anything remotely approaching a neighbourhood basis, and the problems will become acute as numbers decline still further. In 1982 the Department of Education and Science projected the numbers for the 'official' blind education system of no more than 700 (blind) and 1,600 (partially sighted) by the end of the 1980's. But as can readily be seen, this is only a problem so long as it is decided to retain a self-contained system of schools for the visually handicapped alone, more or less completely separated from the rest of the education system. If blind and partially sighted children were educated in ordinary local authority schools, it becomes immediately obvious that it would be possible for them to receive a normal primary and comprehensive secondary education much closer to home. Indeed, in 1973 the National Federation of

the Blind and the Association of Blind and Partially Sighted Teachers and Students estimated that if resource centres for the visually handicapped were established in as few as forty primary and forty related secondary schools strategically located throughout Britain, then 82 per cent of the visually handicapped school population could live well within daily travelling distance of their own homes - a figure that rises to 95 per cent if fifty two centres of each type could be established.³³ It is obvious, too, that by bringing visually handicapped education much more into the mainstream of education, visually handicapped children could benefit from the greater resources and range and diversity of subjects and staff available in the ordinary school. Indeed, the system of integration that has been developed by the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students offers the only viable model, consonant with other objectives, for providing visually handicapped children with a fully comprehensive secondary education with direct access to higher education.

Is this practical? Many would say not, but there has been quite sufficient experience of integrating both blind and partially sighted children into ordinary schools both in Britain and abroad to put it beyond doubt that it is entirely practical so long as the necessary arrangements are made for providing within the ordinary school itself the specialist teaching and support which visually handicapped children clearly need.

This important point concerning specialist teaching and support applies to all handicapped children. Putting any handicapped child

without adequate specialist teaching and support into an ordinary school is not integrated education. As can be seen in the disappointingly few schools which have achieved the successful integration of handicapped children (such as Angmering comprehensive in West Sussex) appropriate staff numbers and training, and equal access to facilities for handicapped children, are the prerequisites of success. So are full back-up services (including physiotherapy, speech therapy and transport) and adequate expenditure on aids and adaptations.

The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students have devoted a great deal of study to the practical aspects of implementing a system of integrated special education for the visually handicapped,³⁴ and the next section outlines their proposals in the context of the total range of provision required for visually handicapped children generally.

The main features of a system of special education for the visually handicapped

In the view of the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, special education for the visually handicapped, like special education generally, should aim to make available a range, continuum or diversity of provision. Only thus can the much talked-of individualization of provision be achieved or anything like a real choice provided. In the view of the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, to comprehend the variety of needs evident among the visually handicapped school

population, three main types of provision need to be made: for the seriously additionally handicapped, provision in residential special schools; at the other end of the scale, for those with comparatively mild visual handicaps, peripatetic support in the local ordinary school; for those in between, the educationally blind and those more seriously partially sighted, as already indicated, a network of resource centres needs to be established in selected ordinary schools throughout the country.

In 1982, the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students summarized the purpose, characteristics and resource requirements of such centres in the following way.³⁵ Four important points will be mentioned.

First, the centres should provide specialist teaching in the skills required by visually handicapped pupils, and also back-up support, materials and advice for those pupils and the members of staff who teach them in the ordinary classes of the school. In particular, after initially concentrating on the teaching of special skills within the resource centre, particularly in the early years at primary level, the objective would be to promote the progressive integration of each blind or partially sighted child into the ordinary classes of the school. Mobility Officers could help in a programme of integrated education, if the officers exist in a given area.

Second, each resource centre would provide for both blind and partially sighted children together, as recommended by the Vernon Committee, and cater for up to 5-10 blind and 10-20 partially sighted children.

Third, each resource centre would occupy about four or five small rooms at the heart of the ordinary school, and would be staffed by specially trained teachers, together with non-teaching assistants. The staffing ratios would be of the order of, in a primary school, one teacher for every five or part of five blind pupils, and one teacher for every ten or part of ten partially sighted pupils, plus one non-teaching assistant for every two teachers in the resource centre; in a secondary school, two teachers for the first 15 pupils, whether blind or partially sighted, plus one teacher for every 15 or part of 15 thereafter, plus one non-teaching assistant for every teacher.

Fourth, and finally, each centre would also have all the necessary equipment and materials, including books and materials in braille and large print, and the resources to produce and duplicate them, plus tape recording equipment, aids to low vision, mobility aids and so on.

The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students have pointed out that although the schools in which resource centres are established should be very carefully selected, in particular for their all-round quality of educational provision, motivation towards the integration scheme and location, they would not need as a rule to be specially adapted in their physical structure. Visually handicapped children have no difficulty in coping physically in special schools that have not been specially adapted for them in any way; and given that one of the purposes of the resource centre would be to provide or secure mobility training and

aids, this should not present any particular problem in the ordinary school either. Nor should there be any great difficulty in making available in the ordinary school whatever in the way of resources is currently made available in special schools. Indeed the ordinary school will probably have a larger stock of 'general' resources from which the visually handicapped child will be able to benefit.

Provided, too, that specialist teaching assistance is made available for the visually handicapped children as indicated above, there should be no problem over providing ordinary class teachers with the back-up support, guidance and advice which they will need in order to be able to cope with visually handicapped children in their classes. Home-school transport services would need to be considerably geared up to meet the needs of visually handicapped children attending ordinary schools with a resource centre, but savings on the cost of sending children away to residential special schools outside their own county would more than offset the cost of this.

In areas of Britain with a particularly small and far-flung visually handicapped population, peripatetic support in local schools may be the only realistic alternative to boarding special education. It is not as good as support from a resource centre within the school, but it operates satisfactorily in sparsely populated parts of the United States, and is generally to be preferred to boarding special education.

If the official 'blind education system' is afflicted by so many problems, and an alternative blueprint without such drawbacks not

only lies ready to hand but has actually been implemented successfully in many parts of the world, why should the 'blind education system', with all its difficulties, have displayed such resilience, and the alternative special educational strategy been taken up in so few quarters in Britain? The answer to this important question must at least in part lie with the institutional resistance and ideological factors to which we now turn.

The institutional resistance to integrated education

It has sometimes been suggested that if integration has such a compelling logic for the official 'blind education system', then nothing much needs to be done in order to bring it about. However, if this is not actually disingenuous, it is extremely politically naive. As Tony Booth pointed out recently, the special education system has a momentum of its own.³⁶ Booth has argued that so long as special schools continue to exist and we continue to carry on running them, there will be places to be filled and people with an interest in filling them. At a time when space is at a discount, even single individuals can make a difference to viability. There will be pressure to retain the less handicapped within the system as a leaven for the other children and the staff. We can soon end up reaching the point where the children are meeting the needs of the institutions instead of the other way around. At the very least, the forces of inertia tell heavily in favour of the special school sector. A major redeployment of resources requires planning, effort, commitment and will. People have to change their established practices and modes of working.

It is much simpler just to carry on operating the well-tried procedures.

As Tony Booth has said:

'There are practical problems in integrating some handicapped children in some parts of the country. But often the practical difficulties have more to do with the reorganisation of jobs and occupational aspirations, with the reallocation of money and resources, than with the needs of children. This inertia within the system is an important human issue, and, any change requires skill, sense and sensitivity.'³⁷

The points that are raised by Booth are well illustrated by the particular problem posed by the special grammar schools for the blind run by the Royal National Institute for the Blind for boys and girls respectively at Worcester and Chorleywood.³⁸ In order to enhance the effectiveness and assure the viability of the two schools, it is planned that in 1987 the schools will come together at the Worcester site, and a major building scheme for the new co-educational school will be undertaken by the Royal National Institute for the Blind.³⁹ Some special schools for visually handicapped children with serious additional handicaps will continue to be needed, but if the integration is going to take place on any scale at all among the blind, the children who have typically gone to Worcester and Chorleywood in the past will be prime candidates for making the transition. Thus the two schools and the new co-educational school present a key impediment to structural reorganization. At a time when one is trying to redeploy resources for special education towards the ordinary school sector, it makes no sense to be making a major new investment in the special school sector, such as the reconstitution of Worcester and Chorleywood unquestionably represents. The creaming off of all the most

suitable candidates would throw up a stumbling block to the development of properly designed projects for supporting the integration of blind children into ordinary schools at a local level of the kind discussed earlier. With all the institutional pressures that inevitably exist to fill special school places once they have been created, rather than going to the considerable trouble of developing systems of support in ordinary schools of their own, it would be a natural temptation for local education authorities simply to send blind children to the residential schools where they know that provision has traditionally been made for them. Furthermore, given the present very general lack of proper provision for visually handicapped children in ordinary schools, those with responsibility for advising on placement have little alternative but to steer children towards this special school sector.

To the extent that the merger of Worcester and Chorleywood does not have the consequences feared above, and local schemes of integration do begin to blossom, then by contrast it will tend to lead to a wasteful over-provision of special school places. If the trend towards integrated education gathers pace, there would in fact be a serious danger of creating a costly white elephant if the residential sector of secondary education for the blind was continued in the manner proposed. We have already seen that the number of blind children of secondary school age may be as low as 350 by the end of the 1980's. As many as a third of these could require the very special provision reserved for those with serious additional handicaps, and not all the rest will be of Worcester-Chorleywood standard.

A selective co-educational school providing 150 places, that is, the size of the two existing schools combined, would thus be bound either to 'scoop the pool' or end up as a half-empty mausoleum. Instead of attempting to shore up an honourable but essentially outmoded tradition, the Royal National Institute for the Blind would be better putting its resources into helping to promote good schemes of integrated education at a local level.

Ideological factors and integrated education

The sort of institutional resistance that has just been described is powerfully buttressed by a series of plausible misconceptions and misrepresentations that might be said to amount to an ideology of special education, and I would now like to make four points concerning this ideology.

First, the essential slipperiness of the notion of integration, its convenient ability to mean all things to all people, makes it a veritable godsend to the practitioners of mystification. Integrated education is sometimes portrayed as treating everyone, handicapped and unhandicapped alike, exactly the same. The opponents of integrated education are thus enabled to argue that integration is incompatible with providing the kind of special help that handicapped children clearly need. But such an antithesis is wholly false. As we have seen, the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students and other responsible advocates of integrated education for the visually handicapped are at considerable pains to specify how the necessary help

can be made available. It is important to emphasise that for them 'integration' essentially means 'supported integration'. The only difference that separates them from their critics is their concern to see help mobilized in the ordinary school at the heart instead of on the periphery of the community.

Second, there is a tendency to talk of anything other than education in a special school for the visually handicapped as integration, regardless of the level of support provided. From there it is but a short step to pointing to the children who have not fared well in ordinary schools that did not have properly constituted resource centres, and who have perhaps had to move into the special school sector, as the 'failures' or 'casualties' of integration. However, it would be quite wrong to write off the whole idea of integrated education in this way, given the almost total absence of properly supported schemes of integration in Britain at the present time.

Third, it has often been said that the mere fact of being educated in an ordinary school does not of itself constitute integration. The same point is made another way when people insist that it is the quality of provision that counts, and not where it is made. But other things being equal, the ordinary school must be better as a base for integration than the special school. Though presence in an ordinary school may not be a sufficient condition of full integrated education, it is certainly a necessary one. This point was perhaps put most sharply for the visually handicapped by the Vernon Committee in 1972.

The committee argued that:

'We are deeply impressed by the argument that, if visually handicapped children are to be fitted through their education to live in the world with sighted people, the best way for them to acquire the necessary ability and confidence is to mix as freely as possible with sighted children during their schooldays. Social events arranged with neighbouring sighted schools may help a little, but contacts tend to be artificial or at least superficial; in order to get to know sighted children and to feel at home with them, a visually handicapped child needs to be in the same school as they are. '40

Fourth, and finally, calls for integrated education are frequently presented as being too 'doctrinaire', 'dogmatic', or 'extreme'. Provision needs to be made, it is argued, not according to some abstract principle, but according to the differing needs of each individual child. Those who can benefit from integration should certainly be integrated, but for those who need the sheltering care of the special school, this option should still be retained. This position sounds very reasonable, but again it caricatures the integrationists' position. For integrationists' no less than their segregationist critics, recognize the need for a properly individualised range of provision, not excluding placement in a special school in cases of appropriate severity. However, in a situation where the special school sector has a virtual monopoly, this argument points entirely in the direction of extending systems of support within the framework of the ordinary school.

The need for planning

Clearly there needs to be planning for supported integration and it is not enough simply to impose, as the 1981 Education Act does,

a general obligation to integrate, subject to considerations of educational suitability and efficiency. It is important to point out that without establishing any mechanism for ensuring that the support necessary to make integration a practical proposition is made available in ordinary schools, nothing very much is likely to happen. Given the current absence of facilities in ordinary schools for children with special needs, the educational criteria are seldom likely to be met. In those circumstances, the possibilities of integrated education will simply be bounded by the limitations that are inherent in existing arrangements.

The 1981 Education Act is far too individualistic in its approach. The act imposes certain obligations to provide the necessary support if a handicapped child should happen to turn up in an ordinary school. However, the crucial point is that without the making of systematic arrangements that might make this more likely to happen in the first place, the arrival of a handicapped child in an ordinary school will be a happy accident at best, but will more probably be ruled out altogether by the inadequacy of existing provision.

The situation can be imagined in concrete terms: in the face of a specific request to integrate, one of two things must necessarily occur - either integrated education will not be attempted for want of the necessary support, or it will, but with disastrous results for the same reason. Many authorities profess a commitment to integrated education in principle, but demonstrate little awareness of the implications of such a commitment in practice. That being so, the

most likely response will probably be simply to drift along with the existing pattern of special schools by sending children away. If this is to be avoided, then there needs to be a planned development at a local authority level of the necessary systems for meeting special educational needs in ordinary schools.

Every local education authority should have a plan, but should it always be a plan for making the necessary provision itself? If the optimum number of resource centres for visually handicapped children is only some forty or fifty each at primary and secondary school level, the answer to this question would seem to be 'no', and this indicates the desirability of a degree of regional planning; each region should probably have a specialist adviser on the visually handicapped. However, the outcome of regional planning has been disappointing. Nor do local education authorities seem very good at cooperating with one another at a subregional level. In these circumstances, pinpointing a number of key local education authorities, strategic in terms of their size and location, and attempting to persuade them to implement a plan for integration, would seem to afford the best prospect of advance. There is some evidence to suggest that neighbouring authorities would then be more than happy to ride on the back of such a plan, just as they do now on the backs of the special schools. In this way the original local education authority could also probably be assured of recouping a fair proportion of its costs.

A problem that local education authorities often come up with is that of the small number of visually handicapped children in

relation to the total school population, or even to that of children with other types of handicap. They often ask the question would it be acceptable to achieve economics of scale by setting up support units for the visually handicapped in conjunction with units for children suffering from different types of handicap? To this question, the answer seems fairly clearly to be that it is certainly acceptable to establish units for children suffering from more than one type of handicap in a single school. However, separate units need to be established, and there probably should not be too many of them - probably no more than two in fact - if handicap is not to impose a disproportionate burden on the school and stretch the staff beyond its limit. Clearly there is a limit to the range of problems that any given staff can be expected to deal with. The most important point to emphasise is that a special support unit must specialize in the distinct problems that are undeniably still thrown up by at least some of the traditional categories of handicap, and of these the visually handicapped are certainly one.

In conclusion: The future of integrated education and the recent Fish Report on special education

The conception of integrated education that is advanced by the National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students represents an essentially moderate form of the proposal, that is, one of 'making ordinary schools special' - of a substantial redeployment of resources from the special to the ordinary school sector - but on a selective basis,

to selected 'centres of excellence' specializing to some degree in the education of the visually handicapped. This model would not commend itself to all integrationists, some of whom, it seems, rightly seeing integration as a logical extension of the comprehensive principle, would regard even this as subjecting the handicapped children concerned to too much invidious differentiation, and would prefer to see all schools being able to respond sympathetically to the individual needs of all types of children.

Integration is not an all or nothing matter. The situation is both fluid and dynamic. Several pioneering ventures in the supported integration of visually handicapped children have been undertaken,⁴¹ but the special school system is under pressure and will unquestionably try to fight back. In the future, things could well go either way. Realistically, one cannot effect a total transformation, even of a subsystem of society such as the education system, all at once. The tender shoots of new schemes of integrated education that have already put down their roots in Britain need nurturing and extending. In that way the integrationists can hope to gain some purchase on the education system that could pave the way for more far-reaching developments later on. But if the integrationists attempt everything at once then they could well fail. Furthermore, integrated education itself is an unending process. There will always be ways in which the participation of handicapped or non-handicapped children in the educational and social life of their schools can be increased.

The attitudes of the public and of professionals to handicapped children have come a long way since the 1944 Education Act, which

referred to those who suffered 'from any disability of mind or body.'⁴² Handicap was then regarded largely as a medical problem, located within the child. Now, we are slowly beginning to recognise that the 'problems' of handicapped children are not their problems, but ours. The purpose of special schools is not to help the handicapped but to cover up the failure of mainstream schools to educate those who do not conform to the vacuous concept of the 'normal' child.

The 1981 Education Act replaced distinct and defined handicaps with a single category of 'special educational needs'.

This recognises that as many as one in five children may require special help at some stage of their education, not just the two per cent who have attended special schools in the past. But the 1981 Education Act is hesitant and ambiguous in its approach to integration, and while the act theoretically gives parents the right to demand that their children be educated in mainstream schools, it has enough small print to enable local education authorities to avoid meeting this obligation.

The act defines special educational need as a child's requirement for a form of education different from that 'made generally available for children'. It then goes on to state that such a child should be educated in an ordinary school provided that provision is made for its needs, that there is 'efficient education' for other children in the school and (the familiar catch-all of educational legislation) that there is the 'efficient use of resources'. This can and does mean anything. The point it evades is that comprehensive schools ought to cater, as a

matter of routine, for diverse needs, that what is 'made generally available' should not exclude any children.

It is this point that emerges most clearly from the Inner London Education Authority's green paper on special education, which was published in July 1985.⁴³ This 300 page document is emphatic that a comprehensive school system that excludes children because they have sensory or physical disabilities, are slow learners or are just a problem in the classroom, is not comprehensive at all.

The report, which was produced under the aegis of a former schools inspector John Fish, says that the Inner London Education Authority should

'draw up plans to make provision within primary and secondary schools to meet the needs of those currently in separate provision'. It adds that plans 'should be set within a defined time scale'.

The report concedes that, in the short term (and, for a very small number, possibly in the long term) 'alternative or different provision' may be necessary but even this should be closely linked to ordinary schools and colleges and 'seen as supportive and supplementary to their work'. The report proposes that every school - and in secondary schools, every subject department - should have teachers who are specifically responsible for special needs. This is a logical extension of the Inner London Education Authority's unjustly-pilloried policy of ensuring that the needs of previously underprivileged groups becomes central to the formation of educational policy, instead of being tacked on as an after thought.

Acceptance of this policy faces two problems.

First, the Inner London Education Authority will have to convince the mass of parents that their children's education will not suffer from learning alongside the handicapped or the disturbed. Its record in putting over its policies for ethnic minorities, homosexuals and girls - including the hysterical accusations that most people are racist and sexist and the obsession with linguistic trivialities - is not encouraging. A calmer and more measured tone is needed to explain that all children will benefit from a greater awareness of special needs. Inevitably, some children will need separate provision on some occasions. The point is that they should remain the clear responsibility of a primary and secondary school, which would make special arrangements when necessary and not banish them to a special school for an indefinite period.

The second difficulty is the teachers. There is a need to train not just the mainstream teachers to cope with special needs but also the specialist teachers of the visually handicapped, deaf and so on to cope with working in mainstream classrooms. Schools that have experienced integrated education have reported that the specialist teachers can only work adequately if they are part of a team - teaching approach, sharing the responsibility for whole classes, rather than working solely as specialised assistants.

Some people might claim that money could be another problem. However, this is largely a false problem. Closing most of the Inner London Education Authority's 110 special schools should release ample resources to fund the adaptation of mainstream schools. This

is why Fish's demand for a timetable is so important. As long as special schools exist, integration will be a distant ideal. Children will be found to fill the places, and resources for special needs in the rest of the educational system will be limited. And, above all else, mainstream schools will continue to evade their responsibilities to develop a genuinely comprehensive education. This final point should be emphasised. The development of a programme of integrated education is part and parcel of the development of a genuinely comprehensive education.

Notes and References

1. Pritchard has written a detailed history of the education of handicapped children, including the visually handicapped. See D. G. Pritchard, Education and the Handicapped 1760-1960 (Routledge and Kegan Paul, London, 1963).
2. See Statistics of Education Volume 1 1976, HMSO, London.
3. See A. I. Harris, Handicapped and Impaired in Great Britain, Part 1, Office of Population Censuses and Surveys, HMSO, London, 1971.
4. See the Report of the Royal Commission on the Blind, the Deaf and Dumb etc., of the United Kingdom, 1889, C 5781, Volume xix.
5. See D. G. Pritchard, Education and the Handicapped 1760-1960 (Routledge and Kegan Paul, London, 1963) page 97.
6. D. G. Pritchard, Education and the Handicapped 1760-1960 (Routledge and Kegan Paul, London, 1963) page 97.
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8. See the Report of the Departmental Committee on Defective and Epileptic Children, 1898, C 8746, Vol. xxvi.
9. See Z. A. Stein and M. W. Susser, 'Families of Dull Children', Journal of Mental Science, 106, pages 1296-1319.
10. See Statistics of Education Volume 1 1976, HMSO, London.
11. Letter from Sir Keith Joseph, then Secretary of State for Social Services, to Alfred Morris M. P., reported in The Times of 9 October 1973.
12. Department of Education and Science, Report of the Committee of Inquiry into the Education of the Visually Handicapped (The Vernon Report) HMSO, London, 1972.
13. These statistics are derived from Statistics of Education 1971, Volume 4, but comparable data are not included in the publications for later years.
14. See The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Educational Provision for the Visually Handicapped Comments on the Vernon Report, 1973.

15. See The Health of the School Child 1969-70, Report of the Chief Medical Officer of the Department of Education and Science, HMSO, London, 1972. Publication of these reports has ceased and the data for 1969-70 are the most recent available.
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18. See Special Educational Needs, Report of the Committee of Inquiry into the Education of Handicapped Children and Young People, Command Number 7212, HMSO, London, 1978. (The Warnock Report).
19. The Advisory Centre on Education has published a detailed commentary on the 1981 Education Act, which contains the full text of the act and regulations. See the ACE Special education handbook (ACE, London, 1983).
20. The Labour Party, 'Labour's plan for disabled people', Talking Points, Number 18, February 1983.
21. Bennett made these points in a debate in the House of Commons concerning schools and further education. See Hansard, Volume 67, Number 7, Wednesday 14 November 1984, Cols. 755-756.
22. Michael Meacher, Alf Morris and Margaret Beckett, As of Right Labour's call for full citizenship for all disabled people (The Labour Party, London, 1985) page 37. Also see Will Swann, 'Statistics of segregation', Childright, June 1984.
23. See The Labour Party, 'Labour's plan for disabled people', Talking Points, Number 18, February 1983. Also see Labour's Manifesto 1983, page 19.
24. Several writers have described and discussed some general schemes of integrated education, in which children with a variety of difficulties and disabilities have been integrated into ordinary schools. See, for example, the following: J. S. Bailey, 'Special units in secondary schools', Educational Review, 1982, 34 (2) pages 107-112; T. Booth and J. Statham, (eds.), The Nature of Special Education (Croom Helm, London, 1982); M. Brown and A. Slater, 'An approach to Warnock - Sherard style', Forum, 1983, 25 (2), pages 45-47; D. M. Galloway and C. Goodwin,

Educating slow-learning and maladjusted children: integration or segregation? (Longmans, London, 1979) and S. Hegarty and P. Pocklington, Integration in Action (NFER/Nelson, Windsor, 1982). Several other writers have described and discussed some specific schemes of integrated education, in which children who are categorized by disability or difficulty have been integrated into ordinary schools. For example, several writers have described and discussed integration schemes involving children with physical disabilities. See J. Alston, 'Children with brittle bones', Special Education: Forward Trends, 1982, 9(2), pages 29-32; E. M. Anderson, Making Ordinary Schools Special: a report on the integration of physically handicapped children in Scandinavian schools (National Council for Special Education, 1971); E. M. Anderson, The Disabled Schoolchild: a study of integration in primary schools (Methuen, London, 1973); C. Barry, C. Gawey, M. M. Byrne, 'The education of physically handicapped children in normal schools', Child Care, Health and Development, 1975, 1, pages 179-184; C. Cope and E. M. Anderson, Special Units in Ordinary Schools: an exploratory study of special provision for disabled children (University of London, Institute of Education, London, 1977); A. Crosby, 'Integrating Handicapped Children: one teacher's experience', Education 3-13, 1981, 9 (167), pages 46-50; G. Jones, 'Integration success story', ACE case study, WHERE, 1981, number 166, page 27; M. Halliwell and B. Spain, 'Spina bifida children in ordinary schools', Child Care, Health and Development, 1977, 3 (6), pages 389-405; M. Halliwell and B. Spain, 'Integrating pupils with spina bifida', Special Education: Forward Trends, 1977, 4 (4), pages 15-18; I. Markova, K. MacDonald and C. Forbes, 'Integration of Haemophilic Boys in Normal Schools', Child Care, Health and Development, 1980, 6(2), pages 101-109; M. O'Moore, 'Social acceptance of the physically handicapped in the ordinary school', Child Care, Health and Development, 1980, 6(6), pages 317-338; P. Rushton, The Marlborough/Ormerod Project: an integration initiative in a rural comprehensive school (Centre for Studies of Integration in Education/Spastics Society, London, 1983); M. Spencer, 'Wheelchairs in a primary school', Special Education; Forward Trends, 1980, 7 (1), pages 12-14 and B. Sturges, 'An integrated unit at St Michael's', Special Education: Forward Trends, 1980, 7(1), pages 12-14. Several writers have described and discussed integration schemes involving children with hearing impairments. See D. Dale, 'Integration on an individual basis', Special Education: Forward Trends, 1979, 6 (2), pages 22-24 and W. Eyre and D. Hall, 'Deaf children in an ordinary school', Forum, 1983, 25 (2), pages 43-45. Several writers have described and discussed integration schemes involving children with mild and moderate learning difficulties. See T. Booth, 'Children with learning difficulties in Scotland', in 'Eradicating Handicap', Unit 14 of E241, 'Special Needs in Education (Open University Press, Milton Keynes);

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25. See the Department of Education and Science, Report of the Committee of Inquiry into the Education of the Visually Handicapped (The Vernon Report) HMSO, London, 1972.
26. See Tony Booth, 'Demystifying Integration', in W. Swann, (ed.), The Practice of Special Education (Basil Blackwell, Oxford, 1981).
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28. See the following three articles by M. S. Colborne Brown and M. J. Tobin: 'Integration of the educationally blind: Numbers and placement', The New Beacon, May 1982, Volume LXVI, Number 781, pages 113-117; 'Integration of the educationally blind: Information from questionnaires to parents', The New Beacon, November 1982, Volume LXVI, Number 787, pages 281-286 and 'Integration of the educationally blind: Parents' opinions and general conclusions', The New Beacon, July 1983, Volume LXVII, Number 795, pages 169-174. Colborne Brown and Tobin summarise their key findings in the last of the three articles.
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30. See M. Jemieson, M. Parlett and K. Pocklington, Towards Integration: A Study of Blind and Partially Sighted Children in Ordinary Schools (National Foundation for Educational Research, Slough, 1977).

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32. See The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Educational Provision for the Visually Handicapped Comments on the Vernon Report, 1973.
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34. See the following: The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Educational Provision for the Visually Handicapped Comments on the Vernon Report, 1973; The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Response to the Consultative Document on the Implementation of Section 10 of the Education Act 1976, 1977; The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Responses to 'Special Educational Needs', Consultative Document on the Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (the Warnock Committee), 1980; The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Regional Planning of Educational Provision for Visually Handicapped Children, 1982, and The National Federation of the Blind, About the National Federation of the Blind (National Federation of the Blind, 1985) pages 9-14. Also see M. Milligan, 'Accepting Blind Children in Ordinary Schools - everyone benefits', integration after Warnock series, WHERE, 1978, Number 142, pages 275-277 and C. Stone, 'Firm stand for blind child', WHERE, 1981, Number 167, page 22.
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38. Worcester College for the Blind was founded in 1866 and was the first school in Britain to provide more than an elementary education for blind children. In 1922 the National Institute for

the Blind became the sole trustee. The equivalent school for girls, Chorleywood College, was founded by the National Institute for the Blind in 1921. See Donald Bell, (ed.), An Experiment in Education The History of Worcester College for the Blind 1866-1966 (Hutchinson of London, 1967) and Phyllis Monk, Though Land Be Out of Sight: the Early Years of Chorleywood College (National Institute for the Blind, London, 1952).

39. These plans were recently announced by the Royal National Institute for the Blind. See The New Beacon, May 1986, Volume LXX, Number 829, page 145.
40. Department of Education and Science, Report of the Committee of Inquiry into the Education of the Visually Handicapped. (The Vernon Report) HMSO, London, 1972, paragraph 5.30.
41. The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students have pointed out that schools where sighted and visually handicapped children have been successfully educated together have existed in parts of the United States for over forty years, now exist and are working well in several countries, and existed in Glasgow for almost the whole of the period between the two world wars, being broken up there only in 1939 with the coming of war and evacuation. See The National Federation of the Blind and the Association of Blind and Partially Sighted Teachers and Students, Educational Provision for the Visually Handicapped Comments on the Vernon Report, 1973, page 28. In the post-war period a nun, Sister Aloysius, was a pioneer in the integrated education of the visually handicapped in Britain. She was responsible for a scheme in which visually handicapped children from St Vincent's School for the Blind and Partially Sighted in Liverpool were integrated into the local grammar schools. Her experiment was a success and the first visually handicapped boy in the experiment went on to university. For more information on the work of Sister Aloysius see Anne Lapping, 'How do we treat the blind as people?', New Society, 14 March, 1968, page 373. For more information also see the obituary of Sister Aloysius, which appeared in Insight, Volume 2, Number 3, Spring 1981, page 65. (Insight was the journal of the Association for the Education and Welfare of the Visually Handicapped).
42. Pritchard has discussed the relationship between the 1944 Education Act and the education of the handicapped. See D. G. Pritchard, Education and the Handicapped 1760-1960 (Routledge and Kegan Paul, London, 1963) chapter 16.
43. See The Inner London Education Authority, Educational Opportunities for All? (The Fish Report) London, 1985.

CHAPTER TEN

EMPLOYMENT AND DISABILITY

In this chapter I intend to do two main things: first, I intend to examine the employment legislation for disabled people and some proposals concerning how this legislation could be made more effective; then, I intend to examine the visually handicapped in employment and some of the important problems that they face.

Employment and disability: An introduction

The social and political struggle to improve opportunities for employment for the disabled is becoming fierce. However, until the past few years there was little conflict of view about the direction of employment policies. For many years after the Second World War, there was a quiet confidence both in the general structures of the welfare state, as apparently confirmed in the government legislation covering the period from 1943 until 1948, and in the special legislation governing the employment of disabled people. Both the private and the public sectors were treated with respect by successive governments in their management of the British economy, and the values of social and workforce integration seemed to be strongly expressed. It was widely believed that it was just a question of time or patience before public levels of tolerance and education would be sufficiently raised, rehabilitation and other services developed, machinery and workplaces adapted, disablement resettlement officers trained in sufficient numbers and employers coaxed or cajoled into willing

compliance, and then high levels of employment among the disabled would be achieved. While this description may be rather crude, it does convey something of the optimism with which employment prospects were regarded in the post-war years. Along with many of the other hopes of post-war Britain a better and more affluent future for the disabled population seemed to be secure.

The historical background will now be briefly sketched, before the present employment situation is described and analysed in relation to the disagreements about policy. After dismally high rates of unemployment throughout the 1930's, the rates of unemployment had fallen dramatically in the early 1940's. In a period of full employment, rising levels of war production and public readiness to introduce sweeping social reforms, disabled people were able to find jobs and both the state and employers were prepared to take positive initiatives to make it easier for them to do so. The widespread realisation too that many people might be maimed by war had revived national guilt over the failure to do much for the war disabled of the First World War. As in other areas of economic and social policy, there were those who were determined not to make the same mistakes as had a previous generation.

It was in this particular context that an official committee, the Tomlinson Committee, prepared a report in 1943 which was to become the basis for policy after the Second World War.¹ The Tomlinson Report proposed a quota scheme, but in the view of the committee, it was clear that the government should not

'try to create employment or preference for disabled persons regardless of their capacity to undertake the work required and of the need for efficiency in production; the aim should be to secure for the disabled their full share, within their capacity, of such employment as is ordinarily available.'

The Tomlinson Committee therefore saw the quota scheme as a way to reduce the effects of prejudice and discrimination; as a means to provide publicity for the principle that most disabled people, given the right job and the right assistance and help, were fully employable on their own merits; as a system that would provide the necessary access to employers, and relevant records and statistics and as a direct way of getting disabled people into jobs. In 1944 the recommendations of the Tomlinson Report were incorporated in a Parliamentary Bill which was enacted as the Disabled Persons (Employment) Act 1944, and which still remains in force.²

The act contained four important measures. The act created, first of all, a voluntary register of disabled persons wishing to work, divided into those capable of working in open employment and those able to work only in sheltered workshops. To qualify, a person has to be, in the words of the act,

'substantially handicapped on account of injury, disease (including a physical or mental condition arising from imperfect development of any organ), or congenital deformity, in obtaining or keeping employment or work on his own account otherwise suited to his age, qualification and experience; the disablement being likely to last for 12 months or more.'

The individual also has to have a reasonable prospect of keeping remunerative open or sheltered employment, as the case may be. The visually handicapped are among those most likely to register

under the act - sixty four per cent of unemployed blind people were registered in April 1983.³

Secondly, the Disabled Persons (Employment) Act 1944 requires employers with twenty or more, workers to employ a quota of registered disabled people, that was fixed in 1946 as three per cent of the workforce. If an employer does not achieve this quota (as shown, for example, in a return he is expected to make to the Job Centre or Employment Office once every twelve months about the workforce) he must offer every job falling vacant to a registered disabled applicant until the quota is reached. Only if disabled applicants do not materialise can the employer be issued with a permit to employ non-disabled workers. It is not an offence for an employer to be below the quota; but it is an offence if he or she then proceeds to engage a non-disabled or unregistered disabled person without a permit to do so. While alternative quota percentages can be fixed for particular types of work or firms, only one alternative figure has ever been suggested and approved - that of 0.1 per cent for ships' crews.

Thirdly, under the act certain occupations may be reserved for registered disabled people. Therefore, at present, special permission is required to employ anyone who is not registered as disabled as a car park attendant or an electric lift operator.

Fourthly, and finally, there were several other arrangements to complete the strategy embodied in the 1944 Act (and the supplementary Act of 1958). There were powers to set up a company to provide work in sheltered conditions (which is now known as Remploy) and to

assist sheltered workshops that were run by local authorities and voluntary bodies. A National Advisory Council and district advisory committees were established to coordinate the strategy and help put it into effect. By the late 1970's the special staff in the employment services included approximately 550 full-time Disablement Resettlement Officers, 60 Senior Disablement Resettlement Officers, 35 Blind Persons' Resettlement Officers and 13 Blind Persons' Training Officers. During the 1960's and the early 1970's, the number of part-time Disablement Resettlement Officers had been reduced from 1,000 to none and the full-time numbers increased from 200 in 1966 to almost 550 in 1977. These were some of the most important measures which were designed to improve employment prospects for disabled people. But what is the nature and size of the employment problem?

Estimates of the size of the employment problem

First of all there is the problem of estimating the numbers of people of conventional working age who are disabled, irrespective of the numbers among them who could be considered to be eligible for employment. One of the most commonly quoted sources of information about the numbers of disabled people of different age is an Office of Population Censuses and Surveys (OPCS) survey carried out by Amelia Harris on behalf of the government in 1969.⁴ Within an estimated 'impaired' population of 3,071,000 aged sixteen and over in Britain there were 1,288,000 aged between sixteen and sixty four. And within an estimated total of 1,128,000 who were appreciably,

severely or very severely handicapped, there were 397,000 aged between sixteen and sixty four.⁵ Part II of the report of the OPCS survey went on to suggest that about 700,000 of the impaired population of nearly 1,300,000 of working age were likely to be in the labour force, and figures of this order of magnitude were upheld in a House of Commons Paper in 1974.⁶ At the time of the OPCS survey in 1969 there were 645,545 on the disabled persons' register and when the numbers began to fall in the 1970's it was at first estimated that 'perhaps only half of the disabled people in employment were registered',⁷ and then that

'there may be considerably more unregistered disabled people in the working population than there are registered disabled people.'⁸

Therefore, the total disabled population of working age has been put officially in the region of 1.2-1.5 millions.⁹

However, there is a great deal of confusion about the numbers who are disabled and who, among that category, should be regarded as being properly within the scope of a comprehensive employment policy for the disabled. Two important points should be mentioned.

First of all, there are many disabled people living in residential institutions, including hospitals, some of whom are eligible for schemes of open employment. They include many thousands of mentally handicapped and ill persons.¹⁰ It is clear that the government's policies need to be based on information about the disabled population living in non-private households as well as private households.

In the second place, there is evidence to suggest that the methodology of the OPCS survey of 1969 was incomplete and that the disabled population was as a result underestimated. Other government sponsored surveys, such as the General Household Survey and ad hoc surveys of the elderly population by Harris and Hunt, an independent national survey by Townsend and surveys overseas by Allen and Cinsky and Anderson, have all produced much higher estimates.¹¹ The estimates from the independent national survey by Townsend are given in table 1.¹² It can be seen from the first two columns of the table that in ranking any population according to disablement the definition of a significant threshold can vary and this can make a big difference to the numbers making up the final estimate of 'the disabled population'. It should be remembered that persons with minor incapacity, or with forms of impairment which they themselves do not regard as limiting their activities, are not included in the second and the third columns of the table. According to two separate sets of criteria, there is evidence (summarised in the table) that the number of disabled people of working age is about double the number assumed in official government reports.

Therefore, it is particularly unfortunate that in the three reviews of employment policy by the Department of Employment and the Manpower Services Commission between 1973 and 1981 (published in 1973, 1979 and 1981 respectively), no attempt was made to develop a better basis of knowledge so that more informed employment policies might be formulated. Nor has any attempt been made to sort out the

Table 1 - The estimated number of people of economically active age (in private households) with disabilities in the United Kingdom in 1969 in thousands

Sex	Age	With appreciable or severe incapacity only ^a	With some, appreciable or severe incapacity ^b	With one or more disablement conditions which limit activities ^c
Males	15 - 40	75	240	450
	40 - 49	80	250	265
	50 - 59	200	460	570
	60 - 64	120	320	320
all adults under 65		475	1,270	1,605
Females	15 - 40	90	295	755
	40 - 49	70	330	490
	50 - 59	220	630	670
	60 - 64	285	600	455
all adults under 65		665	1,855	2,370
Males and Females	15 - 40	165	535	1,205
	40 - 49	150	580	755
	50 - 59	420	1,090	1,240
	60 - 64	405	920	775
all adults under 65		1,140	3,125	3,975

^a On the basis of nine criteria of self-care and household care.

^b Note that the estimates in the first column are included in this wider category.

^c Based on questions about handicapping conditions, together with check list.

Source: P. Townsend, Poverty in the United Kingdom (Allen Lane, London, 1979) pages 1049 and 1050.

different approaches to the definition of disablement incorporated in registration by local social service departments, the rules governing the payment of attendance allowance, housewives' non-contributory invalidity pensions, war and industrial injury disablement pensions and registration by the Department of Employment. It cannot be emphasised strongly enough that policies will remain very rough and ready while the distribution by severity and type of disablement is not measured carefully in relation to the distribution of roles in employment and in sheltered employment.

The problem of unemployment and deprivation in employment

Even if an agreed basis of information about the availability of, and eligibility for, employment among disabled people eludes us, the same cannot be said of their disadvantages compared with the non-disabled population. In relation to employment there are four specific disadvantages which can be documented and which help to explain why disabled people are more likely than others to be in poverty: first, fewer are employed; second, fewer have high earnings and more have low earnings; third, more hours tend to be worked to secure the same earnings and, finally, slightly fewer have good conditions of work. These four points will now be considered briefly in turn.

More people with than without disabilities are unemployed. For example, in 1981 16 per cent of the registered disabled, compared with 8 per cent of the workforce as a whole, were unemployed. Moreover, nearly three-fifths of the former, compared with a quarter of the latter, had been unemployed for more than a year. There were

72,000 unemployed registered disabled, and there were a further 102,000 unregistered disabled people registered as unemployed - making a total of 174,000. Of this huge total, nearly half were under the age of forty five.¹³ However, these are official figures which depend on registration for unemployment, and there is evidence from research that there are many more disabled people who would like to be employed and are capable of at least light or sheltered employment but who do not register for work. Thus, on the basis of a national survey by Townsend in 1969, it was estimated that there were 1,220,000 men and 1,870,000 women under 65 with some, appreciable or severe incapacity. The latter figure becomes 1,245,000 if women between the ages of 60 and 64 are excluded. Those unemployed comprised 28 per cent of men, and 56 per cent of women. Table 2 gives these estimates in more detail¹⁴ (they are subject to large sampling errors but are derived from a sample of the entire population, and broadly correspond with the General Household Survey figures on 'limiting long-standing illnesses'). Two important conclusions can be drawn from this evidence: first, fewer than half the employed disabled were registered and, second, the rate of unemployment among disabled people was much higher, even before the rapid rise in unemployment in the late 1970's, than among the rest of the population of working age.

In Townsend's national study carried out in 1969, it was found that the earnings of the disabled worker were significantly lower than of the non-disabled.¹⁵ According to alternative definitions of

Table 2 - The estimated numbers of men and women with some, appreciable or severe incapacity who were employed and not employed in the United Kingdom in 1969 in thousands

Age	Men		Women		Men and Women	
	employed	not employed	employed	not employed	employed	not employed
15 - 29	80	40	75	85	155	125
30 - 39	65	25	80	35	145	60
40 - 49	200	45	175	155	375	200
50 - 59	310	135	220	420	430	555
60 - 64	220	100	110	515	330	615
	875	345	660	1,210	1,535	1,555

Source: P. Townsend, Poverty in the United Kingdom (Allen Lane, London, 1979) page 1055.

disablement, more of the disabled than the non-disabled had relatively low earnings, and fewer had relatively high earnings for the year as a whole. Townsend found that the degree of disablement was also related to the level of earnings. Townsend found that more of the severely than of the less severely incapacitated had low earnings. There was little suggestion in Townsend's findings that low earnings were a function of fewer working hours. Slightly more of the incapacitated than of the non-incapacitated worked under 30 hours a week. Townsend found that the great majority worked as many hours as the rest of the working population, and as many as a quarter of the men worked more than 50 hours. When earnings were related to hours both disabled men and disabled women were found to have a lower rate of earnings. For people working indoors, conditions of work could also be compared. Ten features of work were listed by Townsend: first, sufficient heating; second, availability of tea or coffee; third, indoor flush W. C.; fourth, facilities for washing and changing; fifth, a place to buy lunch or eat sandwiches; sixth, a place to keep a coat and other articles; seventh, a safe place to keep personal items; eighth, the availability of first aid; ninth, the availability of a phone and tenth, the provision of raised or lower lighting over the individual's work. Townsend found that fewer incapacitated than non-incapacitated people enjoyed all or nearly all of these facilities.¹⁶

It is clear that Townsend's preliminary exploration of the work situation of disabled people needs to be greatly extended. In Britain there is a growing interest in access for physically disabled people

but at present there is little hard information available about the difficulties under which so many disabled people work, and the modifications - to machinery, premises and routines of work - which could be made at little or no cost.

The specialised problems of employment for the disabled

Men and women with certain forms of disability have especially severe problems in obtaining, and keeping, employment. This is true, for example, of the deaf and the hard of hearing, the blind and the partially sighted and people with multiple sclerosis and epilepsy.¹⁷ But it applies with particular force to people with a mental handicap, or with a mental illness.¹⁸ It is clear that to be effective, an overall employment policy would have to be addressed to different categories of the disabled population.

The need to build special components into any general employment policy becomes evident when the problems experienced at particular stages in the development of disability or illness, or stages in the life cycle are closely examined. Therefore, as Blaxter and Buckle have pointed out, youthful disabilities restrict or interrupt education and make the acquisition of qualifications and skills difficult.¹⁹ Martin and Morgan have pointed out that there are major problems of adjustment in cases where a short-term disease turns into a long-term disability, or where a disease is progressively disabling.²⁰ There are also several important questions to be addressed. There is the question of relating degree of disablement to the 'intensity' or the level of employment - which is usually expressed in the terminology of 'open'

employment, sheltered workshops, home worker schemes and occupational therapy or pastimes. Furthermore, there is the particularly acute question of what opportunities for rehabilitation exist for those recovering from damaging injury or disease. Ex-hospital patients, especially if they have been psychiatric patients, have major obstacles to overcome, and there is clear evidence of the difficulties of re-establishment in employment and in the community. For example, McCowen and Wilder have called attention to the problem of the single and homeless living in lodging-house areas of the major cities.²¹

What emerges and stands out from the evidence is the need for accompanying measures if ex-patients are to be re-established in employment. These accompanying measures could include accommodation, basic cash allowances, perhaps certain services, and continuing social support, sometimes by means of support for the family. What also stands out is the need to reduce derogatory labelling of disabled people and enhance their prospects of moving from protected to less protected forms of employment as they recover or learn to accommodate their disability to employment. Researchers have called attention to the stigmatising effects sometimes of working in sheltered workshops, so that the opportunity to move on to 'open' employment rarely arises.²² These particular problems seem to apply alike to employment rehabilitation centres, local authority workshops and training centres, Remploy and workshops for the blind.²³

Many of these general problems apply acutely to disabled women. Only in recent years have the employment and occupational problems

of disabled women begun to be taken seriously. Indeed, if the Tomlinson, Piercy and Tunbridge Reports in the period from 1943 until 1972 and the Department of Employment and MSC reviews during 1973-81 are studied, there is barely any references at all to their problems. Yet, as tables 1 and 2 have shown, the number of disabled women of economically active age and the levels of unemployment among them are much higher than among men. However, since the mid 1970's the growing activities of the women's movement, and the concern expressed about disabled married women in particular, have begun to awaken public interest in this major feature of the employment problem.²⁴

The difference of opinion between disabled people and the state bureaucracy

It is clear that the problem of unemployment among disabled people is therefore larger, and more complex, in relation to workforces and communities, than is acknowledged in discussions by the government and in statements of policy. This point should be fully understood and absorbed if an effective alternative policy is ever to be developed. It is arguable that a narrow, uninformed, and indeed unsympathetic bureaucratic view about employment for disabled people has evolved during the 1970's and the 1980's. This centres on the government management of the quota scheme and the discussion of possible alternatives, and will now be briefly explained. This is a specific example of theories of the development of the 'corporate state' and of the 'bureau-professional'.²⁵

In the early 1970's the Department of Employment decided to review its services for disabled people, and so in 1973 published a consultative document on the quota scheme.²⁶ The consultative document concluded that the scheme was now 'less relevant' than it had been, was 'a considerable administrative burden both for the employer and the Department', used resources which 'might perhaps be better employed on behalf of disabled people in other ways' and meant that the Department was both a 'salesman and policeman'. The document asserted that, in any event, disabled people were losing faith in the scheme; fewer were registering and there was 'no positive evidence' that the scheme exerted 'a significant effect on the prospects of individual disabled people'.

The Department of Employment went on to state that:

'Finally, it can be argued that compulsion in this field is no longer relevant, desirable or practicable and that the quota scheme should therefore be abolished and resources concentrated on improving the employment and training services available to disabled people; both by ensuring that they share the benefits that will accrue from the modernisation of the general employment service and the expansion of general training facilities; and by improving the specialised employment and training facilities provided for disabled people. This would avoid the need to continue labelling disabled people as such; improve the relationship between the Department and employers in this field; make it easier to develop their goodwill; and give the DROs and BPROs more time to devote to their clients, to visit employers and to liaise with hospitals.'²⁷

The consultative document did include a subsequent reference to the possibility that the quota might nonetheless exert some influence on employers to engage and retain disabled people, but there is little doubt that the Department of Employment was pressing for the

abolition of the quota scheme. The Department's document was not welcomed by a wide range of organisations and, after a process of deliberation, the Minister announced in 1975 that the quota scheme would be retained. In 1976 this decision was upheld by an authoritative working party, chaired by Lord Snowdon, which had established a Working Party sub-committee to produce a report on employment. The sub-committee declared that:

'We believe that a statutory framework along the present lines is vital if the employment of the disabled is to be kept to the fore as a specific objective of employment policy.'

Then the Working Party sub-committee went on to propose the introduction of a levy/grant system and various financial incentives to make the quota scheme work effectively.²⁸ The Snowdon Working Party believed that these measures would help to integrate the disabled into the community.

However, in the late 1970's the civil servants within the state bureaucracy returned to their dislike in principle of the quota scheme. In 1979 the Manpower Services Commission published a discussion document which was very much in the spirit of the review of 1973 and invited submissions from interested parties.²⁹ Once again, this document attracted considerable criticism from a variety of organisations representing the disabled. Notable criticisms of the document were made by the Disability Alliance and the General Secretary of the Royal British Legion.³⁰ However, despite this criticism the Manpower Services Commission remained unmoved and in July 1981 formally recommended the substitution of the statutory quota scheme

by a

'statutory general duty on employers requiring them to 'take reasonable steps to promote equality of opportunity in employment for disabled people','

together with a code of practice and a continuation of educational and other measures which were designed to persuade employers to improve opportunities for disabled people.³¹

The main objections to the proposals to scrap the quota scheme

A number of comments can be made on some of the most important issues.

It is certainly arguable that historically the quota was never enforced and that therefore the Department of Employment has never acted as a 'policeman'. In the thirty six years between 1944 and 1980 there were only ten prosecutions under the Disabled Persons (Employment) Act 1944 for non-compliance. Fines were imposed in only seven cases and the total paid as a result of all the cases amounted to £334.³² Furthermore, despite the high rates of unemployment among registered disabled people, permits to employers to recruit non-disabled applicants were readily granted. By 1972 there were more firms issued with permits (25, 875) than there were firms fulfilling their quota (25, 385) and the number of the latter has since 1972 steadily diminished.³³ By 1979 only thirty six per cent of firms and only thirty six per cent of local authorities in Wales, twenty three per cent in Scotland and thirteen per cent in England satisfied the three per cent quota.³⁴ Jordan points out that there were newspapers, trade unions, television companies and even the House of Commons

with registered disabled people comprising fewer than 3 per cent of their employees.³⁵ Lonsdale points out that nearly all government departments also failed to satisfy the quota.³⁶

Secondly, it is arguable that although the failure to satisfy the quota has been attributed to the decline in registration, and hence the physical impossibility of employers all finding enough registered disabled people to reach the necessary figure of 3 per cent, in fact the responsibility for that decline seems to rest with the Department of Employment itself, including its general political direction. There appear to be the following five ingredients: first, an unwillingness to prosecute employers during the 1940's, the 1950's, and the early 1960's when unemployment among the workforce as a whole was very low but relatively high among the registered disabled; second, a failure to expand the number of Employment Rehabilitation Centres and improve their quality; third, a failure to make sufficient grants available for training adaptation of premises and equipment, fares to work and so on; fourth, an inability to prevent unemployment from rising among registered disabled people and fifth, a failure to encourage registration. These five important points can be illustrated from the Department of Employment's annual reports and from empirical research.

The question of influencing 'voluntary' registration is particularly important and intriguing. It would be difficult to substantiate the voluntary nature of the register: since 1944 large numbers of people - especially the war disabled - have been automatically registered.

Mildred Blaxter has undertaken some research among a small sample of disabled people in Scotland and this has helped to reveal the true situation. She points out that:

'The arbitrary nature of the register is usually explained by the fact that registration is voluntary, and so will never represent all disabled workers. As a matter of fact, few people in the sample appeared to appreciate its 'voluntary' status: no one had ever asked to be registered, and only one person (unsuccessfully, but rather unrealistically in his case) had ever asked to be taken off the register. Most workers in the survey represented registration as an administrative procedure arranged by medical and employment authorities together, without much reference to them, or something which happened automatically if, because of health problems, they remained too long amongst the 'ordinary' unemployed. Particularly if they had been registered at school-leaving age, they did not see it as a matter over which they had much choice: they had always been defined as a 'handicapped child', and the label of 'disabled adult' had, in their case, automatically followed. A typical explanation was 'Well, I was put on the register when I left school because I'd been to the special school, see'. This does not necessarily prove, of course, that no individual was conscious of having been offered a voluntary choice: to have been given the label of 'disabled worker' and to admit to having chosen the label, might be different things.'³⁷

Mildred Blaxter's evidence obliges us to look critically at the statistics of registration. What is clear is that during most of the 1960's the total registered did not decline. For the seven years between 1962 and 1968 it fluctuated by a few thousand above and below 650,000. After this, there was a gentle decline of approximately 10,000 a year which then accelerated in the early 1970's and then more sharply in 1978 when it dropped by 33,000. By 1981 there were 460,000 registered disabled people. A problem is to explain this uneven pattern. In 1979 the Department of Employment and the Manpower Services Commission called particular attention to the 'stigma' people

feel in being identified as disabled.³⁸ Yet it is an unconvincing argument to relate such an individualistic explanation to the uneven statistical decline. No doubt detailed historical analysis undertaken by future researchers will help us to understand this puzzling pattern. But two factors deserve to be given close attention. The first is the rise in the rate of unemployment itself at the end of the 1960's, again in the early 1970's and especially in the late 1970's. Registration for the purpose of securing employment must have appeared increasingly unproductive both to disabled people and to employment office staff. A second factor probably was the unwillingness of Disablement Resettlement Officers and other employment office staff to invite people to register or to do so on their behalf as a result of changes in policy in the Department and then the Manpower Services Commission in the 1970s. This could have resulted both from general pessimism about employment prospects and a knowledge of the management's lack of confidence in both the quota scheme and the register.

These possible explanations seem to be confirmed by the way in which the reviews of the quota scheme, and especially the empirical evidence about the views of disabled people, employers and staff, were handled by senior administrators. Indeed, in the reviews of the quota scheme by the Department of Employment and the Manpower Services Commission published in 1973, 1979 and 1981, only small reference was made to the arguments of the Piercy Committee of 1956 and the Snowdon Working Party of 1976, which were both in favour of keeping,

and indeed strengthening, the quota. Furthermore, the arguments of the Snowdon Working Party were not properly addressed and discussed and, despite requests put by voluntary organisations, an informed analysis of the lessons to be learned from employment schemes operating in other countries, and particularly the levy/grant schemes of Western Germany and Japan was not attempted.³⁹

It is arguable that the treatment of evidence about the opinions of disabled people, employers and employment office staff was also peremptory, and the reports of research carried out by the Manpower Services Commission itself were not published, although summaries were available on request. The reports of the research carried out by the MSC show that eighty six per cent of disabled people who were interviewed (there were a total of 988 people in the sample who were either registered as disabled or considered to be eligible for registration) were in favour of a compulsory quota for employers.⁴⁰ The key findings of the survey are summarised in table 3. In the survey there were big majorities in favour of explicit laws, registration and sanctions to ensure that disabled people could be employed. Perhaps surprisingly, there was evidence from the parallel survey of employers' attitudes (seventy eight employers were included) for a 'get tough' policy on the quota. 'Most' employers were found to view it 'as a worthy measure' and, while

'levies were frequently criticised ... some thought levies would prove painfully salutary, and would at least generate revenue which could be used elsewhere.'

Finally, there was also a small survey of 18 Employment Service

Table 3 - The attitudes of disabled people towards protective legislation in 1978

Attitude	Firms should be obliged to employ quota of registered disabled	Employers to pay levy if failing to meet quota	Anti-discrimination laws on disablement	Compulsory publication of company records on employment of disabled
Strongly in favour	44	24	48	32
In favour	42	28	35	48
Against	6	28	9	11
Strongly against	1	10	2	3
Not known or uncertain	6	9	5	6
All percent	100	100	100	100

Source: The Manpower Services Commission Employment Service Division, Survey of Attitudes of Disabled People to Employment Legislation (Manpower Services Commission, London, May, 1979).

Division (ESD) Area Managers. More criticisms of the scheme were made on behalf of area staff by these managers than by disabled people and employers. Nonetheless, there was

'considerable divergence of views among ESD staff as regards what should take its place' and interestingly, there was a 'strong support for greater use than at present of financial incentives to encourage employers to take on disabled people.'⁴¹

In addition, there is evidence of overwhelming support for the quota scheme among members of the British public. In 1980 a special Gallup poll commissioned by New Society and the BBC to mark the beginning of the International Year of Disabled People was carried out, and a national quota sample of 983 people were interviewed. The poll showed that a large majority of voters of all parties were in favour of strengthening the quota scheme, and only four per cent wished to see it abolished.⁴²

In view of this evidence, it is striking that in reviewing policy, senior civil servants should have persisted with what can be shown to have been the view only of a small elite in the administration and, moreover, that their case for change has been so poorly supported and argued. It is possible to interpret their approach as being governed by a pessimistic long-term view of the British economy - that unemployment would continue to increase for several years and that it was inevitable, if not right, for disabled workers to be among the first workers to be axed. One must not forget the important background fact that at the same time as the MSC Employment Service Division was engaged in its scrutiny of the quota between 1978 and 1981, the

Commission was preparing to wind down the number of staff serving disabled people. The MSC's Corporate Plan that was submitted to Ministers in December 1980 for 1981-1985 proposed to cut DRO staff from 1,473 to 1,120 and to cut rehabilitation staff from 997 to 830 during this period.⁴³ Nevertheless, the arguments for the quota also had to be reviewed in their own right. And it can be argued that in (i) adequately representing, and dealing with, the arguments historically of the Tomlinson and Piercy committees, and the Snowdon Working Party; (ii) establishing the employment situation of disabled people, and the views taken towards employment by such people, their representatives, employers and the general public, and (iii) examining with care the experience, and policies, of other countries and reporting how they might be applied in British conditions, the Manpower Services Commission cannot be said to have done its job.

Above all else, it is arguable that the conditioning nature of employment policies does not appear to have been understood by administrators. That is, the nature and scope of employment institutions have not been properly questioned or investigated for disabled people. Theories about the integration of disabled people into employment have been predominately individualistic - that everything depends on the willingness, capacities, skills and other individual characteristics of disabled people themselves. This fits in with the view that employment can only be built upon market principles and that disabled people must make do with low wages or, if they are too disabled, no wages at all. However, the meaning of disability, and therefore the

views taken about the application of the term in different contexts, including situations of employment, is a social construct. Therefore, society helps to shape the social assumptions and practices which employers adopt towards disability, leading them to recruit certain types of people and to make arrangements accordingly in their construction of work procedures, offices and plants. The quota legislation in Britain is just one example of the responsibility that can be consciously exerted on behalf of the nation as a whole to create the right conditions and the right frame of mind among employers and public and state administrators alike to ensure employment for people with disabilities.

This theoretical approach helps us to understand why some disabled people have found it so difficult to find and keep employment. It is partly that employers do not appreciate certain kinds, or levels of skill in disabled people, partly that they do not feel expected, by the force of public opinion, to include disabled people along with other minorities, in representative numbers among their workforces, and partly that they have, as a result, so designed their offices and factories, and their working procedures, including such things as shifts and methods of assembly, and even machines, to make it difficult for minorities, including disabled people, to play a full or even sufficient share in production. It is arguable that through such actions, employers have helped to extend the scope of 'disablement' as applied to individuals. ⁴⁴

Some proposals to improve the effectiveness of the quota scheme

This analysis suggests the main features of an alternative economic and social policy. The substantive problem of unemployment among disabled people is larger and more complex - in relation to the integration of such distinct groups as disabled women, or visually handicapped epileptic, mentally handicapped and mentally ill people, as well as, say, amputees into work forces and communities - than is usually acknowledged in government statements of policy. In the 1980's the problem of creating enough opportunities for employment is huge and affects hundreds of thousands of disabled people throughout Britain. It is arguable that the quota scheme deserves to be retained, but not without also introducing a whole range of supporting administrative and legislative policies so that more disabled people would be employed. I will now outline six supportive measures which could be introduced to back up the quota scheme.

First of all, sanctions could be introduced against those employers who do not observe the quota. A levy on all those employers below the quota could be introduced. A fund could be built up from these levies, which would allow employers meeting the quota to obtain allowances and grants for training, and adaptations of premises and machinery. Government schemes do exist, like 'job introduction' (to subsidise the trial employment of disabled people for six weeks), 'job rehearsal' (a tax-free allowance for disabled people who attend employment rehabilitation centres), fares to work, and capital grants to adapt premises. However, it is arguable that these remain of

marginal value. Furthermore, the quota might also be defined on a weighted basis (as proposed by the Snowdon Working Party), so that people who were more severely disabled would count more against the quota and employers would be eligible to receive higher employment subsidies on their account. Supplementary allowances could be payable to those employing certain categories of handicapped people, including the mentally handicapped.

Secondly, disabled people should, with their prior agreement, normally be registered. The definition of eligibility for registration would include degree of severity and would correspond with the definition used by social service departments under the Chronically Sick and Disabled Persons Act. All those proposed for registration would receive a letter outlining the rights and benefits resulting from registration.

Thirdly, a new system of capital grants for employers to adapt machinery and premises in order to employ groups of disabled people could be administered by the Manpower Services Commission. There is a good case for saying that the present scheme is derisory: for example, £500,000 was allowed for capital grants in 1977-78, and only £11,000 was spent. By 1981-82, the allowance had been reduced to £150,000, and only £16,000 was spent.⁴⁵ There should also be a parallel system of grants for training within firms. There should be new financial incentives for the nationalised industries, public administration and the public social services to submit proposals for employing groups of disabled people.

Fourthly, provision could be made for an Advisory Council which would consist wholly of people elected from the register to review employment policies and advise the Manpower Services Commission. The approval of training schemes, and grants for such schemes, might be the responsibility of the Advisory Council.

Fifthly, the number of places in sheltered and enclave employment could be expanded - at the rate, say, of 5,000 a year for a decade - especially for mentally handicapped and mentally ill people. A certain amount of the new places could be reserved for those people who are presently living in residential institutions. There is far too little sheltered employment at present for those who need it, with no evidence of any increase over the last few years (for example, in 1976 13,755 places were available and by 1980 this number had dropped slightly to 13,666).⁴⁶

Finally, anti-discrimination legislation could be introduced. This legislation could help to establish rights to higher minimum earnings in sheltered workshops and in Remploy, and in forms of employment in adult training centres and residential institutions. The legislation could secure protection against being treated unfairly in other respects in employment situations because of disability.

These proposals are the main components of a comprehensive employment policy for the disabled. Policies of this kind are required both to stop the current disengagement of disabled people from the workforce in Britain, and to heal the fundamental disagreements between disabled people and the Manpower Services Commission.

A wide range of pressure groups and individuals would like to see the quota scheme retained and strengthened, and in recent years these interested parties have put forward several important proposals regarding how the scheme could be made more effective. At the risk of some repetition, I will now consider the most important of these ideas. Then I will briefly consider the attitude of the Royal National Institute for the Blind and the National Federation of the Blind towards the quota, and the proposals that have recently been put forward by the Labour Party about the quota.

In 1984 the Manpower Services Commission established a working group, under the chairmanship of Brian Swindell, to review the quota scheme and to make suggestions for improving the scheme's effectiveness. The group issued its report in April 1985.⁴⁷ The members of the working group were drawn from a variety of organisations including the Manpower Services Commission, the Confederation of British Industry, the Trades Union Congress and the National Advisory Council on the Employment of Disabled People. Chris Heginbotham of the National Association for Mental Health, Peter Large of the Association of Disabled Professionals, Bert Massie of the Royal Association for Disability and Rehabilitation, Michael Barrett of the National League of the Blind and Disabled and the National Advisory Council on the Employment of Disabled People, and Peter Townsend and Alan Walker of the Disability Alliance were the representatives of the voluntary organisations on the working group. These representatives put forward fourteen proposals to improve the effectiveness of the quota scheme,⁴⁸ which I will now consider.

First and foremost, the representatives of the voluntary organisations emphasised that the quota scheme must not be scrapped. They believe that it is essential in principle to maintain the statutory duty of employers to employ a quota of registered disabled people.

Second, the representatives of voluntary organisations believe that the quota should be based on registration. They feel that 'registration' for quota purposes shall include those who require special assistance into employment and are provisionally deemed to be registerable by the Disablement Resettlement Officer (for example, someone who has recently left hospital) and those who accept being listed on the disabled persons register.

Third, more positive encouragement should be given to registration, and all those who come into contact with disabled people and especially staff of the Department of Employment and the Manpower Services Commission, should encourage people to allow their names to be placed on the register in order to obtain the full range of benefits.

Fourth, the number of disabled people of employment age should be properly established. The representatives of the voluntary organisations believe that as a matter of urgency the government should undertake enquiries to establish reliable estimates of different categories of disabled people, and express these also according to severity of disablement. On the basis of international as well as some national evidence the representatives of the voluntary organisations are of the opinion that the true realisable percentage of disabled people with a capacity for employment is above 3 per cent.

Fifth, the representatives of the voluntary organisations believe that the quota should remain at 3 per cent. They point out that there is no evidence that the number of disabled people with a capacity for employment is less than 3 per cent and until better estimates are available, and there has been a period of encouragement of registration, the present quota should be left at 3 per cent. At a later stage there may be a case for applying a higher percentage than the general percentage to certain types of work.

Sixth, the representatives of the voluntary organisations believe that access to paid employment should be facilitated, and all those who express a wish for paid employment should be given every help and facility to do so. This would include those who may be in a position only to work a few hours a week. The representatives of the voluntary organisations add that obstacles in the social security system to part-time employment should be removed, and measures should be taken to encourage employment opportunities involving employment for, say, 10 or more hours a week. They feel that this will be of great help to some categories of disabled persons. The representatives of the voluntary organisations also believe that the important interim function of a small number of hours employment per week should be better recognised in the development of rehabilitation and training. They add that consideration should also be given to developing rehabilitation, training and employment for disabled people in full-time and part-time employment at reduced levels of performance (and, by implication, reduced levels of earnings).

Seventh, the representatives of the voluntary organisations believe that existing grants and allowances should be better publicised. They believe that the fact that there presently exist opportunities on the part of employers to apply for grants and allowances to employ disabled people should be more widely publicised and routinely called to the attention of employers and disabled people.

Eighth, the representatives of the voluntary organisations believe that equity between different types of handicap must be better ensured. They believe that no discrimination should be exercised against disabled people who have particular types of handicap, and that steps should be taken by the Manpower Services Commission and employers to ensure in particular that mentally ill and handicapped people have equal access to employment. They feel that a positive programme of public education for the employment of disadvantaged groups among the disabled population should be launched.

Ninth, the representatives of the voluntary organisations believe that the services for disabled people in employment and the personal social services should be better co-ordinated. They believe that means should be established of finding out whether disabled people who are of employment age on the register of one service would wish to be listed on the other register as well. There will also be those disabled people whose needs are changing and might be transferred smoothly from one service to the other. The representatives of the voluntary organisations believe that in the interests of the disabled population, employment and social services deserve to be better

co-ordinated, and as a priority consideration should be given to youngsters reaching employment age and then to all adults under the pensionable ages.

Tenth, the representatives of the voluntary organisations believe that a modern definition of disablement should be developed. They feel that the definition of disability in different Acts of Parliament should be co-ordinated and brought up to date.

Eleventh, the representatives of the voluntary organisations believe that there are existing measures which should be taken to strengthen the quota scheme. They believe that existing sanctions should be strengthened and administration of the quota scheme tightened up. In particular, they believe that the Manpower Services Commission should be less inhibited about following a prosecution policy for employers who break the law, and should allow fewer bulk permits to release employers from their legal obligations to employ a quota of registered disabled people. They argue that in areas with above average unemployment among disabled people no facility for bulk permits should be allowed. In the mid 1980's over 96 per cent of all permits issued are bulk permits, and the representatives of the voluntary organisations are of the opinion that no quota scheme can operate effectively at this level.

Twelfth, the representatives of the voluntary organisations called for the active involvement in the quota scheme of disabled people. They believe that disabled people should play a much bigger role in the administration of the quota scheme and rehabilitation programmes.

They feel that in time a substantially higher percentage of Disablement Resettlement Officers should themselves be disabled. They feel that there should be training programmes, as part of in-service training, run jointly by the Manpower Services Commission and voluntary organisations representing disabled people.

Thirteenth, the representatives of the voluntary organisations believe that both new sanctions and new inducements should be built into the quota scheme. They believe that consideration should be given to the desirability of extending the scheme by means of a 'levy-grant' principle. They feel that prosecution through the courts for minor offences against the quota is slow and cumbersome and, in any case, has not been much pursued by the Department of Employment in the years since the Second World War. They believe that after warnings, employers failing to meet the quota should be fined substantial sums automatically. They also believe that employers fulfilling or proposing to fulfil the quota should become entitled to a generous scheme of grants and allowances, especially for severely disabled people. They add that the fines could become the basis of additional finance that is required to meet an improved system of grants. There is a range of possible methods of introducing both sanctions and inducements, including taxes and tax reliefs. The representatives of the voluntary organisations believe that a government committee should be appointed to make recommendations about the form of a scheme.

Finally, the representatives of the voluntary organisations believe that consideration should be given to the introduction of anti-

discrimination legislation, though not at the expense of strengthening the existing quota scheme. They feel that the two sets of legislation should be recognised to be complementary.

In summary, it is clear that the voluntary organisations that were represented on the working group, in addition to favouring policies of education and persuasion, are firmly committed to the principle of the quota legislation. They believe that it should be strengthened both by stricter enforcement and by considering legislative changes to improve the scheme. Beyond this, the Disability Alliance and the Association of Disabled Professionals put forward some detailed proposals of their own. The Disability Alliance wishes to retain a strengthened quota scheme operating with levies and grants, similar to that in West Germany. The Association of Disabled Professionals wishes to see the introduction of general anti-discrimination legislation (a part of which would cover employment) as a complement to, and possible strengthening of, the quota scheme or of a combined quota levy scheme. In the future these proposals could all be part of a new package of policies to improve the quota scheme.

In 1984 Susan Lonsdale and Alan Walker published an important book, entitled A Right to Work,⁴⁹ which is in accord with these ideas and which cogently argues the need for some kind of legislative framework to ensure that disabled people obtain employment. Shortly after publication of the book, Lonsdale appeared on In Touch, the weekly radio programme for the visually handicapped on Radio Four,

and on Link, the fortnightly television programme for the disabled, and on each programme discussed the issue of employment policy for the disabled. I now want to consider what she said and the proposals she put forward to improve the situation.

First of all Lonsdale pointed out that the Disabled Persons (Employment) Act 1944 and the quota scheme, as it exists, is in fact a very interesting piece of legislation. It is a form of positive discrimination and potentially a very effective piece of legislation, which is intended to enable disabled people to obtain jobs and to open opportunities for them in the labour market. However, Lonsdale argued that the act has never been properly enforced as it was intended to be enforced when it was passed, such that employers actually fulfill the legal obligations that are on them. She claimed that the quota scheme is being flouted by as many as two-thirds of the firms in Britain, and then put forward several proposals to improve the effectiveness of the scheme.

Above all else, Lonsdale would like to see employers comply with the quota scheme and if they do not, then sanctions should be brought to bear on them. Lonsdale feels that the Manpower Services Commission has an important part to play, and that it should be doing two things. First, the MSC should be monitoring the extent to which employers obey the law and second, the MSC should not be issuing permits to employers to release them from their legal obligations as liberally as they are at the moment.

In addition to enforcing the quota, Lonsdale believes that we have to build both new sanctions and new inducements into the existing

quota scheme, such that employers will be encouraged to actually fulfill their legal obligations. She believes the first thing we have to do is actually inform and make sure that employers actually know that the quota exists and know what their legal obligations are. A statutory code of practice for employers could be introduced for this purpose. Lonsdale then added that Britain could look and learn a lot from the West German scheme, whereby a levy is imposed on employers who do not fulfill their 6 per cent quota in West Germany and the levy then goes into a fund which is then passed back to the employers for purposes such as altering premises and facilitating job premises for disabled people to get work. She also suggested that the quota scheme should be extended to cover government departments, which it does not at present - no government department is obliged to fulfill the quota, although in the past, ministers in government have said that they have a moral duty to do so.

Finally, Lonsdale made an important point about disabled low wage earners. She pointed out that the Wages Council Act of 1979 covers certain industries and makes provision for a minimum wage to operate in those industries, although Section 16 of the act actually makes provision for the exemption of disabled people from the right to receive a minimum wage. The reasoning behind this is that it is assumed that disabled people are less productive than the non-disabled, which seems to be patently untrue. Lonsdale believes that this situation should be changed, and that in the future disabled people should be offered some protection against low pay.

Quite clearly, Susan Lonsdale would agree with the proposals that have been outlined earlier on ways to improve the quota scheme's effectiveness, and her proposals could be used in any future employment policy for the disabled.

The Royal National Institute for the Blind is the major pressure group for the visually handicapped in Britain, and so it is important to consider its attitude towards the quota scheme. In November 1984 Chris Croft, the RNIB's Employment Services Manager, appeared on In Touch and commented on the proposals that had been put forward by Susan Lonsdale to improve the effectiveness of the quota scheme. Croft pointed out that the RNIB has been making representations to the Manpower Services Commission regarding the quota. The RNIB's officers believe that the quota must be enforced more vigorously, and must have a few more teeth put into it. But Croft also pointed out that in the future the RNIB would like to see more education, not just of managing directors and personnel officers, but also of line management, so that their fears regarding disabled people and taking them on will be dispersed and dispelled. The RNIB's officers believe that the rewards of an education programme would be reaped, with more visually handicapped people securing employment and employers being less sceptical and less-worried about taking visually handicapped people on. The RNIB does produce several brochures for prospective employers and others about how visually handicapped people can be successfully integrated into a workforce, but would like to see the government produce more publicity of this kind.

The National Federation of the Blind has called for a higher quota and for a system of grants to employers who make financial sacrifices in order to provide facilities for disabled workers.

In spite of the recent calls for a stricter enforcement of the quota scheme, the Thatcher Government is opposed to the introduction of a stronger legislative framework in this area of policy and has directed its main energies into persuading employers to take on disabled people. Therefore, in November 1984 the Manpower Services Commission published the Code of Good Practice on the Employment of Disabled People.⁵⁰ The purpose of the code, which is voluntary, is to persuade employers in both the private and the public sectors to adopt progressive employment practices in relation to disabled people. The code informs employers about the law relating to the employment of disabled people and informs employers about what the government considers to be good practice in the employment of the disabled. For instance, with regard to recruitment, training and promotion, and it also gives information on where employers can obtain financial and other assistance for employing people with disabilities. The problem about the Code of Practice is that it is full of very good principles regarding the employment of any employee, but it does not have the force of law. It is not backed by a statutory obligation on employers to actually follow the recommendations and principles contained in the Code of Practice. When Mrs Thatcher launched the Code of Practice she said that people must remember that it is there to back up the legislative framework we already have. Certainly it is intended in

principle to back up the law, because we do still have the Disabled Persons (Employment) Act 1944 on the statute book regarding employer's obligations to take on disabled workers. But the Code of Practice has a problem, because it states that all employers 'should consider' inviting suitably qualified disabled candidates for jobs, particularly if they are below the quota. Now that seems to contradict the law because it is quite clearly the legal obligation of employers to invite all suitably qualified disabled candidates for jobs, not simply something that they 'should consider'. The biggest concern is that what is essentially a voluntary code of practice will eventually take the place of the law which already exists. This would be regrettable because the Disabled Persons (Employment) Act 1944 is in principle a very strong, good employment protection measure for disabled people. Instead of promoting the voluntary Code of Good Practice, the government would be better putting its resources into introducing a more comprehensive legislative framework to ensure that disabled people obtain employment.

There are important disagreements between the Conservative and Labour Parties concerning employment policies for disabled people, and the Labour Party has pledged that if it is returned to power then it will introduce new employment policies for the disabled. In 1985, for example, the Labour Members of Parliament, Michael Meacher, Alf Morris and Margaret Beckett criticised the government's policies and outlined their alternative strategy. They argued that:

'the government, via the Manpower Services Commission, has cut the number of Disablement Resettlement Officers drastically and has abandoned any pretension of enforcing

the quota. There are neither the staff nor the resources to provide effective rehabilitation services and especially for people with the greatest difficulties in achieving independence, such as the mentally handicapped and people recovering from serious mental illness. Further, many Tories are hinting at the introduction of a purely voluntary system in respect of employing disabled people - a voluntary system backed by the voluntary code of practice that has been recently introduced. Disabled people have a right to have their employment interests and opportunities protected by statute. Labour's priorities must include a stricter enforcement of the quota scheme, backed by effective financial penalties, which can then be used to subsidise the better employers, along the lines already developed in West Germany. Expansion of the MSC's counselling, training, and assessment facilities will be a necessity and the status of the Disablement Resettlement Service will have to be urgently reviewed to rescue it from its present status as a Civil Service 'backwater'.⁵¹

Employment services for visually handicapped people

Having considered the quota scheme and how it could be improved, I now intend to examine the visually handicapped in employment. The historical background will be briefly sketched,⁵² before the present employment services and employment situation for the visually handicapped are described and analysed. Then, finally, I intend to examine the proposals of the National Federation of the Blind to improve employment opportunities for the visually handicapped.

Care of the visually handicapped is a long standing British tradition, and the first training establishment for the visually handicapped in Great Britain was founded in 1791. There is a long historical background to the relationship which exists between the Department of Employment, and more recently the Manpower Services Commission, and the Royal National Institute for the Blind. This can be traced back to the 1940's when the RNIB established its

employment service which pioneered opportunities for work for visually handicapped people on the open employment market. The RNIB developed and consolidated its employment service covering approximately seventy five per cent of the local authority areas in England, Wales and Northern Ireland. It received some financial support from local authorities during the 1950's and in the early 1960's, but it was in the 1940's that the then Ministry of Labour and National Service recognised the RNIB's rehabilitation service and gave some financial support towards the cost of rehabilitating newly blind people, preparing them for the vocational training and subsequent employment. During those years the RNIB's Employment Officers were able to establish working relationships with the Disablement Resettlement Officers based at Employment Exchanges, and in October 1963 the Ministry of Labour implemented the recommendations contained in the Piercy Report⁵³ and assumed responsibility, particularly for placement in industry but also in general for a National Employment Service for Blind People. A number of the RNIB's Industrial Employment Officers were transferred to the Civil Service taking with them valuable experience which enabled the Ministry of Labour to consolidate its Blind Person Resettlement Officer Service by bringing into that service some of its own expertise from officers who had formerly worked as Disablement Resettlement Officers.

Local authorities are involved in this process. Local authorities have been responsible for the welfare of the visually handicapped since 1920 when the first Blind Persons Act was passed. Each local

authority maintains a register of all blind people living in the area and employs social workers to look after their needs. Some local authorities and voluntary organisations also provide homes for the visually handicapped and the RNIB has set up a number of homes and hostels for blind workers. Newly registered blind people who do not wish, or are not able, to take up employment may undergo short courses of social rehabilitation which are sponsored by local authorities and these courses are provided by the RNIB.

There are also courses of employment rehabilitation for visually handicapped people in the employment field. The objects are in the main the same as those at any Employment Rehabilitation Centre but at the centres specially dealing with visually handicapped people, great emphasis is placed on the need for the newly blind to achieve personal adjustment to blindness including, above all else, maximum independence and mobility. These courses are available at the Queen Elizabeth Homes of Recovery for the Newly Blind, Torquay, and at Alwyn House, Ceres, Fife. The Torquay centre, run by the RNIB accommodates seventy two men and women, whilst Alwyn House, managed by the Edinburgh and South East Scotland Society for the Welfare and Teaching of the Blind, has accommodation for up to twenty. The length of the course is flexible and may vary from four to twelve weeks according to the needs of the individual. Fees are met by the Employment Service Division, who also pay maintenance allowances and travelling expenses.

Vocational training is provided for the visually handicapped. Visually handicapped people may undertake training at a commercial

training college which is run by the RNIB, at Letchworth Skill Centre, or in a workshop for the blind. The only course of industrial training provided directly by the Training Service Division is the engineering course at Letchworth Skill Centre. The length of the course is usually ten weeks and trainees are given introductory training in machine operating, inspection, assembly and the use of braille measuring instruments such as micrometers, vernier rules and gauges. Personal maintenance allowances and travelling expenses are paid by the Training Service Division. Training in piano tuning is undertaken at the Royal National College for the Blind and also at the London College of Furniture. Commercial and professional training is arranged by the RNIB at their commercial training college. The courses include telephone, shorthand-typing, audio-typing and, at a new college, purpose built in north London for the training of physiotherapists. On these courses, maintenance allowances and travelling expenses are paid by the Training Service Division. For other professions, such as law and the Church, visually handicapped people follow the normal training requirements of the professional bodies concerned in the same way as sighted people.

The Blind Person Resettlement Officer Service has an important part to play. The Employment Service Division (and before them the Department of Employment) has been responsible for placing visually handicapped people in industrial employment since October 1963. Before then, the task was shared between the RNIB and some local authorities. There are now over thirty specially trained officers

known as Blind Persons Resettlement Officers (or BPRO's) stationed at the Manpower Service Commission's offices throughout the country. Their particular responsibility is to place visually handicapped people in work of a kind suitable for them, and to assist them in every way to settle or become resettled in the working community. In their daily work the BPRO's are in close liaison with the welfare officers of local authorities. The duties of the BPRO's include interviewing visually handicapped people in need of employment, advising on suitable forms of employment, assessing the need for rehabilitation or training, and encouraging employers to consider the employment of suitable visually handicapped workers. They also provide a regular follow-up service which ensures that any problems arising from the employment of individual visually handicapped people can be speedily dealt with and employer and worker are free to call upon the Blind Persons Resettlement Officer for advice at any time.

The BPRO's are, as necessary assisted by, and work in co-operation with over ten technically qualified Blind Persons Training Officers (or BPTO's) who are responsible for the provision of any necessary training on the job, investigation of work processes, advising on technical questions which arise and assisting in the induction of visually handicapped people into jobs. They often spend the first four or five days of the employment, helping the visually handicapped worker to master a particular process, find his way about the factory and over the route between home and the place of employment. A senior Blind Persons Training Officer, in post in a

head office, gives overall guidance and advice on technical problems arising from the employment of visually handicapped people.

The RNIB's Employment Service has an important contribution to make. The placing of visually handicapped people into commercial and professional occupations is still mainly in the hands of the RNIB's Employment Officers. In 1986, the RNIB had eight Employment Officers who offer the RNIB's general employment service. There is, of course, constant liaisons between the RNIB's officers and the Blind Persons Resettlement Officers and a large number of visually handicapped people are placed in both the industrial and commercial fields as a result of this cooperation. There are special arrangements to meet the particular needs of visually handicapped school leavers. Two centres, one at Hethersett run by the RNIB and one at Harborne run by the Birmingham Royal Institution for the Blind, provide courses of about one year's duration for visually handicapped adolescents. The courses provide continued education, vocational guidance, and social adjustment and are sponsored by local authorities.

The National Federation of the Blind has attempted to supplement the RNIB's general employment service by offering its own employment advisory service and by publishing literature for visually handicapped people on looking for jobs.⁵⁴

Changes in employment trends

In recent years, there have been important changes in employment trends, and the general trend in placing has been towards open employment and away from sheltered employment in workshops for the blind.

The employment of visually handicapped workers in open industry is based essentially on the principle that they can, and should, do a full week's work in return for a full week's wage, and there are no occupations which are specially reserved for visually handicapped people. The development of new fields of employment is a continuing process and the number of employers engaging visually handicapped workers for the first time has been steadily increasing over recent years.

Since October 1963, the date when the combined placing service was set up, the joint efforts of the RNIB, the Manpower Services Commission, and St Dunstan's have resulted in more than 12,000 visually handicapped people being placed in an ever widening variety of jobs.

A good example of a breakthrough into a new field of employment is that of computer programming. As a result of discussions which the RNIB initiated with the Department of Employment and other government departments, it was decided in 1966 to set up an experimental computer programming course for visually handicapped people. The success of this experiment was achieved through close cooperation between government departments, the RNIB and the computer manufacturers who devised some ingenious adaptations of equipment and procedures. Well over one hundred visually handicapped people have been trained and placed as computer programmers, some of whom have since been promoted to more senior posts.

A very recent trend is for more visually handicapped people to be finding jobs in white collar occupations, and fewer in repetitive

industrial work. At one time approximately seven hundred occupations in thirty five major industries had been opened to the visually handicapped, but with the changes in technology and in work practices many visually handicapped workers have been displaced from their traditional manual occupations. This was not unexpected as the automation of many repetitive machine operations which visually handicapped people had been satisfactorily undertaking for many years had already been foreseen.

Registered blind people have been harder hit than sighted people by the rise in unemployment. In November 1984, for example, more than two and a half times as many blind people were unemployed as non-disabled people.⁵⁵ To put it another way, approximately 8,700 visually handicapped people were unemployed, which is a large number. Hardest hit are those seeking employment in industry. The Royal National Institute for the Blind is concerned about the high rates of unemployment among the visually handicapped population, and has introduced several measures to help to deal with the problem. For example, as part of its £25 million development programme, the RNIB is expanding its Commercial Training College, so that more visually handicapped students can take the courses in secretarial skills, telephony, computer programming and the use of the Optacon.⁵⁶ In this way more visually handicapped people will receive the qualifications which are required to compete on equal terms in the job market. In an employment environment dominated by economic recession, telephony stands out as a buoyant pool of job opportunities

for visually handicapped people⁵⁷ and the new college will produce more newly qualified telephonists than ever before.

The RNIB is also examining ways of helping visually handicapped people towards self employment. There are many courses available at the moment to the general public to teach them what they need to know to start up a small business, and the RNIB and the Manpower Services Commission propose to make such a course available to visually handicapped people, putting the teaching material into braille, large print and on tape.⁵⁸

In addition to these measures, the RNIB has shifted quite a lot of its activity towards trying to stop people who are currently employed who are losing their sight from resigning their jobs. The RNIB is talking directly to employers and explaining to them how visually handicapped people can remain a useful member of their workforce. The RNIB is putting campaign advertisements in newspapers of all kinds, not just the heavy press but also the more popular press as well, aimed directly at people who are losing their sight and their friends and family, stating that if a person knows someone who is losing their sight then please persuade them to contact the RNIB before they give up their job. The RNIB will then see to it that such a person will be given the necessary aids, advice and other support, so that he can continue in a job.

Finally, the RNIB is concerned with those visually handicapped people who are already unemployed. The RNIB is in regular contact with the governing councils of the sports associations to try to

encourage them to take more account of visually handicapped people in the activities they are doing. In 1985 the RNIB brought out a leaflet covering over fifty different activities that visually handicapped people can undertake, many of them in integrated settings with sighted people. Through these measures the officers of the RNIB hope that those visually handicapped people who are unemployed will receive guidance on where to receive education for leisure.

Special aids to employment

The fact that in recent years visually handicapped people have been placed in an ever widening variety of jobs has been reflected in the increasing number and types of special aids to employment which have been issued to visually handicapped workers by the Manpower Services Commission. Under the Employment Service Division's Special Aids to Employment Scheme, which was started in 1947, visually handicapped people can be loaned special tools or equipment which would not be required by sighted people doing the same work. Up to 1973 the annual cost of this scheme had never exceeded £10,000. However, since then the scheme has expanded substantially, and blind people have benefited most from this special facility. In fact some 70 per cent of the aids are supplied to visually handicapped people.⁵⁹ Detailed information about the number of aids provided to blind and sighted disabled people has only been maintained during the last few years, but in 1975-1976, 446 of the 550 aids issued were to visually handicapped people. In 1976-1977, 544 of the 639 aids issued were to visually handicapped people, and in the financial

year 1977-1978, 521 of the 669 aids issued were to visually handicapped people. The further expansion of the scheme is planned.

Some of the more expensive aids which have been introduced in the past few years are the Optacon, closed circuit television, computer terminals, speaking calculators and tape recorders. These will now be briefly discussed in turn. The Optacon is an electronic device which enables visually handicapped people to read the printed word by touch. It is being further developed and a proto-type has been made which actually reads out the printed word. Research is also being conducted to produce a machine which will reverse this process and print the spoken word. Closed circuit television has recently been developed for use by partially sighted people. It enables print to be magnified up to fifty times. Computer terminals have been modified to give a braille print-out. The speaking calculator already gives a spoken readout of figures on a display and this new development is being extended to measuring equipment for use by visually handicapped people. Finally, a wide variety of tape recorders have been issued to visually handicapped people in employment.

These aids have been developed recently. There is ongoing provisions of such aids as braille micrometers and other precision braille measuring instruments, some of which enable visually handicapped inspectors to operate within limits of less than one tenth of a thousand part of an inch.

A study of visually handicapped workers in local government

Relatively little research has been undertaken regarding visually handicapped workers and the opportunities and the problems

that they face. However, in 1983 the Royal National Institute for the Blind expressed a keen interest in conducting a survey of visually handicapped workers in local authority employment as local government is often the largest single employer in an area and offers a wide range of jobs from unskilled manual to senior executive posts. In 1979 just over two million people worked for local authorities (that is, nine per cent of the workforce). In 1983 the figure had risen to over 2.5 million. The RNIB's Vocational and Social Services Department embarked on the survey to establish how far visually handicapped people have taken advantage of the numbers and the range of jobs available in local authority employment.

A contracted agency, the Independent Research Bureau, conducted the personal interviews of the visually handicapped workers in the local authorities and Miss Deborah Mullins was appointed by the RNIB to execute and write up the findings of the survey. Her report was published in 1984.⁶⁰

I now intend to examine Mullins' report in some detail because it contains some important findings. Indeed, although the report is restricted to an examination of visually handicapped workers in local government, many of its findings will have a familiar ring to visually handicapped people in almost any field that one cares to name.

Mullins found that of the over 2.5 million people employed by local authorities, only 600 are in fact visually handicapped. The report covered 456 authorities and they were selected to try to give a representative cross-section of all types of local council. Over half

of them did not employ any visually handicapped people at all and even in those councils who did employ the statutory three per cent quota of disabled people a disproportionately small number of them were visually handicapped mainly, the report says, because of 'a lack of applicants and a lack of suitable jobs'.⁶¹ The types of jobs done by the 267 visually handicapped people identified by the survey varied from unskilled or semi-skilled manual, twenty four of them, to teachers and social workers, twenty five, and not surprisingly one of the largest single groups, thirty, were those who worked specifically with visually handicapped people as Technical Officers, teachers and social workers. It was intriguing to discover that there was even one accountant amongst the listed occupations. But the traditional clerical, typing and telephony skills still very much dominated. In various categories they accounted altogether for 107 of the 267 jobs covered by the survey. The report quotes one employer as saying: 'Everyone has a vision of blind people looking after switchboards and doors.'⁶² It is fair to assume that visually handicapped people who apply for jobs will know what the employer means.

The report also looked at the career development of those visually handicapped people who have managed to get jobs with local authorities and the case histories quoted in the report are very revealing of the problems many visually handicapped workers come across. For example, one case history is concerned with a Mr Y:

'Mr Y has been totally blind since birth and started in local government thirty-two years ago as a telephonist in the Engineers Department. He has since been promoted to grade T2 and works in the Social Services

Department group on Health and Safety, arranging meetings at department and committee member level and co-ordinating a members' dictation service. He is on a scale between £4-6,000 per annum. He uses a Perkins braille to keep records and minutes of meetings. He would like a Versa-braille so he could use a computer terminal thereby saving time, but he was unable to acquire one, partly because of the cost and partly because his Employment Officer felt he could manage without one. He feels his employer should have made more effort to provide the special equipment he needed. '63

The provision of aids is looked at in some detail in the survey.

159 of those interviewed felt that their opportunities of promotion were limited by visual handicap, over half of them because of reading problems. The report makes it clear that a large number of people, the majority of the partially sighted interviewees and nearly a third of those who were registered blind, did not know about the Personal Reader Service. This is a scheme introduced in the autumn of 1982 and administered by the RNIB, whereby Manpower Service Commission grants are provided to pay for up to fifteen hours reading time per week.

The next most common reason for failing to advance in their careers, given by 69 interviewees, was misunderstanding by superiors of their abilities. For example, one case study reports on Miss F2:

'Miss F2 has been totally blind since childhood and has worked as an audio-typist in a County Council for ten years using a braille scale and a shorthand machine. She is on a scale between £4-6,000 per annum. She has eight 'O' levels and RSA Typing and shorthand at 120 and 140 words per minute. She feels overqualified for her job and has not been given the opportunity to work on word processors or electronic typewriters. '64

Another frequently quoted problem was the inability to drive.

For example, one interviewee said:

'Discrimination against blindness is only because of an inability to drive - hence the need for a mobility allowance - you can then compete equally with a sighted person. I have to use public transport where my colleagues use cars. If a mobility allowance was available I could make arrangements for a different form of transport. My travel expenses are only a fraction of those of my colleagues. '65

The survey makes it clear that those councils which did employ visually handicapped people were generally pleased with them. 18 council representatives felt they were 'as efficient as their sighted counterparts', 13 thought they were a little less efficient, but 6 felt they were a little more efficient. Only one council reported that visually handicapped people compared badly with sighted employees in punctuality and attendance. 31 councils said they were the same as anyone else, but 13 said they were better.

Despite the job finding services provided by the RNIB and the Manpower Services Commission most of the people interviewed had found their jobs by their own efforts, 105 through newspaper advertisements, another 50 through family and friends or their own initiative. The Blind Persons Resettlement Officers and the Disablement Resettlement Officers are credited with only 41 job placements and the RNIB Employment Officers with only 13. This is not altogether surprising, says the report, when one considers that the majority of councils do not inform the RNIB or the BPRO's of any vacancies. But the majority of councils do inform the Disablement Resettlement Officers of vacancies and this report recommends strongly that there should be more liaison between all these agencies, which are supposed to be helping visually handicapped people to get jobs.

The report also looks at what happens to local government officials who lose their sight. Here the councils seem to think that there was less of a problem. Where possible people will redeploy and there are some good examples:

'Mr X2 ... has worked in local government for twenty-eight years. He lost his sight after he entered this employment and he now suffers from panoramic vision having no central vision. Prior to sight loss he worked as a painter and decorator (craftworker) but was transferred to the Technical Services Department as a clerical worker (grade Misc 1) at onset of handicap. He is now a telephonist (Misc 2) operating a radio for mobile vans, operating the weighbridge and filing. He uses a variable speed tape recorder and spectacle-mounted low vision aid to help him carry out his job. He says that 'the council created this job for me' and feels happy with his job and the opportunities to show his abilities. '66

Another example concerns Mr Y2:

'Mr Y2, whose sight deteriorated whilst he was in District Council employment, started work as a refuse collector (fully sighted). As a result of his sight loss he was moved and became a paper bailer, sorting bails and salvaging materials. He comments 'they created this post for me'. He now works in the Environmental Health Department processing applications for loft insulation and calculating grants. He uses a 1,000 watt lamp in conjunction with a magnifier for reading and a talking calculator for calculating grants. His only problem was a drop in wages - as a refuse collector he had received a bonus. '67

These are encouraging cases, but it is in relation to the provision of aids by the Manpower Services Commission, often in consultation with the RNIB, that the survey reports 'frequent criticism'. Of 132 people who had had some contact, either with the MSC or the RNIB, half, sixty six, felt that the assistance they had been given was unsatisfactory. There was a general feeling of lack of communication. One employee said:

'I think it would be helpful if staff employing you were aware of the technology available to blind people. It might be helpful if the RNIB put aids on display at the office equipment exhibitions so that employers could see what they can do to help blind employees. '68

And individual complaints were levelled against the people from the Manpower Services Commission or the RNIB who were supposed to help with aids and equipment. A Liaison Officer wanted a variable speed cassette recorder to assist him in his work:

'I spoke to a chap and he pooh-poohed the idea and said he didn't think it was advisable. I've run across two who have no soul to work with the blind. '69

Another employee said:

'I would like to see a more enlightened view by RNIB Employment Officers when approached for new aids. '70

Often the aids that are needed are not expensive. In fact, just over one-third of those interviewed use no special aids at all. Many people said that lighting was a problem, of which local authorities took no account. A higher wattage lamp, or a window blind to shield someone against glare, might make all the difference to a person's ability to cope with a job. But 75 per cent of the interviewees said that they had never even tried to obtain the aid they had wanted, sometimes because they were not sure how to go about it, sometimes because they thought funds were not available. There seems to be a great deal of ignorance amongst employers and employees about the help available through the MSC's Personal Reader Service. Also, throughout the report it stresses the importance of exploring all the potential of new technology in making jobs available to visually handicapped people.

But, on the credit side, Deborah Mullins concludes that there is ample evidence that many local authorities are willing to consider suitably qualified visually handicapped applicants and declare that:

'The RNIB should take steps to exploit the findings of this report by a concerted effort to place visually handicapped people in local authority employment. '71

In summary, some of the major findings of the report are that three-quarters of the visually handicapped people working for local authorities do not apply for the piece of technical equipment that they really want, many do not know of the existence of a Personal Reader Service which could help them in their jobs and the vast majority of them got those jobs through personal initiatives, rather than through a local authority or RNIB placement officer.

Since the report was published in December 1984, the RNIB's Employment Officers have promoted the findings of the survey and have tried to implement the recommendations of the survey. The RNIB has made an attempt to liaise more closely with local authorities and with the personnel departments and the line managers within the authorities, to ensure that visually handicapped employees know of the Personal Reader Service and the various aids which are available.

The RNIB is conscious of the fact that local authorities are potentially a large source of employment for the visually handicapped, and so in June 1985, held a one day forum for people connected with local authorities. At the forum, Anthony Aston, the Head of the Vocational and Social Services Department of the RNIB, pointed out

that many of the local authority representatives who were present at the forum were very well aware of the fact that their performance in employing disabled people to date has been quite poor, and that as responsible major employers they are not and have not done enough in this respect. This is a serious situation because some local authorities are the largest employers in their area.

Aston recognised that there are some inherent problems in finding jobs for visually handicapped people in local authorities. It is not simply the economic situation that local authorities find themselves in, because policies by central government are causing a difficulty, it is problems of structure within the local authority: Aston pointed out that what often happens in local authorities is that applications for jobs are received by a central personnel unit. These applications are then vetted and forwarded to the line managers who are responsible for conducting the interviews and deciding who should be appointed. Aston pointed out that the RNIB's Employment Officers frequently find themselves talking to the personnel staff and not to the line managers when the Officers are supporting visually handicapped people's applications for jobs. Aston pointed out that frequently the RNIB's Employment Officers find that these staff are more than willing to try and help and to try and implement the policy that the local authorities have of employing disabled people. But the line managers often are not aware of what is available to assist visually handicapped workers and are not aware of what the capacities and limitations of visually handicapped workers are. Aston pointed out that the central

problem very often is to educate the senior staff in the various departments of the local authorities to be less prejudiced in taking visually handicapped people on to the staff. At this point the Disablement Employment Officers that are employed by local authorities have an important part to play, because these officers can have a direct influence on the local authority senior staff. The one day forum was important because it helped to educate local authorities about the needs of visually handicapped workers, and where further assistance can be found.

The recommendations of a Royal National Institute for the Blind survey on the Civil Service (published in 1980) have resulted in more visually handicapped people joining the Civil Service and have generated greater career opportunities within it. It is to be hoped that Mullins' study will lead to more visually handicapped workers being employed in local government.

The incomes of visually handicapped workers

It should not be imagined that visually handicapped people in gainful employment have no income problems arising from their visual handicap. There is evidence to suggest that the great majority of visually handicapped workers are low paid by any standards. The best available survey of the earnings of visually handicapped workers in open industry probably still is that reported in 1966 by Duncan Watson, then the President of the National Federation of the Blind and now Chairman of the Royal National Institute for the Blind.⁷² He reported that the average gross earnings of a sample of visually

handicapped workers in open industry was, at that time, under £15 a week, compared with a figure of about £20 for the labour force in Britain as a whole. These figures are now, of course, out of date, but there is no reason to think that the general pattern they reveal has significantly changed. Visually handicapped people working alongside sighted people are probably always paid the 'rate for the job' in their particular establishment. The low wages of visually handicapped workers, therefore, are due to the fact that they are so commonly placed in low paid jobs, often 'women's' employment and often in firms with little trade union organisation. If a blindness allowance for all visually handicapped adults were introduced, then this would help to supplement the incomes of low paid visually handicapped workers and would also help them to meet the extra costs of living that are imposed by blindness.

Sheltered employment

Up until now I have considered visually handicapped workers in open employment. Those visually handicapped people who cannot compete on equal terms with sighted workers in ordinary employment but who, under sheltered conditions, are capable of making a substantial contribution to their maintenance are employed in workshops for the blind. Traditional trades such as basket-making, mat-making, brush-making and knitting, are now being replaced by modern trades including furniture, bedding, wire-work and some industrial sub-contract work. With the substantial increase in the numbers of visually handicapped people placed in open employment, there has

been a corresponding decrease in the number entering workshops for the blind. About 10,000 visually handicapped people are employed in Britain and of these, two thirds are working in open employment and the remaining third in sheltered workshops and in home worker schemes.

The officers of the National League of the Blind and Disabled, a trade union for handicapped employees in the workshops for the blind, believe that the workshops should not simply be regarded as occupation centres, but as a viable means of efficient employment. They have called for the expansion of the sheltered workshops, and for central and local government to make more use of the productive capacity of the workshops. In 1974 Tom Parker, then the General Secretary of the League, put the case for this in the following way:

'The workshop movement has developed because of the financial provision made by the local authorities. We wish to pay tribute to the generosity of the authorities for the financial contribution they have made, and are still making, towards the cost of employment of blind persons in the sheltered workshops. We regret, however, that in many instances they have failed to make use of the productive capacity which they have helped to create. If purchasing officers paid a visit to these establishments they will see products which are regularly required by the local authorities. Our members have demonstrated that with the necessary training and the availability of suitable machinery, they are capable of contributing towards the needs of both central and local government units. We are completely satisfied that if the Purchasing Officers of the authorities would get into discussion with the management a planned system of production could develop which would ultimately lead to a reduction in the costs of providing this very necessary employment for blind and disabled workers for whom they are responsible. It is unfortunate but the question must be asked 'why is it that although the local authorities are so very generous in contributing towards the cost of this employment, yet too often fail to make use of the productive capacity which they have created?'. ' 73

In 1982 Michael Barrett, the present General Secretary of the League, returned to this theme and argued:

'The number of trades carried out in workshops is well over 60, and the outlets for the goods are through both retail and wholesale outlets, but in addition many workshops carry out contracts for government and local authorities. Work undertaken for local authorities and government is based on the priority suppliers scheme, one which we feel has not been used adequately by the powers that be. We feel that much more effort should be made by them to purchase goods from sheltered industries.'⁷⁴

With the right initiative, sheltered workshops can be efficient and viable, if not actually profit-making, and there is a good case for arguing that the blind workshop sector should continue to be a significant source of employment for a large number of visually handicapped people.

Recently, the Labour Member of Parliament Laurie Pavitt identified another important problem concerning the sheltered workshops. He pointed out that:

'Blind people are at a disadvantage compared with other disabled people regarding sheltered workshops. Because blind people are provided for in an earlier Act than other disabled people, they cannot return to a sheltered workshop after leaving it. In a period of prosperity blind people leave sheltered workshops and find jobs in the community. When there is a recession, however, they find themselves out of work . . . and are not permitted to return to sheltered workshops. An attempt should be made to provide such a facility for the blind to bring them into line with other disabled people.'⁷⁵

On behalf of the National League of the Blind and Disabled, Pavitt took a strong delegation to the Minister of Health about this matter several years ago, but unfortunately they received no further help.

Some visually handicapped people who are not capable of working in open employment and who are unable to attend a sheltered

workshop are employed as home workers. The blind home workers scheme is run by the local authorities with some financial support from the Manpower Services Commission.

The National Advisory Council on the employment of Disabled People has been looking into home worker schemes for the disabled. It is no secret that some people would like to abolish the home worker schemes run by local authorities and voluntary agencies for the blind. In 1982 in their joint evidence to the council the Royal National Institute for the Blind and the National Federation of the Blind opposed any such move, pointing out that home worker schemes are often the only alternative that visually handicapped people have to living on fixed social security benefits, and in some cases (such as visually handicapped housewives) they provide the only available source of independent income. Despite these recommendations, the number of home workers that the RNIB supports has been declining steadily very slowly over the years so that by 1985 the RNIB supported just over a hundred home workers. A report was published in 1983 which recommended that central government ought to be doing a lot more to promote home worker schemes. That report has been rejected by the Manpower Services Commission and by central government, and local authorities are becoming increasingly cautious about funding home worker schemes. In the past, these schemes were for the less able blind person a means of enabling them to earn a living at home. However, nowadays home worker schemes are a viable channel for the blind person who is indeed extremely able

but is unable to get a job in the sighted world. For this reason, the number of home worker schemes should be expanded and should be seen as a legitimate source of employment for significant numbers of visually handicapped people.

In conclusion: The proposals of the National Federation of the Blind to improve employment opportunities for the visually handicapped

The National Federation of the Blind, which is a pressure group of visually handicapped people, has seriously considered what can be done to improve the opportunities for employment for the visually handicapped, and now finally I intend to consider the Federation's arguments and proposals.

A United Nations' resolution of 1948 guarantees all visually handicapped people the 'Right to Work'. We in Britain have accepted this in theory but have fallen lamentably short in realising it in practice. There are approximately 25,000 visually handicapped people of working age in England and Wales, and of these only about 10,000 are in employment⁷⁶; of the remaining 15,000, about half are classified by the Department of Employment as 'not capable of work' and the other half as 'capable of but not seeking work'. The average unemployment rate among the 10,000 or so working, is always significantly higher than the national average and in recent years it has fluctuated around ten per cent. But if the whole 25,000 visually handicapped people of working age are taken into account - and it is certain that many of them should be - then the real unemployment rate is undoubtedly much higher than the official average and

may be as high as forty five per cent. Figures from Scotland and Northern Ireland are not included because official returns are calculated on a different basis. Their inclusion, however, would certainly not brighten the picture.

The aim of the National Federation of the Blind is to see that the 'Right to Work' becomes a reality for all visually handicapped people regardless of the severity of their handicap and regardless of considerations of profit and loss. The Federation also aims for the abolition of the practice of segregating the visually handicapped from sighted people at work. For those visually handicapped people capable of working under the discipline of ordinary management, the members of the Federation believe that open employment will normally be preferable, given an appropriate degree of support. For those visually handicapped people burdened severely by additional impairments - who need to work more slowly, or who need prolonged or frequent absences from work - the members of the Federation maintain that sheltered employment in special workshops or factories, will normally be preferable. The members of the Federation therefore wish to see the provision of a graded range of employment units, ranging from establishments suitable for employing the very slowest to factories in which discipline approximates closely to normal working conditions. The members of the Federation have argued that all such units should employ a high proportion of able-bodied workers - about forty per cent - as is the practice in Russia and Sweden. The members of the Federation have argued that these sighted workers

should undertake tasks which the visually handicapped workers could not do and thus extend the productive output of the units.

The Federation has claimed that the present system of sheltered employment for visually handicapped people is unsatisfactory because it provides work for only a tiny minority of visually handicapped people, segregates the visually handicapped from sighted people and offers little incentive to visually handicapped people to graduate from sheltered to open employment, and because the factories concerned run constantly at a loss. The Federation has claimed that its proposals - if implemented - would provide work for all visually handicapped people, would desegregate the present special factories and workshops, would encourage rehabilitation from sheltered to open positions and would establish sheltered factories and workshops as profitable concerns. The members of the Federation have claimed that the major reason why there are so many visually handicapped people 'capable of but not seeking work', and why so few visually handicapped people graduate from sheltered to open employment, is the unsatisfactory conditions of open employment for most visually handicapped workers. The Federation has claimed that society discriminates against visually handicapped workers by expecting them to put up with worse conditions and opportunities than sighted people. The Federation has also claimed that the range of jobs visually handicapped workers are allowed to do is far too narrow. Nearly every skilled and semi-skilled factory worker is placed in a small range of jobs in the engineering industry. Two out of every

three visually handicapped white-collar workers, below professional level, are either telephonists or typists. With so many people in so few occupations, the Federation has claimed that it is hardly surprising that visually handicapped people have a higher rate of unemployment - even in official terms - and lower rates of earnings than their sighted counterparts. The Federation has claimed that there is discrimination by many employers against employing visually handicapped workers who are qualified. The Federation has claimed that this is clearly demonstrated by the difficulty visually handicapped people have in obtaining jobs. Certainly many visually handicapped people have difficulty in obtaining work - about one-half of the visually handicapped people who go through rehabilitation each year have to wait twelve months or longer for their first appointment and those who become redundant have little hope of finding a job quickly, and it is not uncommon for them to wait as long as two years before finding another position.

Therefore, the Federation has called for measures which will widen the range of jobs that visually handicapped people can do, which will help them to attain remunerative employment and which will strengthen their ability to seek out work in the labour market. To achieve these goals the Federation recently put forward six proposals.⁷⁷

First of all, the Federation proposes that legislation should be introduced making it illegal to discriminate against a disabled person seeking employment on the grounds of his or her disability. Second, the Federation calls for a strict enforcement of a quota system. Third,

the Federation calls for a disablement employment tax to be levied on all employers with relief of tax in respect of each disabled person employed. Fourth, the Federation calls for adequate grants to be made available which would be paid to employers who incur costs in order to employ a disabled person. Fifth, the Federation calls for a substantial increase in the number of Blind Persons Resettlement Officers and training officers, so that they can pursue jobs for the visually handicapped more vigorously. Finally, the Federation proposes that a sustained programme of multi-disciplinary research into the means of providing work, both sheltered and open, for visually handicapped people, should be carried out in the context of a permanent institution organised on the lines of the Swedish Handicap Institute or the Russian Institute of Defectology. At the moment, no such organisation exists in Britain, and there is a need for one to be established.

The arguments that have been put forward by the Federation are convincing. Some of the Federation's proposals have much in common with what has been suggested by other commentators, and in the future all of these measures could be effectively used in an informed employment policy for the visually handicapped.

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CHAPTER ELEVEN

DISABILITY AND INCOME

In this chapter I intend to do two main things: first, I intend to examine financial need among disabled people generally and the social response to that need, and then I intend to look at state benefits for the blind and consider whether these are adequate.

There is a close relationship between disability and financial need. On the one hand, disability creates extra needs and costs and on the other, it frequently results in a reduction in employment status or earnings for disabled people or members of their families. This relationship has been demonstrated in a series of official and independent research studies. However, the financial implications of disability have been inadequately recognised in government social security policies. The developments have been piecemeal, with the addition in recent years of a relatively large number of benefits covering a relatively small number of disabled people. The result of this is an extremely complicated array of, often overlapping, benefits which lacks any apparent coherent framework, is confusing and complex, and which still leaves many disabled individuals living on low means-tested benefits. Moreover the social security system has managed to create important divisions in financial status between different groups of disabled people based not on need, but on the place where the disablement took place, the type of disability and the age of onset of disability. The special needs created by disability have not been recognised in the form of a disability income, despite

assurances from both ministers and opposition spokesman since the 1960's. In all industrial societies income is of fundamental importance to participation in community life, and for the disabled their special needs require compensation in addition to the need for income maintenance. The right to income in respect of disability has yet to be established in the United Kingdom.

This chapter examines the financial status of disabled people and outlines the central financial problems that they face. It also discusses the extent to which existing provision has ameliorated these problems and outlines the basis for an alternative comprehensive disability income scheme, which the Disablement Income Group and the Disability Alliance have called for. The first stage of this analysis is an examination of the main sources of income of the disabled.

The main sources of income for the disabled

Access to income through earnings is severely restricted for many disabled people. The survey that was undertaken by Harris, Cox and Smith for the Office of Population Censuses and Surveys (OPCS) revealed that excluding the retired and 'housewives', only six per cent of the very severely handicapped were working, and a further four per cent were earning less than £2 a week in a centre for the handicapped. Only thirty per cent of the severely handicapped and nearly half of the appreciably handicapped were working.¹ As Lyth and Walker have pointed out, this pattern of restricted access is a function of employment capacity and factors of demand such as

the attitude of employers to the disabled.² The result is that most of the disabled do not work and depend on the state for all or a substantial proportion of their income. According to the survey by Harris, Cox and Smith four-fifths of the very severely handicapped receive state benefits.³

The main sources of income of disabled people are retirement pension, supplementary benefits, invalidity pensions, and industrial injury and war pensions. Over half of handicapped people receive the state retirement pension. About two-fifths of the severely and very severely handicapped and one-third of the appreciably handicapped receive incomes in the form of supplementary benefit. Even very slight handicaps can result in dependence on this minimum income, meaning that between twenty and thirty per cent of those with minor handicaps were receiving supplementary benefit.⁴

The pattern of social security provision for the disabled has evolved on the basis of two separate philosophies: compensation, deriving from legal concepts of tort and common law liability, and the concept of insurance to provide income maintenance. As Atiyah points out, the Workmen's Compensation Act of 1897 marked the first major departure from the long-standing common law principle that liability for compensation must be based on fault.⁵ The Act established the legal liability of the state to compensate employees in certain industries (and after 1906 in most industries) for loss of earnings capacity due to accident or industrial disease arising out of and in the course of employment. There is evidence of widespread

industrial injury prior to 1897 but little to suggest that compensation was widely available; in fact as Bartrip points out workers often had their wages stopped or were dismissed if they were injured.⁶

Between 1914 and 1916 provisions for war pensions were influenced by the principle developed in the Workmen's Compensation Act of partial recognition of compensation for loss of earnings. From 1917, however, loss of faculty became the main concept which governed entitlement. Disablement pensions were paid in addition to earnings. This was a crucial departure in the development of social security and represented the first recognition by society of the right of people with disabilities to financial compensation irrespective of their earnings or other sources of income.

The Inter-Departmental Committee on Social Insurance and Allied Services, which was chaired by Sir William (later Lord) Beveridge, was highly critical of Workmen's Compensation. Beveridge proposed that industrial injury compensation should be part of a unified plan for social security and argued that a complete solution to anomalies would be only found in a completely unified scheme for disability which does not differentiate on the basis of cause.⁷ However, the post-war Labour Government rejected Beveridge's proposal for the similar treatment of all sick and injured people and established the completely separate scheme that still exists today. Long-term disablement benefits under the National Insurance (Industrial Injury) Act of 1946, were based not on incapacity for work, nor on loss of earnings, but, like war

disablement pensions, on loss of faculty, involving assessment of the degree of disablement by comparison with a normal healthy individual of the same age and sex. As with war pensions, pension assessments normally range from twenty per cent to one hundred per cent in ten per cent bands. For assessment of less than twenty per cent a lump sum payable is normally made.

Developments in national insurance also took place in the immediate post-war years. A flat rate weekly sickness benefit was provided for those who were incapable of work. In 1966, earnings-related sickness benefit was added to the flat-rate sickness benefit, but it could only be drawn for a period of twenty six weeks. From 1971, the distinction between short-term and long-term beneficiaries was formalised by the replacement of sickness benefit for those who had been off work for more than six months with invalidity pensions. The introduction, in 1972, of small invalidity allowances on top of invalidity pension represented another departure in compensation for the disabled, because they are paid according to age at onset of disability. However, the allowance is not paid to people disabled within five years of retirement age, even if they remain disabled for another twenty or thirty years.

During the 1970's there were several important new developments in both compensation and non-contributory insurance benefits for disabled people.⁸ In the first place, a general attendance allowance was introduced in 1971 to match the 'constant attendance' allowances paid under the war and industrial disablement schemes,

although the former is paid at two rates and the latter five. The attendance allowance

'is a comprehensive universal benefit based neither on the compensation principle, nor on the insurance principle, but on evidence of severe disablement, however caused, which requires attendance.'⁹

Secondly, in 1975, a non-contributory invalidity pension (NICP) was introduced and was paid at sixty per cent of the contributory pension to people of working age who were not able to work, but who did not qualify for the invalidity pension because they had not paid (sufficient) national insurance contributions. Thirdly, a mobility allowance was phased in for different groups between the ages of five and sixty-five over a three year period from January 1976. This allowance is paid to those who are unable or virtually unable to walk for six months because of physical disablement. Fourthly, in 1976 invalid care allowance became payable to those (except married women) who cannot work because they have to stay at home to care for a severely disabled relative. Finally, in November 1977, the housewives non-contributory invalidity pension (HNCIP) was introduced. Faced with a substantial backbench revolt during the latter stages of the Social Security Benefits Bill of 1975, the then Labour government accepted the extension of the non-contributory invalidity pension to married women who were 'incapable of performing normal household duties' as well as incapable of undertaking paid employment. The introduction of HNCIP was delayed for two years, which the government claimed was because a new principle was involved, namely the payment of benefit with respect of ability to perform normal household duties.

Therefore, in a relatively short period of time the principles of compensation and insurance, as embodied in the war and industrial injury and national insurance schemes, have been extended and enlarged to meet one of the special expenses associated with disability, attendance, which has a direct parallel in the war and the industrial injury schemes; and also the more general need for mobility that is associated with disability. In addition to this, non-contributory insurance benefits have been introduced to meet the needs of those unable to work due to disability or because they are caring for an individual with a disability. Finally, as Loach has pointed out, the need for income on the part of married disabled women has been recognised, albeit inadequately and in a discriminatory way.¹⁰ However, rather than representing a series of blocks in the construction of a comprehensive framework of benefits, the result is an incoherent mixture of benefits which do not mesh together, but overlap considerably for some groups while missing out others altogether.

The financial needs of the disabled

It is important to ask if these allowances and other sources of income are adequate. The financial needs of the disabled stem directly and indirectly from disablement which restricts their participation in customarily accepted roles and relationships and their access to resources. It has already been noted that disability involves special expenses, such as that caused by the need for attendance, or incontinence, or wear and tear on clothing caused by

personal aids. For example, three-fifths of disabled wheelchair users interviewed by Hyman in a recent study said that they spent extra money on heating because of disability.¹¹ Several years earlier the survey that was undertaken by Harris, Cox and Smith for the Office of Population Censuses and Surveys had shown that just under one-third of impaired people said that they had at least one source of extra expense because of disability.¹² But there are other financial and social implications of disability and the way in which it is interpreted by different institutions and groups.

First of all there is the restriction of access to various roles and institutions, especially labour market opportunities. Many disabled people or members of their families are prevented from working or are restricted in the sorts of work or the number of hours they can do. Harris, Cox and Smith found that over two-fifths of disabled people said the number of hours they could work was limited by their disability.¹³ Secondly, the disabled often have to pay more for the same goods and services as non-disabled people.

This pattern of restricted access to resources and additional costs created by disability has resulted in two main financial problems for disabled people, and the social security provision aimed at meeting their needs has created a third. Most importantly there is the problem of poverty among the disabled. A long series of official reports and independent reports have demonstrated that a disproportionate number of disabled people live in poverty or on its margins. Despite this record, however, the true scale of poverty amongst disabled people has been considerably underestimated.

The official OPCS survey was crucial in establishing not only that a significant proportion of disabled people were living on supplementary benefit (thirty per cent), but also that an additional seven per cent (250,000 people) were entitled to benefits but not drawing them.¹⁴ This result was subsequently explored by two studies,¹⁵ but one was carried out at least six months and the other at least a year after the main inquiry. These studies found at least 70,000 people eligible for supplementary benefit and willing to claim them. There were another 100,000 who were not willing to claim, an unknown proportion of whom were eligible for benefit. The OPCS survey also established that financial need varies with the severity of disability. Thus two-fifths of the very severely handicapped had incomes of less than their supplementary benefit scale rate entitlement, compared with just under one-quarter of the severely and appreciably handicapped and one-fifth of those with minor handicaps.¹⁶

These important findings have been substantiated subsequently by independent research. For example, a national survey of household resources and standards of living by Peter Townsend carried out in 1968 and 1969 found that the proportion of people with even minor disabilities who were living on incomes below the supplementary benefit level (eleven per cent) was more than twice that for the non-disabled.¹⁷ The proportion of people with appreciable or severe disabilities aged 15 and over (sixty-eight per cent) who were living in income units with incomes in the previous year below or on the

margins of the state's standard of poverty was nearly three times that of the non-disabled.

Most importantly, the survey by Townsend again demonstrated the strong correlation between the degree of disability and poverty. Moreover, although there is a close relationship between disability and age, this correlation held constant regardless of age. For example, nearly three times as many people aged between forty and retirement age who were appreciably or severely disabled as non-disabled were living in income units with incomes close to or below the state's poverty line.¹⁸ For those aged between fifteen and thirty-nine the proportion more than doubled. A comparison between those with no incapacity and those with severe incapacity shows that the proportion living in poverty or on its margins increased from twenty-four per cent to fifty-eight per cent as the severity of incapacity in the sample increased. This finding is supported by the analysis of the General Household Survey data carried out for the Royal Commission on Income Distribution and Wealth, which concluded that:

'Those suffering from the greatest physical handicaps also suffer a very high incidence of financial hardship.'¹⁹

This analysis also revealed a high incidence of low incomes amongst people with permanent disabilities. More than half the families where the head was permanently disabled were living on incomes on, below, or just above the poverty line.

Table 1 shows estimates of the number of people with disabilities living in poverty or on its margins. These must be

treated as considerable underestimates of poverty amongst the disabled because they exclude, for example, the institutional population; they are derived from official statistics from which it is difficult to distinguish people with disabilities and they do not cover a period in which unemployment doubled. These estimates must also be treated with caution because they rely on comparison with the state's standard of poverty, which affords a bare minimum living standard and which gives scant recognition to the special needs created by disablement. Thus, a special study undertaken by the Department of Health and Social Security in 1972 of families receiving supplementary benefit found that 'relatively few' of the long-term sick received lump sum payments for exceptional needs.²⁰ A more recent study by Stowell of disabled people receiving supplementary benefit found that additional requirements (formerly exceptional circumstances additions) accounted for seven per cent of the income of the less severely handicapped and nine per cent of that of the severely handicapped. However, Stowell concluded that:

'In a large majority of cases . . . these allowances are still far from being sufficient to meet the extra costs incurred.'²¹

Therefore, despite the existence of a great deal of evidence that a disproportionately large percentage of the disabled are living in poverty or on its margins, the government has consistently underestimated the extent of this poverty. Official government statistics show that just under one-quarter of supplementary benefit claimants have been sick or disabled for three months or more.²² However,

Table 1 - Numbers and Percentage of Total and Disabled Population Living in Poverty or on the Margins of Poverty in 1977

Level of income	Total population					
	Over pensionable age (000s)	Under pensionable age (000s)	All ages (000s)	Disabled over pensionable age (000s)	Sick and disabled under pensionable age (000s)	Disabled of all ages (000s)
Below supplementary benefit level	760	1,270	2,020	250	70	320
Receiving supplementary benefit	2,000	2,160	4,160	790	240	1,030
At or up to 40 per cent above supplementary benefit level	3,010	4,830	7,840	860	400	1,260
More than 40 per cent above supplementary benefit level	2,750	35,960	38,720	690	1,380	2,070
Total	8,520	44,220	52,740	2,590	2,090	4,680
Below supplementary benefit level	8.9	2.9	3.8	9.7	3.3	6.8
Receiving supplementary benefit	23.5	4.9	7.9	30.5	11.5	22.0
At or up to 40 per cent above supplementary benefit level	35.3	10.9	14.9	33.2	19.1	26.9
More than 40 per cent above supplementary benefit level	32.3	81.3	73.4	26.6	66.0	44.2
Total	100	100	100	100	100	100

Note: The estimate of sick and disabled persons under pension age applies to those sick or disabled for three months or more and includes dependents in the income unit.

Source: DHSS (SR3) Analysis of FES 1977 for columns 1, 2, 3 and 5. The distribution of column 4 is based on evidence about those of pensionable age who were 'appreciably or severely incapacitated' in P. Townsend, Poverty in the United Kingdom (Penguin 1979) page 712 (and survey printout).

largely because of the exclusion of disabled elderly people from these statistics they are a considerable underestimate. The Disability Alliance has estimated that approximately one-third of all claimants suffer from some incapacity and two-fifths of supplementary pensioners are appreciably or severely disabled.²³

Low incomes and other resources of the disabled

As well as the problem of poverty, the disabled suffer disproportionately from low incomes and limited access to a wide range of other resources. The disabled in work are more likely to be low paid than their non-disabled counterparts. The OPCS survey found that half of the impaired single income units who were working had incomes below forty-two per cent of average earnings, and one-quarter had earnings below thirty-two per cent of the average.²⁴ Some of the lowest wages are paid in sheltered workshops, factories and training centres. An official survey by the Department of Employment of wage rates in these organisations, conducted in 1973, revealed that 19 out of 25 local authority workshops paid basic wages of just over half of average male manual earnings, as did 24 of the 32 workshops run by voluntary bodies.²⁵ It was estimated in 1964 that the wages of disabled people were 25 per cent lower than the national average.²⁶ Research carried out for the Royal Commission on Income Distribution and Wealth demonstrated that despite the introduction of the attendance and mobility allowances, 'the incidence of low incomes amongst the permanently disabled is high.'²⁷

In addition to low incomes, the disabled have a much lower level of other resources than the non-disabled. If we take the value

of assets as well as net disposable income, the proportion of people living below or only marginally above the state's poverty line nearly trebles from seventeen per cent amongst those with no incapacity, to fifty per cent for those with severe or appreciable incapacities.²⁸

The extent of this deprivation has been clearly described by Peter Townsend:

'More of the incapacitated than of the non-incapacitated, for each major age group, were in debt or had no assets or had less than £100. Fewer had assets over £5,000. Fewer of the disabled were owner-occupiers, held a personal bank account, owned a car or had personal possessions other than furniture or clothing (such as jewellery, silver and antiques) worth £25 or more.'²⁹

Townsend found that disabled people were more likely than the non-disabled to experience housing and environmental deprivation, lack basic amenities, to have dietary deficiencies and experience social deprivation. Not surprisingly, this deprivation is mirrored by subjectively felt deprivation, and a greater proportion of the appreciably and severely handicapped than the non-handicapped, in all income groups, said that they had difficulty in managing on their income.³⁰ A more recent survey by Martin and Morgan of people off work due to prolonged sickness supported Townsend's findings. The proportion of those who found it difficult to manage financially rose from forty-two per cent of those off for one month to sixty-six per cent of those off work for 12 months.³¹

The inequities in social security provision for the disabled

The proportion of disabled people aged 15 or over living in or close to poverty is three times that for the non-disabled. In addition

to this, the disabled have to contend with gross inequities in the provision of income by the state to different administratively defined categories of disabled people. Two individuals with equally severe disabilities may receive widely differing amounts from the social security system depending on where and when they became disabled. The best known inequity is that between war and industrial injury disablement pensioners and other disabled people. As Walker has pointed out, preferential benefits are available to relatively small groups of people under the industrial injury and war pension schemes, while the majority rely for all or part of their incomes on means-tested supplementary benefits.³²

This inequity can be illustrated by the case of a 30 year old married man with two children who suffers a complete fracture of the spine and is paralysed from the waist down. He is assessed as 100 per cent disabled. Before the accident he earned £90 per week gross, but after the accident he is totally incapable of any work. The family would be entitled altogether to £65.69p, made up from industrial injury benefit, earnings-related supplement and child benefit. If not eligible for industrial injury benefit, but eligible for national insurance benefit, the family of a man with similar disabilities would receive £2.75p less. After 26 weeks the man receiving industrial injury benefits will receive £194.25p, including invalidity benefit, disablement pension, constant attendance allowance, exceptionally severe disablement allowance (the last three being awarded for life), mobility allowance and child benefit. If not

eligible for industrial injury benefit, but eligible for national insurance benefit, the family of a man with similar disabilities would receive £2.75p less. After 26 weeks the man receiving industrial injury benefits will receive £194.25p, including invalidity benefit, disablement pension, constant attendance allowance, exceptionally severe disablement allowance (the last three being awarded for life), mobility allowance and child benefit. If not eligible for industrial injury benefit the total for the family will fall by £82.85p to £111.40p, made up from invalidity benefit, attendance allowance, mobility allowance and child benefit. Even in cases of very minor injury the industrial preference is currently worth £21 a week. Furthermore, these entitlements do not depend on contribution conditions. A further comparison can be made with an equally severely disabled person who has a congenital disability. Assuming the same family commitments, his entitlement would be £103.30p, consisting of long-term supplementary benefit (including child benefit), mobility allowance and attendance allowance.

In addition to these inequities, NCIP and HNCIP are paid at a rate which is sixty-three per cent of the contributory pension. There are some, albeit small, additions for the blind and the partially sighted. For example, an addition of £1.25p a week (£2.50p for a couple both of whom are blind) is payable to registered blind people receiving supplementary benefit. There is also a special tax allowance of £360 (£720 for a married couple both of whom are blind) for registered blind people.³³ Then there are differences

created between disabled people according to the age at which they become disabled. For example, an invalidity allowance varying between £6.20p, £4 and £2 is paid to invalidity pensioners who become disabled before the age of 35, 35-44 and 45 to five years before minimum pension age respectively, and nothing thereafter. Similarly, mobility allowance cannot be claimed after the age of sixty-five (or before the age of five). There are no benefits paid specifically in respect of disablement in old age or childhood.

Social security provision for the disabled

The response of society to the financial needs which accompany disability has, at best, been inconsistent. Both the Conservative Party and the Labour Party have expressed commitments over the last twenty years to the introduction of a comprehensive disability income for the disabled. For example, the Conservative Party's manifesto at the election in 1979 proclaimed:

'Much has been done in recent years to help the disabled, but there is still a long way to go. Our aim is to provide a coherent system of cash benefits to meet the costs of disability, so that more disabled people can support themselves and live normal lives.'

However, despite a long history of such commitments the characteristic approach of successive governments has been piecemeal. Although new benefits have been introduced in recent years which recognise that those who have been unable to contribute to the national insurance scheme should have access to benefits as of right,³⁴ these have been set at a level below that of the contributory benefits and below the state's standard of poverty. Therefore the majority of disabled

people continue to rely on supplementary benefit which entails a statutory right to a minimum income, with several important qualifications, but also a large element of administrative discretion. The discretionary additions have become increasingly important in supplementing low incomes in recent years,³⁵ but there is no right to their award. This latter point was emphasised by the restriction of access to these discretionary additions following the introduction of new social security regulations in November 1980.³⁶ Moreover, also in November 1980, the government reduced the level of long-term national insurance invalidity pension by £1.85p for a married couple. In other words, even minimum rights are precarious and may be withdrawn along with discretionary welfare.

Apart from these problems, the piecemeal development of social security provision has created an extremely complex system, based on several different principles and a large number of different criteria for eligibility. The crude hierarchy of provision between industrial injury and supplementary benefits has already been identified and discussed. As Simkins and Tickner have pointed out, the result is not only gross inequities between equally severely disabled people but also a great deal of confusion.³⁷ Rarely is a disabled person able to survive on one benefit alone. Many of the regulations appear to be arbitrary: whether benefits are taxed or not, whether earnings are taken into account, whether benefits are offset against supplementary benefit or not, whether appeals are made to an independent board, tribunal, medical tribunal or commissioner.

For example, industrial death benefit, invalid care allowance, invalidity allowance when paid with retirement pension and mobility allowance are taxable, while the following benefits are not: industrial injury and war disablement benefits, attendance allowance, death grant, invalid care allowance when paid with invalidity pension, invalidity pension and supplementary benefit. These apparently arbitrary divisions in the taxable status of benefits create some very complicated calculations and difficult decisions for disabled people. For example, a married man over retirement age in April 1981 who was receiving a lower rate invalidity allowance would be £101 better off receiving retirement pension than invalidity benefit. Moreover, the earning restrictions on retirement pension are considerably more generous than those on invalidity benefit.³⁸

Another result of the complex, incoherent structure of social security for disabled people is the 'invalidity trap'. People under retirement age must spend a year receiving supplementary benefit at the ordinary rate in order to qualify for supplementary benefit at the higher, long-term rate. As a result of this approximately 70,000 invalidity pensioners are caught in a trap. They have an income which is lower than the income they would receive on the long-term rate of supplementary benefit, but which is too high for them to qualify for the former. They cannot qualify for the latter, though their situation is a long-term one and their income is less than the minimum regarded by the state as necessary for people in that situation. The financial consequences of being caught in

this trap are serious. Apart from the difference in weekly rates of benefit (£1.25p a week for a single person), entitlement to supplementary benefit can also entail access to additions for heating, diet and laundry, as well as the possibility of single payments, and entitlement to free prescriptions and other benefits. An unknown number of widows as well as invalidity pensioners are caught in the trap.

It should be obvious that in such a complex system of benefits it is very difficult to establish rights clearly. The system is very expensive to maintain, not only in terms of administrative costs involved in calculating often very small sums of supplementary income, but also in terms of the physical and psychological impact on social workers, welfare rights advisers, and disabled people and their families. Furthermore, there is the problem of stigma which attaches to low means-tested benefits and helps to deter people from claiming them. For disabled people, these problems of complexity are made worse by physical, intellectual or emotional handicaps. The processes of seeking information and claiming are extremely difficult for some people and impossible for others without help. For example, Casserly and Clark found that six out of ten of all claims they investigated could not be pursued effectively without contact with another individual, usually a relative.³⁹

The combined impact of these problems can be seen in the non take-up of different means-tested and other benefits. The National Consumer Council has pointed out that the take-up of means-tested benefits ranges from thirty to eighty per cent.⁴⁰

But there is also a considerable shortfall in the take-up of other benefits. The government estimates, for example, that 100,000 people who are receiving supplementary benefits would be eligible for NCIP if they claimed it. There is no estimate of those eligible outside the supplementary benefit scheme. There are large variations in the award of attendance allowances between different regions of the country, from eighty per cent of claims being awarded in London West, to fifty-nine per cent in Wales.

The significant extent of the under-claiming of benefits by disabled people has only begun to emerge in recent years as a result of a series of disability rights projects. The work was started by Casserley and Clark in Strathclyde in 1977, who interviewed seventy-two disabled people attending a local day centre, assessed their entitlement to various benefits and helped them to claim those benefits. Casserley and Clark found that only six people were already receiving their full entitlement and fifty successfully applied for benefits or had their benefits increased. The average weekly increase in 1977 was £6.10p and the group gained £15,000 a year as a result of this intervention.⁴¹ Since 1977 similar studies have been carried out in three other areas of the country, one based on a day centre and the other two on a sample of people with severe disabilities. In Harlow, a survey conducted in the Pyenest Training Centre increased the take-up of supplementary benefit by six per cent, attendance allowance lower rate by fifty-seven per cent, mobility allowance by twenty-five per cent and weekly allowances to supplementary benefit

by 183 per cent. Out of one hundred trainees, extra weekly benefits were received by forty, worth over £9,000 a year.⁴² Projects in Chapeltown in Leeds and in North Yorkshire, have also successfully increased take-up, especially of attendance allowance.⁴³

The usual response to this problem of take-up has been regular campaigns to encourage people to claim benefits to which they are entitled. However, these campaigns usually only last for a short period of time, and do not always reach their targets. The social security system remains complex and difficult to understand and leaflets and application forms use bureaucratic and complex language which tends to deter claimants. In recent years, there has been an increase in campaigns against so-called scroungers and these too have an important deterrent effect by influencing the psychological climate within which benefits are both claimed and administered.

This examination of social security provision suggests that the minimum rights and discretionary welfare approach on which post-war social security developments have been based, following the Beveridge report, has not succeeded in securing the clear right to income of disabled people, and I now intend to outline the basis for an alternative income scheme for the disabled.

An outline of a comprehensive disability income scheme for the disabled

The piecemeal addition of new benefits over the last fifteen years has helped some groups of disabled people, but has introduced increased complexity and confusion, and above all else, has failed

to eradicate poverty amongst the disabled. In view of this, the Disability Alliance has argued that the long-term policy objective must be threefold: to eliminate poverty, to bring the incomes of disabled people up to the levels of those of the non-disabled population, and to distribute resources so that people with equally severe disabilities are entitled to similar amounts, irrespective of the cause or the place where disablement occurred.⁴⁴ Furthermore, since financial need is closely related to the severity of disability it is essential that this fact is recognised by the payment of benefits according to the severity of incapacity, rather than the approach favoured in many other countries, which relies on the loss of earnings.

The case for this kind of comprehensive disability income paid as of right has been widely recognised for many years, and the Disablement Income Group and the Disability Alliance have been campaigning since the 1960's for such a scheme to be introduced. The Disablement Income Group and the Disability Alliance have put forward a number of proposals concerning what form this benefit might take,⁴⁵ and I now intend to consider these proposals.

The Disability Alliance suggests that the first component of a comprehensive disability income would be a disablement allowance intended to compensate people for the degree to which they are restricted from following ordinary activities. This would be a long-term benefit, paid to disabled people of all ages over two years old. The amounts paid would increase with the severity of disability and therefore would recognise differences in need resulting from

disablement. Like the war and industrial injury disablement pensions these allowances would be paid regardless of whether or not they had earnings or received other social security benefits.

The Disability Alliance suggests that the second component would be a disablement pension intended to provide income maintenance along similar lines to the current invalidity pension. Therefore, the disablement allowance is not intended to be sufficient on its own to live on, but is meant to compensate disabled people for some of the general expenses of disabilities and for activities and earnings foregone. The Disability Alliance suggests that the disablement pension should be paid at the full contributory rate to those who are unable to work. This income maintenance benefit might also be paid on a sliding scale to allow for partial incapacity for work, a practice common in other European countries. This benefit should not be related to earnings since this would discriminate against disabled people who have been unable to earn or who have had their earnings depressed by disability.

Thirdly, the Disability Alliance suggests that there would be special allowances to meet some of the specific needs and expenses created by some disabilities. Certain impairments create special needs, such as that for a special diet on the part of a diabetic, and the maintenance of guide dogs and provision of writing and reading aids on the part of the visually handicapped. Therefore, apart from the general compensation for the severity of disablement, there will be people whose impairments result in particular expenses or the

need to incur particular expenses. The attendance and constant attendance allowances are examples of benefits already paid in respect of such special expenses.

This proposal raises important questions concerning the method by which disabled people might be identified for the purposes of paying an allowance which varies according to the severity of disability, and secondly, the cost of implementing it. On the first issue the 'loss of faculty' method of assessment used under the industrial injury scheme does not approximate to the 'degree of severity of disability' approach suggested here.⁴⁶ There are, however, precedents in assessing the degree of functional incapacity in official and independent research undertaken by Harris, Cox, and Smith and Sainsbury,⁴⁷ and in the administration of benefits such as the attendance allowance and the mobility allowance. This experience might be used to construct scales for assessing the severity of disability and these could be administered by an independent Disablement Assessment Board.

Regarding the costs of a comprehensive disability income scheme, it is important to mention two points. Firstly, the government have claimed that the cost of this proposal would be as much as £3,000 million a year. This figure has been challenged by the Disability Alliance, who argue that the scheme would cost considerably less than the official estimate. Despite this challenge from the Disability Alliance, Peter Townsend has pointed out that there is still no available breakdown of the official estimate.⁴⁸

Secondly, a start could be made on the programmed introduction of a comprehensive disability income scheme at a relatively low cost, by starting with the most severely disabled, and other less severely disabled groups could be phased in as resources allow.

A summary of some important points concerning income and disability

This discussion has examined financial need amongst disabled people and the social response to that need. It has shown on the basis of a long series of official and independent research, that a large proportion of disabled people are in acute poverty, and a still larger proportion experience severe deprivation relative to the non-disabled. In the face of these financial needs disabled people must be content with a complex and confusing social security system, which affords some small privileged groups preferential treatment, such as those injured at work and those who can combine different benefits, while others must subsist on bare minimum incomes. A comprehensive disability income scheme could be developed in the future on the basis of the existing structure of benefits and administrative experience. However, it should be realised that if the right of disabled people to an income in respect of their disablement is to be established, a clear and fundamental break must be made with the limited minimum rights and discretionary welfare approach which has dominated social security provision for so long. Experience has shown that social justice for disabled people is unlikely to result from any further piecemeal additions to existing social security policies. The Labour Members of Parliament Michael Meacher, Margaret Beckett and

Alf Morris, pointed out in 1985 that the next Labour Government 'is committed to a comprehensive disability income scheme',⁴⁹ and so hopefully improvements in benefits for the disabled would be made by such a government.

Having looked at state benefits for the disabled in general and how these could be improved, I now intend to look at the specific state benefits for the blind and consider whether these are adequate.

The state benefits for the blind

The present state benefits available to the blind are inadequate and should be immediately improved. There is, of course, a wide appreciation of the burdens which are imposed by blindness. As Colin Low, the former President of the National Federation of the Blind, pointed out recently, many of these burdens have a financial aspect.⁵⁰ For example, a blind person cannot manage, as many of us can, with a cheap ballpoint pen and a pad of paper but needs a typewriter or a braille writing machine. He uses the telephone more, and at more expensive times. He often needs to pay for a companion or take a taxi when he travels. For example, it is difficult for him to do his own decorating, clean his own windows, cut his own hedge, mend a fuse or rewire a plug.

The point of mentioning these restrictions on what a blind person can do is to emphasise that blind people have extra expenses because of their blindness. There are some 130,000 registered blind people in the United Kingdom, some seventy-five per cent of whom are over the age of sixty-five - over retirement age. Unlike

those who are war blinded, people who are born blind or who become blind through natural causes in adult life receive no benefit or pension. It is true that blind people on supplementary benefit receive a supplement of £1.25p per week. Blind people earning enough to pay tax receive an allowance against tax of £360 per annum, or £720 per annum for a married couple. So the principle is conceded by the state machinery that blind people require assistance on account of their blindness.

However, it is reckoned by the various organisations representing the blind that over a third of blind people have an income under £2,000 per annum and more than half have an income under £3,000 per annum. So it follows that many are not getting the full value, or any value at all, from the tax concession. In fact in 1982-83, 30,000 were claiming the tax relief, which is worth £108 per annum for somebody on the standard rate, and 41,000 were on supplementary benefit. That would appear to leave some 59,000 receiving neither the supplementary benefit supplement nor the tax relief - the blindness gap, as it is called. Some 59,000 blind people, most of them on low incomes, were getting no state assistance at all on account of their blindness.

The blind people who are on supplementary benefit receive the rather exiguous additional allowance of £1.25p. This is a tiny sum which has not moved in cash terms since 1966, and seems to have been sinking in real terms since it was introduced in 1948, when it stood at 15 shillings. If this extra allowance of 1948 had been increased in line with the movement in the retail price index it would have been £8.21p in November 1983, and not £1.25p.⁵¹

The organisations representing the blind have misgivings about the present situation and feel that blind people should be entitled to a benefit, which would be called a blindness allowance, which would be equal in amount to the mobility allowance. This blindness allowance would help blind people to meet the extra costs that are imposed by blindness. It has been estimated that this benefit would cost approximately £100 million a year.

The Conservative Government concede the case for such a blindness allowance. For example, in the House of Commons on 24 July 1979 Mr Prentice declared that 'the case for an income in the form of a blindness allowance is unanswerable on its merits.'⁵² However, despite this recognition nothing has happened in the subsequent seven years, because the Conservative Government claims that the money for such an allowance is not available. Since the mid 1970's three major organisations, the Royal National Institute for the Blind, the National Federation of the Blind and the National League of the Blind and Disabled, have campaigned vigorously for a blindness allowance for every blind adult to be introduced. In December 1980 the campaign reached a climax when a petition, signed by half a million people, was presented to Parliament. This is presumably now just gathering dust on the shelf. On 13 November 1984 the organisations representing the blind made the most recent attempt to date to persuade the Government to introduce a blindness allowance, when the Labour Member of Parliament Laurie Pavitt raised the issue in the House of Commons. However, on that occasion the Government

once again refused to introduce an allowance. It is time that the Thatcher Government made a resolution to respond positively during their second administration to a claim they felt unable, for various reasons, to meet during their first administration.

The Labour Party has a greater appreciation of the problems of the blind, and the Labour Party's manifesto at the general election of 1983 pledged that Labour would introduce a £10 a week blindness allowance as a first step towards the introduction of a new cash benefit for the disabled.⁵³ In the Conservative Party's manifesto, on the other hand, there was no reference to helping blind people specifically.

In some ways, the Blind Persons Acts of 1920 and 1938 showed, by the standards of those times, a greater concern with the plight of blind people than we have since evinced, for these were in effect blindness allowances, or they provided blindness allowances, with an age threshold. These were repealed by the 1948 National Assistance Act which contained rather weaker provisions concerning welfare, workshops, meals, and recreation, and in any case these were not specific to the blind as they included the deaf and the dumb also.

Our present apparent indifference to the plight of the blind may well partly be due to an erroneous belief by most people that a blindness allowance is already in existence. That of course is not the case. On the contrary, it appears that in comparison with the rest of Europe, the United Kingdom is not in the same league in its statutory treatment of the blind, which is an important point which I will return to later.

An immediate way the Government could help the blind would be to grant them the mobility allowance. The important question of mobility is an area of inadequate assistance for the blind. It may come as something of a shock to those unfamiliar with these problems that people who are blind and cannot orientate themselves in their environment are not entitled to mobility allowance unless their lack of mobility is a direct result of an ambulant disorder; that is, nothing to do with their blindness.

It must be obvious that blindness much reduces effective mobility, or makes it much more expensive. Here I want to briefly refer to the judgement delivered in 1984 in the case of Christine Lees, a blind person then thirty years old who applied in 1979 for a mobility allowance, refusal of which by the Medical Appeals Tribunal was upheld by the Social Security Commissioner. It went to the Court of Appeal, where on 9 February 1984, her appeal was dismissed.

The important point to stress is that it is only because of such inadequate provision for the blind that the case had to be brought at all. Any such claims must at present be based on the Mobility Allowance Regulations of 1975, paragraph 1 of which specifies that:

'A person shall be treated, for the purpose of Section 37A (of the Social Security Act 1975)' -

that is the mobility allowance, and then I paraphrase a little, only under the following conditions:

- '(a) he is unable to walk; or
- (b) his ability out of doors is so limited, as regards the distance over which or the speed at which or the length of time for which or the manner in which he can make progress on foot without severe discomfort, that he is virtually unable to walk.'

Then there follows sub-paragraph (c) which is less relevant.

This means, or appears to mean, that people who are capable of walking in the sense that they can put one foot in front of another, provided that they are steered or have some apparatus for steering, and can cover a reasonable amount of ground, do not satisfy the statutory provision for an award of a mobility allowance.

In the case of Christine Lees, the commissioner said of blindness in general, not her blindness,

'It is an affliction which is wholly unrelated to the physical power to move one leg in front of another.'

Later he said:

'But unfortunately for the claimant her inability to control the direction in which she goes is a handicap which has nothing to do with her ability to walk in the first place, and accordingly is something which cannot be taken into account in determining whether the claimant satisfies Regulation 3 (1) (a) or (b).'

This brings me to my main point. In order to provide further assistance to the blind, an additional subsection could be added to the regulation extending the concept of immobility to cover severely impaired or restricted mobility arising from blindness; that is, due to a faulty steering mechanism in addition to a faulty mechanism of propulsion. There is a good case for this change in the regulations to be made. After all, all vehicles need both. The impairment of sense of direction is surely as important as the impairment of the means of locomotion and, in fact, potentially more dangerous. This is not to suggest that deprivation of locomotion is not a terrible affliction or that mobility allowance is not a great advance for the disabled; they certainly are so. But why should the blind be excluded from receiving mobility allowance, when there are so few other state benefits to assist them at the moment?

It is clear from this discussion that many blind people appear to be falling between a number of stools. The tax allowances are a very modest benefit and are available to fewer than a quarter of blind people. The supplementary benefit additional allowance has fallen drastically behind inflation. In the absence of some further decision by the courts or some amending legislation by the Government, blind people do not qualify for mobility allowance and even claims to attendance allowance seem to qualify in far fewer cases than one would have expected. There is an indeterminate, but apparently large, number of blind people who qualify for none of these things.

The present situation is simply not good enough. A blindness allowance is a sine qua non of a civilised society, and should be introduced without delay. The cost of such an allowance would be a minute proportion of the social security budget, and would be of particular benefit to those blind people on low incomes.

Allowances and services to the blind in EEC countries

While provisions for the blind have deteriorated considerably in Britain, they have progressed remarkably in the rest of Europe. In all the EEC countries, except Britain, Ireland and Greece, blind people receive a disability allowance, usually supplemented by a specific blindness allowance. In addition, governments do far more to provide financial compensation for blindness.

West Germany is one of the best examples of this. The quota laws are applied far more rigidly than they are in Britain; and if employers fail to take on the required number of blind people, they

have to pay monthly fines, which are used as a fund to provide any necessary equipment for the employers who are complying with the quota. Unlike St Dunstan's in Britain, the West German Federation of the War Blinded are entitled to spend their resources on the blind, irrespective of whether they are civilians or war casualties. The Central and Provincial Government are responsible for providing the total cost of running rehabilitation centres for the visually handicapped. In Britain, the Royal National Institute for the Blind paid half the cost of running Clifton Spinney; the local authorities paid the other half, but in some cases imposed a means test on applicants.

Again, the West German Government spend a considerable amount of money on research aimed at improving the lives of blind people, whereas in Britain, it is a case of relying on charitable funds.

The Manpower Services Commission does provide new technological equipment for those needing it at work but it makes no financial contribution to the research which produces it. In West Germany equipment is provided, not only when it is needed for work, but also when it would improve the quality of the social and the personal life of the blind person. For example, Baillex (which produces paperless braille) and computer-based aids are readily available.

Social security benefits in West Germany, which are in addition to the blindness allowance (about £41), amount to eighty per cent of the national average wage, while in Britain the weekly amount is £1.25p, only 50 pence more than in 1948.

In other EEC countries provisions for the blind are rather a 'mixture', but the disability allowance remains the constant factor.

In France, a blind person who is doing piece-work has his earnings made up to the national average wage by the state. Blind people who live alone can obtain a cash allowance to pay for such services as home helps which they can arrange to suit their own convenience and not just when the social services department can fit it in.

In Italy, blind people can obtain a 'guide allowance' of over £90 a month. Also, at the start of their military service, conscripts are given duties as escorts to the blind, in the towns where their barracks happen to be.

In Denmark, favourable interest rates on mortgages are available to blind people wishing to acquire their own accommodation. In Sweden, (which like the EEC countries has a disability and blindness allowance) an adapted minibus is made available to disabled and blind people - not to go to hospital, for which there is an ambulance service - but so that they can go out to visit their friends. The cost to individuals is the equivalent of the public transport fare.

As regards employment prospects, it is the Soviet Union which heads the world in the number of blind people employed per thousand. Their factories are given government contracts, such as for portable television sets, so they are able to plan ahead.

It is only through campaigning energetically, that the blind in Britain can succeed in achieving the same high standards as the rest

of Europe. The political parties in Britain are all agreed that the case for a blindness allowance is unanswerable; so is it that the block occurs somewhere in the civil service which has an important influence on successive governments?

The social security reviews and the visually handicapped

Despite Norman Fowler's claim that 'disabled people on low incomes will benefit significantly', up to 100,000 blind people are likely to be worse off if the Government's plans for reforming social security are implemented. The Social Security Bill, which is currently passing through Parliament, will give the Government the power to introduce changes previously outlined in both a Green Paper and a White Paper. Supplementary benefit will be replaced with a new system, called Income Support. A total of £450 million a year will be cut from Housing Benefit expenditure.

In 1986 there are 36,000 blind people receiving supplementary benefit to make their weekly income up to the Government's own poverty line. Under the proposed Income Support scheme, to be introduced in April 1988, they will receive a weekly personal allowance, plus an additional flat rate disablement premium. It is the 29,000 blind pensioners receiving supplementary benefit who stand to lose most from the changes.

Although the Government's 'illustrative figures' initially imply that blind pensioners will be £2.90p a week better off if single, and £3 a week if married, the reality is that most will lose. This is for two reasons.

First, some housing costs now met by supplementary benefit will no longer be paid by Income Support. All claimants will lose the full cost of their water rates, and twenty per cent of their general rates. Assuming even the lowest level of rates, this initial gain will soon be eroded. Owner-occupiers will also lose an additional £1.85p a week, now paid to cover the cost of maintenance and insurance on their home.

Second, this gain is only in comparison with the minimum a blind pensioner can expect to receive. Yet many get more than the minimum because they receive one or more 'additional requirements' on top of their basic weekly allowance. These additions cover the cost of blindness, special diets, extra heating, laundry, special clothing, help with housework, and attendance needs. All these will be abolished when Income Support is introduced.

12,000 blind people will be £3.70p a week worse off through the abolition of the diet addition alone, paid to blind people who also have diabetes. Many others will lose through the loss of laundry addition, paid to those unable to do their own laundry and often worth £3 to £4 a week. The higher heating addition, paid to the most severely disabled, is worth an extra £3.25p a week, while the domestic needs addition meets the full cost of paying for domestic help.

Many, particularly the more elderly and blind people with other disabilities, receive more than one addition, frequently totalling £10 a week, and often more. It will be blind pensioners most in need of financial help that will lose most from the proposals. In turn a

small number, no more than 3,000, of younger and healthier blind people will gain.

In addition to supplementary benefit claimants there are 70,000 blind people with incomes low enough to entitle them to Housing Benefit. After April 1988 all Housing Benefit claimants will have to pay a minimum of twenty per cent of their rates, and the proportion of income taken into account when Housing Benefit is calculated (known as 'the tapers') will be increased.

The effect of these changes will depend upon individual claimants' rent and rates levels, but even those paying relatively low levels of rent and rates will lose. For example, someone paying weekly rent of £14 and rates of £5 a week will lose up to £4.50p a week in Housing Benefit. People paying rent and rates above these levels will lose more.

These changes will affect blind claimants on very low incomes. The rent and rates levels above will cut the benefits of single blind people with incomes less than £82 a week. The comparable figure for a blind couple is £100 a week. Some of these will lose entitlement to Housing Benefit altogether.

Partially sighted people will also be affected. Although partially sighted people who are long-term sick and disabled will get the disablement premium, unemployed partially sighted people will not. Partially sighted pensioners will receive only a lower rate of pensioner premium. As all partially sighted people now receive recognition of their extra needs when Housing Benefit is calculated, these changes will not only cut many partially sighted claimants'

income but will represent a lowering of status for partially sighted people within the social security system.

These cuts in weekly benefit will be complemented by abolishing the range of single payments claimants can receive. Single payments can be made for a wide range of items, including replacement clothing, repairing or replacing essential household equipment, furniture, and so on, and can be particularly useful for younger blind claimants setting up an independent home for the first time. These will be abolished and replaced by a Social Fund which will make loans, recoverable from weekly benefit, to people in particular circumstances. Although it is not clear from the proposals what the circumstances will be, it is clear that many people who receive single payments will not receive help from the Social Fund, and even those who do qualify may be deterred by the need to repay a loan.

The Fund will be operated by special staff with wide discretionary powers. Claimants will, therefore, lose the legal entitlement to benefits they now have. To make things worse, there will be no right of independent appeal, as there is now, against decisions made by Social Fund staff. On top of this, the size of the Fund will be cash-limited - so beware anyone who wants some help at the wrong end of the financial year.

Finally, the changes will also give lower incomes to visually handicapped people in the next century. The State Earnings-Related Pension, paid in addition to the basic state retirement pension, will

be cut drastically after the year 2010. People will receive a pension based on their lifetime earnings, rather than the best twenty years as now, and on twenty per cent rather than twenty-five per cent of these earnings. This will particularly affect people who lose their sight later in their working life and those whose incomes have been consistently low.

There is one further, and very practical, problem for blind people. The Government has not yet suggested a suitable definition of blindness to govern payment of the disablement premium. If registration as blind under the 1948 National Assistance Act is adopted as a criterion, then blind people in Scotland, who are not registered under the 1948 Act, and unregistered blind people will not receive this additional payment. This will be a serious step backwards from the present supplementary benefit system where the blindness addition is paid to unregistered blind claimants provided they are 'so blind as to be unable to perform any work for which eyesight is essential.'

The problem behind the Government's proposals is a complete misunderstanding of the financial needs of visually handicapped, and other, disabled people. The general irony of the cuts is that they are being implemented at a time when the Government, through the Office of Population Censuses and Surveys, is conducting a major survey to assess the income needs of all disabled people. The survey, which should report in 1987, may of course show that disabled people require more benefits not less. If Norman Fowler does genuinely want to

assist disabled people on low incomes the most decent thing he, and the Government, can do is postpone the social security reforms until the outcome of the disability survey is known and has been adequately discussed. Unless this happens, visually handicapped people on low incomes will not benefit significantly.

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