

AN EXAMINATION OF EVOLVING POLICY AND PRACTICE
IN THE REHABILITATION FIELD IN MANITOBA, IN
RELATION TO STANCE AND ENDS-IN-VIEW; AND
AN EXPLORATION OF POSSIBLE FUTURES

By

Katherine Rose Adina Horne

A thesis submitted in partial fulfillment
of the requirements for the degree of

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ABSTRACT

If we look at the historical evolution of policy and practice in the rehabilitation field we note that these have been directed toward independence and employment. This end-in-view has never been reachable because of economic and social reality. Full employment has not been achieved. Social reality for all people requires interdependence rather than independence.

This thesis explores a number of underlying assumptions (stances) which have contributed to the present dilemmas in the rehabilitation field in Manitoba.

In particular we note the influence of the Marsh Report (Canada, 1943) which focused on full employment as a solution for Canadian social reconstruction. This is contrasted with the Beveridge Report (Great Britain, 1942) which identified social responsibility as the primary end-in-view for all citizens. The implications of these and other policy statements (such as those produced by the consumer movement) are explored.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS.....	i
PREFACE.....	v
 Chapter	
1. INTRODUCTION.....	1
Statement of Problem.....	2
Sources of Information.....	4
Explanation of Terms.....	5
2. THE PROBLEM EXPLORED.....	8
3. DESCRIPTIVE OVERVIEW OF CONDITIONS AFFECTING THE FIELD OF REHABILITATION.....	16
Statement of Conditions.....	16
Early Period of Rehabilitation in Canada 1600's - 1800's.....	17
1890 - 1942 (Health and Welfare, 1980).....	19
Modern Rehabilitation Field -- Conditions.....	27
Historical Overview of the Society for Crippled Children and Adults in Manitoba (SCCA Annual Report, 1951-81).....	34
4. STANCE.....	40
Level of Significance.....	40
Division of Systems.....	43
Normalization.....	46
Policies Viewed as Outdated.....	48
End-In-View Not Being Met.....	51
Repercussions on Agency Services.....	51

Services and Stances.....	52
Work-Employment.....	54
Need and Service.....	56
Ramifications for Rehabilitation.....	58
Relationships Mismatched with Present Ends-In-View.....	60
Three Relational Frameworks.....	66
5. PRACTICE PERSPECTIVES IN THE REHABILITATION FIELD.....	68
Ten Guidelines of Practice.....	71
Implications for Practice.....	72
CONCLUSIONS.....	77
BIBLIOGRAPHY.....	79
APPENDIX A.....	89

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PREFACE

One Body with Many Parts

"...For the body itself is not made up of only one part, but of many parts. If the foot were to say, 'Because I am not a hand, I don't belong to the body,' that would not keep it from being a part of the body. And if the ear were to say, 'Because I am not an eye, I don't belong to the body,' that would not keep it from being a part of the body. If the whole body were just an eye, how would it hear? And if it were only an ear, how would it smell? As it is, however, God put every different part in the body if it were all only one part. As it is, there are many parts but one body.

So then, the eye cannot say to the hand, 'I don't need you.' Nor can the head say to the feet, "Well I don't need you." On the contrary, we cannot do without the parts of the body that seem to be weaker; and those parts that we think aren't worth very much are the ones which we treat with greater care; while the parts of body which don't look very nice are treated with special modesty, which the more beautiful parts do not need. God himself has put the body together in such a way as to give greater honour to those parts who need it. And so there is no division in the body, but all its different parts have the

same concern for one another. "If one part of the body suffers, all parts of the body suffer with it; if one part is praised, all other." I Corinthians 12:14-26 (Good News Bible).

Chapter 1

INTRODUCTION

This thesis is attempting to illuminate a number of incongruencies in the rehabilitation field.

The search began when I found myself as a student social worker using people the way I did not and do not want to be treated--like an "it" to be manipulated and shuffled along the bureaucratic "assembly line." I was horrified at my capacity to seek out weaknesses rather than strengths, to try to fit the person rather than facilitate growth and development. At the same time, I saw the strengths and potential for growth and at times was open enough to work with another in a relationship where we were communicating as one person to another rather than as service provider to receiver. This has evolved into a basic assumption of this paper, stated by Reuben F. Nelson:

The primary divisions in our society are not tidy we/they divisions (we who are honourable, who understand that persons are persons, versus they, who manipulate persons as objects); nor are they then/now divisions (then they manipulated persons as objects, but now we cherish them as persons); nor is it here/there (here in this situation in this place we understand that life is inherently shared experience, but there they do not do so).

The main division runs within, rather than between us, and so none of us are in a position to cast stones cavalierly at any others.

...we have three choices. First, we can create enemies where none existed before, and so solve the tension of dealing with evil that is within all of us. Second, we can quietly and tacitly agree that since we are to some degree corrupted, none will call the other to account. Having learned that none has clean hands, we misread the lesson and give up speaking to one another about what is most important to us. Third, we can learn the difficult art of relating to one another frankly and honestly as if our behaviour mattered, and doing so without trying to pull moral rank. (page 53).

This thesis is an attempt at the third alternative.

The rehabilitation community appears to be going through a change process that could lead to either the first or second choice unless we have a firm grasp of the threads by which we can create a pattern based on the reality of unique gifts to be shared in community.

Statement of Problem

My interest in the topic evolves from my experiences within the rehabilitation field as client, consumer, researcher, social work student, and board member of a rehabilitation agency.

Through my contact with social workers, I began to perceive that there were certain mind frameworks or stances that influenced the purpose, intent and goals of the relationship built between myself and a social worker, and between myself and a social agency.

Some of these stances led to a process that was restrictive and often focused on the one goal of employment, with the expectation that the client must "fit."

Other frameworks led to multi-ended futures with

the ultimate intent of personal and social development and growth. Work here was understood as part of development. This perception was reinforced as I worked as a consultant-researcher in Ontario. There, different concepts in housing for the disabled were being advocated. These included nursing homes, group homes, open-ended institutional living, adapted apartments, and the emerging concept of independent living. Again, I noted that both stances were evident, the restrictive and the multi-ended. This perceived duality of stances* led me to search out additional incongruencies in the rehabilitation field.

Incongruencies were identified in a number of places:

1. Incongruencies between different agencies and services within the field.
2. There is an incongruency between actual outcome and perceived end-in-view, as perceived by both professionals and clients.
3. There are incongruencies between services and perceived needs as perceived by professionals and clients.

These are all issues, not problems, in that they require understanding and resolution or ordering, not a solution. Illuminating these dilemmas hopefully will help us to recognize and cope with the stresses, tensions,

*In this thesis the word "stance" is being used to mean the philosophical assumptions underlying policy and practice. I have borrowed the concept from Donald A Schon, as outlined in Beyond the Stable State and elaborated on by Miriam Hutton in personal conversations.

and incongruencies which are current in the area of rehabilitation. These dilemmas and incongruencies exist for the client, within the services provided, and for the professional working in the field.

This led me to examine the underlying assumptions of policy and practice in the rehabilitation field, which has become the major focus of this thesis.

A basic assumption underlying this thesis is that an awareness of stance will have direct bearing on outcomes and will help in reducing the discrepancy between goals and purposes, as stated through policy, and the actual practice which emerges.

The purpose of this thesis is, therefore, to increase both knowledge and consciousness about the existing stance dilemmas in the rehabilitation field.

While much of the research is based on the broader Canadian constituency, the primary focus will be upon rehabilitation in Manitoba.

It is hoped that in addition to illuminating present dilemmas, insight into future possibilities will be apparent. In particular, it is hoped that relationships between professional and client may be seen as a process of co-creation of social reality.

Sources of Information

The sources of information for this thesis include:

1. A literature review of: change theory; policy

formation; social work practice; the historical development of rehabilitation services in Britain and Canada and the USA; a number of government documents and stance papers on employment and guaranteed annual income; and board minutes and annual reports of the Society for Crippled Children and Adults in Manitoba (SCCA).

2. Observations and practical experiences of: working on the Board of the Society for Crippled Children and Adults; working in a variety of research, administrative and consultive positions over the last three years in Winnipeg and Ontario; working with consumer organizations both in Ontario and Manitoba; and being a client of rehabilitation social services over the last twenty-three years.
3. Informal interviews with parents, counsellors, consumers, clients and administrative people in the rehabilitation services, also volunteers, educators, and practioners. The interviews centered on the process and the practice of rehabilitation services.

Explanation of Terms

Rehabilitation has been defined as a process whereby a former capacity is restored--to restore to a condition of health or useful and constructive activity.

The word habilitation came into use in the 1960's when the concept of rehabilitation did not reflect the

work that was being done with children and adolescents. Webster defines "habilitation" as: "to make capable, to qualify oneself."

The concept of habilitation reflects more closely the stance taken in the final chapter, however, the more common word rehabilitation is used to encompass both systems.

The concept of field is used in the generic form meaning that there are a variety of systems working in the one field. Two that I specifically examine are the consumer movement and an agency primarily involved with co-ordinating services and supplying services centered upon employment and counselling services.

There are two key concepts that may be difficult to differentiate: value and worth.

Value as understood in this exploration encompasses the inherent goodness of a person. Worth is tied into economic utility and usefulness. Value is often denigrated through criteria that is focused on worth.

The term practice reflects the holistic stance of this paper. Practice includes purpose, value, context, end-in-view, and method. The methods of social work have evolved from a variety of backgrounds and stances, including theological, psychoanalytic, medical, organizational, economic, and political theory (Klien, 1971, Bartlett, 1970). The overall practice of the profession of social work has been influenced by the context in which

the profession is working and the professionals perception of his roles and place and functions (Cowgen, 1977). One of the primary concepts that has influenced practice in the rehabilitation field has been the relationship between environment and person (Sheffield, 1931, Meir, 1965, Siporin, 1970, Grinnel, 1973). In the past, methods have often concentrated either on one or the other and not the interface of each with the other.¹ In particular we note the emphasis on such environmental factors as accessibility to buildings, increased mobility, and the development of prosthetics.

¹Presently, however, there is a resurgence in the interest of interface and the tasks that are needed to accomplish the equilibrium between person and environment. Presently we still view the environment having more control over people rather than people having control or being able to create environment (Germaine and Gitterman, 1980). In the future, we may need to analyse the difference between physical environment and social environment and the repercussions of this for practice.

Chapter 2

THE PROBLEM EXPLORED

The policy statements of the rehabilitation field fall into two categories: first, the broader statements of purpose, and second, the agency mandate statements related to specific conditions.

The broader statements of purpose reflect a stance, or philosophical assumption. The agency statements growing out of specific conditions will reflect a narrower focus or intent. Both may reflect an "end-in-view," but the agency intent may more often be described as an objective or outcome expectation. Let us examine first some possible orientations for human purpose and relationship.

Rollo May (1969) suggests that historically there have been three prevalent perspectives on man's relationship to his world. Before the Renaissance there was a focus on the relationship between man and God. This perspective gave rise to viewing people as inherently valuable because of their relationship to God. He called this World View I.

May's World View II suggests that after the Renaissance and continuing through the industrial

revolution, man became involved with discovery through manipulation and change. Man's relationship to his world became focused on action rather than illumination of man's purpose. Action was seen as deriving from rational thought. Nietzsche, according to Grant (1969), believed that human beings before the modern era were involved with the illumination of horizons. Modern man has been consistently destroying those horizons with no new ones to take their place. "Horizons" according to Nietzsche manifest themselves in the perceived "reality of belief." For instance, when man became conscious that God was dead, the greatest horizon was thrown out. If God was dead there is no innate "goodness" in the world, only values. Values are made only relative to time, situation, and place.

One of the underlying value assumptions of western society is that each person is inherently an independent individual. An independent individual can be perceived as "whole" and self-contained, with rights, responsibilities, and obligations. His needs are contained within self and are not owned by his neighbours. Further, these needs can be defined in terms of greater or lesser needs, ie., needs for survival--food, water, clothing, housing--are defined as greater needs, whereas the need for entertainment, companionship, work, and love are defined as lesser needs. Values then, and indeed people themselves, are viewed in light of how "useful" they are in this present situation.

Human beings are seen as adaptive, manipulative, and driven from the history to the present. Man is pushed along his evolutionary scale through his reactions to the events present in his environment. Man is creative in his adaptive powers and his ability to measure and manipulate "the whole." Manipulation is rooted in measurement and knowledge. Thus, we can understand the primacy of science.

Science is an active process, but in science there are only binary operations. One can prove something to be true or not true; there is no third alternative. A binary operation works fine when one works with "dead aspects of the universe" but in the life of human relationships there is always a binary-plus-one operation taking place (Schumacher, 1977). In human relations, there is always the third alternative. For example, you can love, hate or be uninvolved or dispassionate. A person can be dependent, independent, or interdependent. To date, policies of social welfare have often tried to deal with human problems as "dead aspects of the universe," i.e., the problem either exists or does not exist; it can be solved or not solved; it is assumed that there is one best way for solving the problem and that all other ways will not work.

In the second world view, human need becomes equated with "economic reality." Development becomes a matter of "useful fit." An example of this world view can be seen in the Vocational Rehabilitation of Disabled Persons Act, 1961, (VRDP Act) which stipulates that a

disabled person is not disabled if employed (Horne, 1978).

May's third world view attempts to counter this preoccupation with scientific manipulation and fit and to recapture something of man's worth and purpose. In the third world view, man is seen not as binary but as multi-dimensional.

Man's social reality is made up of the relationship of physical structure, mental structure, emotional response, and spiritual calling.¹ Therefore, the third world view does not negate God or science but reflects the contribution of both. Schumacher (1977) argues that there are four levels of being, each drawing on parallel levels of knowledge. To limit man's knowledge to the physical realm denegrates man's innate worth.

In order to participate in the third view, one must know through understanding. Schumacher (1977) suggests that knowledge of understanding can only come from experience. Similarly, Finkelstein and Wolfenberger have identified certain patterns of relationships. The custodial relationship can be found in the era of almshouses and poorhouses where disabled people were viewed as sinful or the victims of natural justice and were therefore isolated from the community. The need to isolate was complimented by the charity ethic and the emerging

¹Holistic thinking might be seen as an expression of this third world view, or stance.

protestant work ethic. A person with a physical disability began to be seen in terms of his work potential, and he was valued for his work, not his person. The work became the object of value. The charity ethic, of course, focused on the good works of those giving the charity, rather than on the recipient of charity. This again can be seen as reinforcing the value of the "doing" or the work performed. The person with a disability was seen as dependent upon the work of others.

At an earlier stage (before the Elizabethan poor laws) all men had been seen as having a relationship with God. Therefore, the physically disabled were seen as having innate value within the relationship. To care for the physically disabled, hospices were established and run by churches within the community. To care for the handicapped was to provide a service to God, regardless of the social or economic value of the disabled person. All people were seen as dependent on God.

In the late Nineteenth Century, we begin to see an increase in scientific and medical knowledge. Some of this was applied to the disabled who were increasingly seen as sick. The inability to fit was viewed as sickness rather than sin. The focus of the medical process became one of striving for normal healthy functioning. The person, however, was often expected to adapt to the existing environment. Rarely was the environment seen as maleable. For example, there was a great emphasis on such

things as getting people to walk regardless of the physical disability. (In the children's classic, Heidi, the romantic solution for "crippled" Clara was to go to the mountains to gain her strength so that she could walk.) Gradually, more attention was paid to developing prosthesis and braces and other physical aids. These were all geared towards making the person appear normal. While there is some overlapping, these various world views can be seen to relate to the three problem areas identified at the beginning of the thesis.

The rehabilitation field reflects all of these stances on world views. For example, services for children in Manitoba currently appear to reflect May's World View I. The custodial function can also be identified. Adult services in the workshop setting are following an economic/employment orientation (May's World View II). In the federal report, Obstacles (1981), the parents of an autistic, retarded child discuss being asked by professionals, what do you know that can help us (page 46). In this instance, professionals and parents are participating together in knowledge building (World View III).

Presently there is often a mismatch of stance with practice expectations. For example, if one looks at the services for adolescents and adults in the Society for Crippled Children and Adults of Manitoba, one can identify both custodial care and employment-independence goals for clients. These appear to be based on age and intellectual

capabilities rather than policy (SCCA Annual Reports, 1952-1981).

It is difficult to interrelate differing world views or stances. Individuals who hold one may not recognize differing views and may not be able to relate appropriately to others with another perspective.

As conditions and stances change slippage occurs between the purpose and the reality of practice.

The social services have evolved from a number of world views. (These were not necessarily identical to May's three world views suggested here as examples). In addition, professionals in the helping services will each bring a world view or stance based on their own professional values. The rehabilitation field, drawing as it does on several disciplines, (for example, medicine, engineering, education, social work, theology, psychology, and economics), will reflect a diversity of stances.

Any method or technique of intervention has its own stance. We may attempt to revitalize old methods by supplying a new perspective or a new stance (Klien, 1971, Lacomte, 1979).

In adapting from one method to another or from one view to another, we may either enrich or contaminate. For example, the introduction of a medical view may mean that to be a client is understood as being "sick." The sick role thus suggests the giving up of adult responsibility and acting in a childlike, dependent role (Derksen, 1980,

Stream, 1979, Steinburger, 1980).

World view has sometimes been circumscribed by method and outcome. Thus purpose becomes defined by method and outcome, reflecting the underlying stance of method (Klien, 1971).

In our concern to find a perfect solution, we have often concentrated on outcome and method rather than on process or purpose. The development of the technique for method has obscured the importance of the whole.

These problems will emerge more clearly as we trace the historical development of policy and practice in the rehabilitation field.

Chapter 3

DESCRIPTIVE OVERVIEW OF CONDITIONS AFFECTING THE FIELD OF REHABILITATION

The rehabilitation field has been shaped by a range of conditions. Conditions may be made up of events and circumstances (which include economic, political, technological and environmental factors).

The field will be described primarily in relation to service conditions in Canada, bringing in relevant international conditions that affect the field in Canada and more specifically, Manitoba.

In the following chapter I will examine the underlying purposes and assumptions under the heading of stance.

Statement of Conditions

The major events and influential circumstances that have increased activity in the rehabilitation field have been war and response to periods of economic transition. In addition communicable diseases that leave after-effects (such as polio), medical intervention (thalidomide), and accidents, all had an impact (Cull and Hardy 1977, Brown 1978).

Early Period of Rehabilitation in Canada 1600's - 1800's¹

The Native population took care of their disabled members in their community through herbal and spiritual healing processes. They were known to have set fractured bones, performed surgery and excorsized evil spirits.

As the French settlers began to create their North American home, they went through major transitional phases. During and before the founding of Quebec City in 1608, handicapped persons (most of whom were mentally ill or retarded) who could not be looked after by their family and friends were shipped back to France. The European population of New France in 1666 was only four thousand people and the community could not support long-term social services. The main thrust had to be on physical survival. As the population grew and agriculture became the main economic base for the community, villages were formed. The Roman Catholic Church became involved by supplying hostels and asylums for the mentally and physically disabled. These places of residence were often shared by the mentally ill and 'reformed' prostitutes. Between 1780 and 1824 there was a growing transition from rural, hunting and farming to urbanization; this was accompanied by an increase in the spread of communicable diseases such as tuberculosis. At this time, the

¹The historical material throughout this chapter has been based upon Health and Welfare. Canada's Disabled Persons in Canada, 1980.

Legislative Assembly of Quebec passed a policy that all disabled people should receive a per diem allowance of one shilling and eight pence.

In 1834 there was an epidemic of cholera and smallpox. This induced the channelling of public funds to the disabled population and those families left without a breadwinner. At this time there was also an increase in the use of asylums and poorhouses.

In 1867, The Dominion of Canada was formed. Health care and social services were regarded as a provincial jurisdiction with federal options to promote and create cost-sharing programs. An exception was made for the Native-Inuit population and for mariners and veterans. These exceptions were particularly significant in the development of the rehabilitation field in Canada as we know it today.

Manitoba joined confederation in 1871 and the City of Winnipeg was incorporated in 1873, with the second Riel rebellion taking place in 1875. Shortly after this, church-supported services for the retarded and homeless began.

Elsewhere in Canada, Alexander Graham Bell (who invented the telephone in 1876) was married to a deaf woman. Through grants and subsidies Bell had a great influence on training centres for the deaf. A controversy on the philosophy and methodology for teaching the deaf evolved between Bell and E. M. Gallaudet, President

of the National Deaf Mute College at Washington, D. C. The College used the oral-manual method, while Bell endorsed lip reading and voice. The clash was going to influence the education of deaf people well into the Twentieth Century, and is still evident today in Manitoba.

It became government policy to build asylums for "idiots and feeble-minded" and sanatoriums for tuberculosis. In this, Manitoba followed Ontario in 1890 by building the Home for Incurables in Portage La Prairie. This became, in 1936, the Manitoba School for the Mentally Retarded. (It is interesting to note that it was only in the late 1930's that professional nurses began working at the school and social workers did not really become involved until the mid 1960's when there was a shift from institutional care to community services.)

1890 - 1942

A series of business recessions (1873-1879, 1884-1887, 1893-1896, and again from 1914-1915), the First World War, the Winnipeg General Strike of 1919, the economic expansion of the 1920's, the drought and depression of the Thirties, and the Second World War were all socially important. Each was a period of tremendous upheaval and turmoil. Some other significant events were: the organization of the Canadian Red Cross (1896), the creation of a number of organizations for the blind (1890-1916) including the Federation of the Blind, and the

founding of the Victorian Order of Nurses (1898). The Canadian National Institute for the Blind was founded in 1918 by E. A. Bakes, a blind veteran of World War I. The CNIB in Winnipeg was established in 1926.

It was also around this time period that sheltered workshops for the blind appeared, for example, in 1911, the Montreal Association for the blind organized a library and a broom shop to provide sheltered employment.

In 1917, two ships collided in Halifax Harbour. The resulting explosion levelled the port and surrounding urban areas. More than 1,700 were killed and thousands were injured. The Halifax Relief Commission was created in 1918 and over \$27 million was raised (\$18 million from Canada, \$4.8 million from Great Britain, \$750,000 from the State of Massachusetts, and \$3.8 million through public subscription). The funds were utilized for rehabilitation services and pensions. Some persons were still drawing pensions in 1976.

During the expansion of the rehabilitation services directly after the First World War there were two levels of development occurring: the federal policies concerned with Veterans Affairs and the private agencies that evolved from increased need.

After the First World War, the federal government returned all welfare and rehabilitation issues back to the provinces and to private enterprise. The Veterans were supplied with hospitals and allowances, but with

little emphasis on rehabilitation. Guest (1970) points out: "This conservative reaction, fueled by the Russian Revolution and, for some its Canadian counterpart, the Winnipeg General Strike (1919), was mirrored in the federal government's failure to carry forward with post-war reconstruction."

In 1918, the Canadian Mental Health Association and the Great War Veteran's Association were formed. The War Amputations of Canada followed in 1920. The Canadian Welfare Council (now known as the Canadian Council of Social Development) was founded in 1920 as well.

The Toronto Hospital for Sick Children (founded in 1875) became world renowned for its pioneer work with physically disabled children. In 1922, the Ontario Society for Crippled Children was formed in Toronto. By 1932, the society cared for almost 5,000 children and by 1938, the caseload had increased to 23,000 children. In 1925, the fraternal organization of Shriners opened hospitals for crippled children in Montreal and Winnipeg. Around this time many hospitals were being built by religious and philanthropic groups. These eventually became part of the publicly-supported medical systems in the various provinces.

Due to the increasing number of work related accidents, and labour unrest, Ontario enacted the first Workmen's Compensation Act in 1914. This act had a no-fault clause which revolutionized compensation for injured

workers not only in Canada but also in the United States. In Manitoba, Workmen's Compensation began in 1917.

Improved public health care increased the life expectancy of the whole population including the disabled. The most prevalent disabilities were blindness, deafness, and mental retardation. With the introduction of intelligence testing in the late Nineteenth Century there was a shift from custodial, protection practices to a more educational approach. The educational framework, however, was still rooted in special facilities and classes for the disabled. The practices that evolved often came from charity organizations and interested individuals rather than government. This educational trend can be seen in the variety of institutions emerging, including the Mawkey School of the Deaf in Montreal, the Halifax Asylum for the Blind, the Evangelical Church of the Deaf in Toronto, and the Manitoba School at Portage. These all espoused a practice of educational training; however there was a shortage of qualified teachers and it soon became clear that the institutions were primarily "human warehouses" concerned with custodial care.

Unfortunately, many types of disability were categorized under "mental retardation." The intelligence tests in use for many years did not allow for accurate distinctions between mental retardation and other disabilities. For example, tests involving language were inappropriate for the deaf and mute; tests involving motor

co-ordination were inappropriate for people with cerebral palsy or other physical difficulties.

It is interesting to note that even in 1980 the Cerebral Palsy Association of Ontario was trying to find a more relevant intelligence testing procedure which was not dependent on motor skills or language (personal conversation with Board Member, 1980).

The War Veteran's Allowances Act, 1930, and the Blind Persons Amendment (1937) and the Old Age Pensions Act were the first movements of the federal government to become involved with separate programs for the disabled. The blind allowance program covered those people who were over 40 and blind. It was thought that if the allowance was given to anyone younger it would weaken the resolve to find employment.

During the late 1930's, Manitoba endorsed a program of government-paid "municipal doctors" for rural Manitoba (Manitoba Women's Institute, 1981).

During the 1930's, the Canadian Welfare Council rejected proposals by government reports that the federal government take responsibility for all unemployed employables. This stemmed from a conviction about individualizing need rather than seeking a broad minimum base for service. (This meshed with the psychoanalytic approach then in vogue). However, there were a growing number of social workers who saw the need for federal support in this area because of the gross inequalities between municipal and

provincial welfare programs.

During the Depression, a group called The League for Social Reconstruction was formed which had a profound influence on political and economic thought and practice up until the 1960's and 1970's. Some of the members included NDP Leader David Lewis, Vincent Massey and Roland Mitchner (both of whom became Governor-General), William Dennison, long-time mayor of Toronto, and well-known academics such as Frank Underhill, and Harry Cassidy. (Horn 1981).

This group of thinkers took a strong democratic-socialist stand. Their vision was to release the energy and productivity of industrialization for public ends and social development by using government planning and democratic political control.

During the Depression years, the federal government had reluctantly become involved with make-work projects, building hospitals for veterans and supplying prosthetic devices for war amputees. The clients were largely "burned-out vets," and/or immigrants who had moved hoping to find relief. The devastating drought in Manitoba caused larger numbers of people to move to Winnipeg from rural communities.

Following the outbreak of World War II post war reconstruction plans were being made in most countries. This led to the development of far-reaching policy statements for all the social services. These policy statements

reflected the social concerns that were apparent during the depression and post World War I years, as well as the needs emerging from the Second World War. Most of the statements became blueprints of the "welfare state" (Guest 1980).

One of the first such statements was made in Britain in the Beveridge Report (1942) which identified "five giants that stood in the path of reconstruction and progress: want, disease, ignorance, squalor, and idleness." Beveridge viewed the most devastating of these as want. Want was seen as the failure to gain adequate income, which in turn led to disease, ignorance, and squalor and to idleness. The Report perceived the inability to fulfill one's social responsibility as the major outcome of these five giants. The Beveridge Report put the emphasis on income as a means towards creating conditions for people to become involved in their community, in a socially responsible way. Thus, the Report gave a philosophical base and conceptual framework for the organizational and developmental planning of social services in Britain. The main organizational thrust was centered on income security to eradicate want. This included a double redistribution of income through: (1) a comprehensive and universal social insurance plan to meet interruptions or loss of earning power arising from sickness, disability, unemployment or old age: and (2) a system of children's allowances to counter the failure of the wage system to take account of

family size. In addition, maternity grants and funeral grants would be paid to help meet these common life situations which called for unusual expenditure. What was revolutionary, however, was the proposal for a universal health service that would "ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domicillary or institutional, general, specialist or consultant." (Beveridge Report 1942).

The philosophical base that I have identified seems to be that want leads to an inability to carry out ones social responsibility. So the reason for income security and full employment, health care and other services is to enable citizens to assume their own social responsibility, and thus contribute to community life. Thus we can see the groundwork laid which led to many changes for the rehabilitation field.

In Canada a parallel blueprint for reconstruction was also developed.² The Marsh Report (1943)³ called for

²Another significant policy statement on social reconstruction for the Post War era was the Atlantic Charter (1941). This charter identifies, among others, the following two freedoms - freedom from fear and freedom from want.

³It is interesting to note that this report was written in less than a month. Marsh, however, had read the Beveridge Report. The Marsh Report reflects the Beveridge Report in using some of the same wording. Cassidy and Whitton took an opposite stance to Marsh on income security rather than seeking full employment "to lift people from poverty." (See Guest 1980).

Modern Rehabilitation Field -- Conditions

World War II profoundly affected the rehabilitation field. In 1940 a sub-committee was formed, comprised of military personnel, civilians, and civil servants with the mandate to develop a comprehensive plan for rehabilitation services on a national level. This plan included clothing allowances, rehabilitation grants, transportation, housing, war service annuity, re-establishment credits, vocational training, university education, unemployment benefits, pensions, medical treatment, insurance, land settlement, reinstatement of employment, loans, and preference for public service jobs. The benefits became law October 1, 1941, under the Post-Discharge Re-establishment Order and its amendments. This was followed by the Veteran's Rehabilitation Act.

Near the end of the Second World War, hospitals were built, staff trained, and doctors from the military were directed to these well-equipped hospitals to continue working with the armed forces to help rehabilitate those men who were injured in the war to "fit the booming economy" and to help repay the country's debt to these men (Woods, 1953).

Under the leadership of Dr. Gustave Gingras at the Veteran's Hospital in St. Anne de Bellevue, the "rehab team" was being established. The team was composed of a number of specialists including "psysiatrists, psyschiatrists, psychologists, physiotherapists, occupational

therapists, speech therapists, medical social work, and employment counsellors, as required." The team was focused on the individual and the ability to become employed. The same approach was taken by Dr. A. T. Jousse at Lyndhurst Lodge at Toronto.

The Canadian Paraplegic Association (C.P.A.) was founded in 1945 by a group of 225 war veterans with spinal cord injuries. The C.P.A. added to the veteran's hospital program such services as family counselling, employment counselling, adjustment to a wheel chair, and advice on housing and modifications to living accommodation. They also made representation to government and other agencies. Later, they expanded their mandate to include all those with spinal cord injuries. This included some of the polio victims from the polio epidemic of the early 1950's. Indeed, this polio epidemic gave a beginning impetus to open veterans' services and facilities to the civilian population. For example, DVA doctors with rehabilitation skills were called into consultation during the polio crisis.

Because of the numbers of veterans and the number with physical disabilities, there was an increased awareness of the needs of the disabled.

Up until this time the conventional practice among the medical profession, and social work, was that young babies viewed as "defective" should be placed in institutions as soon as possible before the parents became too

attached to the baby. In the institutions they would be "looked after" and "taken care of." It was expected that this would prevent the parental stress of having to live with a "defective" child, the associated guilt feelings, the terrific financial burden, and the social isolation (Ellege, 1948, page 36).

Generally at this time, public schools were not accepting physically-disabled students. There were a number of special schools in Canada for the blind and the deaf, and one near Hamilton, Woodedden, which accepted people with a variety of disabilities. However with an increase in numbers it became apparent that there needed to be alternative means of education and care for the disabled (Horowitz, 1959).

Parent groups of disabled children began to emerge. For example, the Cerebral Palsied Association and The Canadian Rehabilitation Council for the Disabled were parent organizations which were founded during this period. As more public knowledge was gained about the conditions of the institutions and more support came from parent groups to bring the babies home, the more the pressure was built up to do something. Along side of this, research was being done on how to get people back into the community after a long bout of polio that had institutionalized them (Horowitz, 1959, Ellege, 1948). It was found that the more quickly people were put into the community after the initial crisis was over, the better they recuperated and

adjusted. This then led to support systems being built in the community including public health nurses, volunteer visitors, and support from the local clergy, as well as out-patient services for physiotherapy, speech therapy, psychiatry and orthopedic care. Special schools were established within larger communities to teach the basic knowledge that people needed to cope in the world and yet be flexible enough to meet individual therapy regimes (Ellege, 1948).

Around the same time, parent pressure groups began to lobby all levels of government and private agencies, hospitals, universities, training facilities, to set up programs to teach their children basic living skills so that they could become independent adults when older and be given the opportunity to live fulfilling lives. A major parental concern was also who would provide care when they no longer could.

Within a ten-year period, the rehabilitation field blossomed from a few church-sponsored, private agencies to a network of private and government services. These included a range of large and small institutions, public and private agencies, and services under both public and private auspices. In general, they were divided into four systems. These four systems are the Veterans' Administration, the Workmen's Compensation Board for the injured worker, The Adult Services for the disabled and the Children's Services for disabled people under eighteen years of age

(Brown, 1978).

This paper is concentrating on the Adult Services and the Children's Services, understanding that both Veteran's Administration and the Workmen's Compensation Board has had a direct influence on the other services (Brown, 1978).

This major expansion reflected greater awareness of need, a wide variety of community involvement, and an increase in knowledge and technology.

However, little public knowledge was available on how to enter the emerging service systems. In the mean time, government and professional groups were trying to prioritize who should get the services immediately and who could wait.

The government decided to put its emphasis on those people deemed employable and to leave the rest, ie., those deemed unemployable--children, older people, and those severely physically disabled or emotionally disabled, under the jurisdiction of private agencies such as the Crippled Children and Adults, March of Dimes, parents' groups (for example, the Cerebral Palsied Association, self-help groups, the CNIB, and the Canadian Paraplegic Association).

This line of action was taken knowing that government services would have to change as increasingly more difficult cases were brought into the public system, and also in the hope that technology advances in the rehabilitation field would alleviate some of the problems related

to mobility and communication. During the latter part of the 1960's and early 1970's, professionals in the government agencies were talking about the "cream of the crop" being picked out and only harder cases being left within the rehabilitation field. Meanwhile the workers in the private agencies were engrossed in developing new technologies and techniques to enable the disabled to cope with their physical environment. Thus they did not perceive the gaps between public and private services.

Three other significant events occurred during this period. In 1951, a National Conference on Rehabilitation of the Physically Disabled met in Toronto. This conference urged the continuing presence of the federal government in the rehabilitation field. An advisory committee co-ordinated national planning of modern rehabilitation programs and government services. A consequence of this was that the Federal-Provincial Vocational Rehabilitation of Disabled Persons Program (VRDP). This provided a basis for cost sharing between the federal and provincial governments and led ultimately to the VRDP Act of 1961, and a Special Placement Section of the National Employment Service for placing disabled persons in the work force.

Universal Medicare (1957) provided "free" or insured services to all Canadians including the physically disabled.

The Thalidimide crisis (1959-1962) created a new

group of physically handicapped children who needed specialized services of a different order. This also proved to be a watershed event in altering people's attitudes toward the infallibility of medical science. It is interesting to note, however, that at the same time, certain disabilities such as arthritis were responding to the "wonder drugs" of ACTH and cortisone.

The 1960's continued with residual and incremental policy planning. Space technology had an impact on all technological development. The rehabilitation field was enriched by technological adaptations to improve physical manipulation of the environment, for example, electronic wheelchairs, computer controls for communication and increased accessibility. This led to greater social expectations, by both clients and professionals.

The 1970's will be remembered for the oil crisis and subsequent fiscal restraint at all levels of government. The increased social expectations from the 1960's was reflected, however, in increased demands from the disabled. Thus, the rehabilitation field of the 1970's is characterized by the rise of the consumer movement. The 1970's is also the beginning of a new direction in the policy planning of the federal government. The policies began to center on affirmative action for certain groups in relationship to specific issues such as housing, transportation, education, employment, and health care.

This trend of policies towards issues rather than

disability has caused a vacuum within agencies and for those social service workers working under the agency's mandate. This will be explored further in a more localized historical overview of the Society for Crippled Children and Adults and the next chapter dealing with stance.

Historical Overview of the Society for Crippled Children and Adults in Manitoba (SCCA Annual Report, 1951-81)

In 1946, the Cerebral Palsy Parents' Council with help from the Winnipeg Kinsmen Club, opened a treatment centre at the Winnipeg Children's Hospital. Health and Welfare Canada had done a series of governmental studies, 1944, 1945, 1946, 1949, all of which indicated the lack of co-ordinated services and insufficient services to meet the growing need. On June 2, 1949, Mrs. Roland McQueen, ex-director of the Welfare Council of Greater Winnipeg, called a cross-agency meeting and invited Mr. R. W. Hopper from the Ontario Society for Crippled Children. Through this meeting, interest was created and Mrs. Gordon (Margaret) Konantz did a report in two months outlining the need for a co-ordinating body for rehabilitation services for children and offered a slate of officers for a Crippled Children's Association.

In March, 1950, the Board was incorporated and in April of the same year, Mr. P. Jolliffe was hired as the Executive Director. He spent two months in Toronto observing methods used by the Ontario Society for Crippled Children. In May, the Manitoba Medical Association held a

seminar on the "Treatment of Cripples" and endorsed the new agency.

In 1951, the Society became the Provincial Chapter of the Canadian Foundation of Poliomyelitis (March of Dimes) and became involved in the rehabilitation of citizens with a disability resulting from polio. This marked the beginning of adult services. Nineteen-fifty-two was also the beginning of a severe polio epidemic and a subsequent rapid growth of services. Up until this time, all of the services were community based with the Society co-ordinating services within the different agencies and different parts of the hospital-medical community. In 1954, the Province of Manitoba held a Royal Commission on Rehabilitation. As a result of this commission's report, the Society was designated the central rehabilitation agency for the physically disabled in 1955. Thus, the name was changed to the Society for Crippled Children and Adults of Manitoba (see Appendix A).

This move of combining children's services and adults' services was the first of its kind in Canada. Until this time, most of the adult services were centered in Workmen's Compensation, CNIB, and/or Veteran's Affairs.

The VRDP Act, as indicated earlier, divided governmental services into rehabilitation services for those deemed employable, and those who were deemed unemployable were left in the hands of private charity organizations.

In Manitoba, the division line took a different

form. The Rehabilitation Services of the province gave the mandate to the Society to develop services for employable physically disabled persons while they concentrated on services centered on the mentally retarded, and information services for the public. This had a number of corresponding stance dilemmas which will be explored in the next chapter.

In 1956, a sheltered workshop was opened with the mandate to prepare people to work in business and industrial employment opportunities in Manitoba.

The name and premises changed in 1966 to Employment Preparation Centre. (One of the increasing concerns to the disabled members of the Agency's board is that much of the income generated at the Centre is being used to offset some of the costs of the Society; at the same time those people being "trained" there are working for less than the minimum wage.)

With the increasing demand for all kinds of services and personnel, there was an increasing demand for volunteer funding. The March of Dimes and the Easter Seals Campaign were the main source of fund raising (excluding government support). In 1961 there was a cut in funding so that there was a subsequent cut in services. The agency had to cut services that did not relate to the end-in-view of vocational employment, and shuffle clients to other agencies whether these were homes for the aged, chronic care hospitals, or sheltered workshops. In 1961, the VRDP

Act was enacted whereby the federal and provincial governments shared costs for rehabilitation services.

In 1962, the Kinsmen Centre was built on Sherbrook for a Nursery for Deaf Children and to house the Society's administration office. It became the centre for all services for the Society in Winnipeg. The building also became home for the Canadian Paraplegic Association, Multiple Sclerosis Society, and the Manitoba League of the Physically Handicapped (MLPH). In 1965, the Society became a member of the United Way of Winnipeg. This was also the year of the Social Services Audit in Winnipeg which pointed out the overlap and lack of co-ordination between agencies in the rehabilitation service system. The Audit endorsed a move from the Society and three other agencies to form Services for the Handicapped, Manitoba, Inc. (Social Service Audit, 1969, page 108). The recommendation was not acted upon however.

In 1966, the Canada Assistance Plan was enacted which broadened the scope of social services, including those for the disabled, but still involving a means test.

In 1965, the Society became involved with group programs under the work of a group social worker, Mr. Vernon Gray. This probably reflected the increasing interest in group dynamics in the 1960's (Klien, 1971). It is interesting to note that this program was primarily set up for those people labelled as unemployable. In the beginning, the program consisted of handicrafts, swimming,

outdoor, and recreational activities. Gradually, through input of the disabled people themselves it broadened out to include educational activities, discussion groups, and photography. This was followed by a series of conferences on recreation facilities for the disabled population where a number of social workers (who were themselves handicapped) went to a conference and put forward a consumers' stance. This consumers stance is a significant development of the 1970's.

Then in 1973, the Canadian Rehabilitation Council for the Disabled (the national organization of which SCCA of Manitoba belongs) through federal government initiation held a conference of physically handicapped people in Toronto. A steering committee was formed and the Manitoba League of the Physically Handicapped began in 1974. This consumer group began addressing the environmental barriers and pressuring both municipal and provincial governments to focus on public accessibility issues.

It is interesting to note that in 1975-76 there was a considerable cut in funding for group programs of the SCCA; so much so that by 1979-80 the group programs again consisted mainly of handicrafts and swimming.

Through the work of the Manitoba League and others, a national Consumer Organization was formed called the Coalition of Provincial Organizations of the Handicapped (COPOH). Two groups of social workers within Manitoba were involved in the development of this national coalition.

One group was the physically disabled social workers (primarily associated with the paraplegic association) and the second was other social workers employed by the SCCA. This formation of a coalition reinforced the emerging "consumer" stance.

Chapter 4

STANCE

This Chapter will identify emerging themes within the historical overview and illuminate further the discussion begun previously.

The major stance themes as I have identified them are related to relationship and ends-in-view. These stance themes are evident in the dilemmas between policy and practice.

We have seen how the returning Veterans of the various wars gave an impetus to the development of physical aids. Increasingly these began to be seen as aids to preparation for employment. This push toward employment also grew out of a strong economic concern which has been especially prevalent in North America since the 1930's.

These trends can be seen in the two very significant reports, the Beveridge Report (Great Britain, 1942) and the Marsh Report (Canada, 1943) which synthesized much of the social thinking of their time.

Level of Significance

We have seen how the Beveridge Report identified five giants impeding reconstruction and progress. (These

were: want, disease, ignorance, squalor, and idleness. The biggest was seen as the eradication of want, defined as the lack of income to obtain the means of a healthy subsistence, adequate food, shelter, clothing, and fuel.) We have noted the importance of enabling people to fulfill their social responsibilities. Want is not seen by Beveridge as the same as unemployment. Employment will be an important part of allaying want and idleness, but it is not the primary end-in-view. Social responsibility is.

The abolition of want was seen as requiring state intervention and personal responsibility (page 6). Beveridge sought to provide provision against interruption and loss of earning power. But since there were many for whom earning was not possible or for whom income from earnings was inadequate, income insurance was also seen as needed. We note again that the end-in-view is income, not employment.

In contrast, the Marsh Report appears to be seeking a comprehensive employment policy. This can be seen in the argument for supplying resources in order to lift people from poverty, through the provision of full employment. This stemmed no doubt from the Great Depression of the 1930's with its disastrous unemployment and inadequate relief provision. The Marsh Report emphasized that training and employment programs were essential buttresses to prevent people "falling into poverty" (Guest, page 112).

Indeed, the Report suggests that employment is



needed to reduce poverty not only for the individual, but also to prevent "penurious old age and the necessity of parents becoming dependent on their married children in later life and straining the resources of these families" (Marsh Report, page 30).

In contrast to Beveridge who focused on enabling all people to carry out their social responsibility, Marsh selected groups of people in need of help. These persons were viewed as inherently dependent under the given conditions, and therefore required charity or training. This led to further isolation and denegation of personal value. In addition, there is an emphasis on minimum standards, rather than on maximizing opportunity to fulfill social responsibility. A person appears to be valued on the basis of his/her economic worth.

As stated before, these two policy statements provided the blueprint for modern social services. The rehabilitation field as part of the social services in Canada was strongly influenced by the stance enunciated in the report. For example, the Labour Relations Act (including the minimum wage regulation), The Jury Act, The Election Act, The Education Act, The Vocational Rehabilitation Act, all reflect a similar stance to Marsh in viewing the disabled as dependent with little ability to carry out social responsibility.

The Canadian Assistance Plan (1966), Canada Labour Code (1966), Unemployment Insurance (1971), The Blind

Persons Act and Disabled Persons Act (1951) later to become the Vocational Rehabilitation Act (1961), Workman's Compensation (1918, 1946), The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (1977) (for extended health care services), and The Human Rights Act (1980) while providing resources for disabled people are shaped by Marsh's underlying stance of "lifting people from poverty," and the goal of normal employment.

Division of Systems

It is interesting to note that in 1958, the Canadian Welfare Council made a statement to the then Minister of Labour, Mr. Mitchell, in regards to a National Program for the Rehabilitation of the Disabled, classifying disabled people as follows:

1. Those whose disabilities are such that they do not require special assistance in order to enable them to obtain permanent employment, or live reasonably normal lives.
2. Those whose disabilities are such that, with special help in regard to medical and/or psychiatric treatment, vocational counselling, placement, and social casework service, they can compete with normal persons in employment and in every-day living. This group can be further divided (a) children whose disability will hinder their education and their later employment, and (b) adults.
3. Those whose disabilities are such that they can never

be expected to compete in the open market and for whom the provision of sheltered workshops or special facilities for homework are, at best, the only form of employment and for whom the desirable plan is that they may be helped to make a more satisfactory adjustment to the limited type of living possible for them.

They go on to recommend that the federal government programs cover category 2(b) those people who are adults, and give priority to those people who are physically disabled and not socially or mentally disabled, ie., "those with reasonable prospects of rehabilitation, as determined by age, the type of disability, and the recency of its occurrence." The reason for the priorities were stated as follows:

1. The morale of these groups has not deteriorated to the extent that can be anticipated on the part of other groups.
2. Experience with these groups, which present in general less difficult problems of rehabilitation, will produce more immediate results, which will be of assistance both in the interpretation of the program to industry and to the disabled person, and also in the immediate problems of personnel, inexperienced in work with the disabled.
3. The present facilities for particular groups such as those disabled through industrial accident or through military service can be more readily adapted and

extended to this group.

4. The cost of supporting the younger group over the full period of their lives as unemployable persons is greater; the economic gain of rehabilitating these persons is also greater since they have the maximum years of earning ahead of them, have already in many cases established work habits and skills which may be utilized, and have in all probability more people dependent upon them for support (C.W.C., 1958, page 6).

These statements appear to assume that the program would become better as more technical knowhow was applied, industry accepted the philosophy of rehabilitation, and disabled people within the system gained confidence, and more trained professionals working with the disabled would produce better outcomes--outcomes which can be identified as full employment. In the meantime, other (private) agencies would prepare children and those people not deemed ready for the government services. Public funds could augment private funds (C.W.C., 1958).

We note throughout all of this the focus on employment as an end-in-view. It is also interesting to note that the medical doctor had to assess physical ability and disability in terms of employment possibilities and make a decision as to whether or not medical intervention would improve those possibilities for work. That was the sole criterion for medical rehabilitative intervention after the crises of life and death was stabilized (C.W.C.,

1958, page 9).

The only person who was deemed not directly interested in the goals of employment was the social worker who was supposedly interested in listening to the person's fears, in order to change personal attitudes about disability and rehabilitation. There was little indication of changing other people's attitudes, ie., doctors, employers, and/or educators, or even the community at large.

In the VRDP Act (Canada, 1961) we again note that the emphasis is on the preparation of people for remunerative employment rather than on the provision of income, or the fostering of creative work, or enabling a person to fulfill their social responsibility.

Normalization

Another end-in-view appeared to be to have each handicapped person independent of society, whereas the British Disabled Persons Employment Act of 1954 stressed the interrelationship and interdependency of people in regard to their work and place of employment, by emphasizing the relationship established between employee and employer.

An emerging stance in the late 1960's and early 1970's was that the best lifestyle for the disabled was the "normal" lifestyle. The concept of "normalization", as defined by Nagi and Wolfensburger (1968, 1978), emphasized

living in the community as a productive member would mean the place of work and residence should be where other people work and live respectively. The concept was valuable in its time. However, in the rush towards "normalization" we have sometimes tried to quantify the concept of "normal", rather than understand it as an unmeasurable quality. Again there is an emphasis on independence and an omission of the understanding of social responsibility and interdependence.

In Britain and Europe as indicated by Grant and Titmuss (1978, 1971), "normal" is equated with a concept of interdependence in so far as they view society as the result of a mutual effort.

In North America, the concept of normal is expressed in terms such as: independence, self-actualization, and the ability to produce and consume products and services.

Canadian social services were, however, influenced in some measure by British policies. This duality of stance has caused dilemmas in the rehabilitation field in both policy practice and the relationship of the field practitioner to client/consumer. Thus, most rehabilitation agencies are shaped by the legislation and the thrust toward economic independence, employment, and normalization. Individual workers and day to day practice may reflect an emphasis on social interdependence. There is a need for a realization that one is never truly independent but is necessarily interdependent for a purpose beyond employment

or even self-motivation and actualization.

Policies Viewed as Outdated

In the early '70's Canadian attention was focused on what Charlotte Whitton had called "the living wage" but was now being called the Guaranteed Annual Income (Guest, 1980). Once again, debate centered around the economic need for full employment. (It is interesting to note that the disabled employee is specifically exempted from minimum wage laws as a way of increasing their attractiveness as employees.) In the 1970's, the need was seen to bring up to date the VRDP Act and the Canada Assistance Plan.

Traditional agencies were having to deal with larger numbers of people who did not "fit" the criteria of the Vocational Rehabilitation Persons Act. These people were deemed unemployable and therefore not suitable for existing services which were primarily geared towards employment rather than vocation. This discrepancy was identified in the Social Services Review (1977). As part of the work of the review committee, the VRDP Act was reviewed. The committee developed four options to deal with the existing dilemmas. They were as follows:

- a) Renew without change the existing Vocational Rehabilitation of Disabled Persons agreement between Canada and the provinces pending a new legislative framework for all social services.
- b) Modify the present agreement, leave the present VRDP Act in force pending development of a new general

legislative framework for all social services.

- c) Modify the present VRDP Act to broaden the objective of the program and modify the VRDP Agreement, pending development of a new legislative framework for all social services.
- d) Design a new Rehabilitation of Disabled Persons Act, expanded in scope.

Option (a) continued the existing focus of the program, namely rehabilitation of the physically and mentally disabled to obtain employment.

Option (b) would have continued the current focus of the program but in addition would have provided for support of services in pre-vocational situations and services to maintain employment and through a broader range of services would allow the program to serve more disabled persons.

Option (c) would have further increased the number of clients served by including physically and mentally disabled persons capable of attaining goals other than employment.

Option (d) would have further expanded the client group to include the "socially handicapped" who would benefit from a program of rehabilitation services.

The Social Services Act of 1977 and the Social Services Financing Act, 1978 would have extended federal cost sharing to non-medical costs such as transportation, access to housing, support technology, and other support

services, such as peer counselling, life-care assistance, etc. Neither of these Acts were passed, but it started a vigorous debate over appropriate delivery systems. As a result of this debate and through pressure of consumer groups and other organizations other governmental offices began to examine ways and means of creating a more accessible environment (Perceptions, Sept./Oct., 1980, page 36).

The National Building Code in 1973 through Supplement 5 created a precedent by requiring all new businesses and public buildings to meet minimum accessibility requirements. This provision, however, had to be endorsed by each province, and was subject to provincial interpretation. Some provincial governments tried an affirmative action program for employment but had to stop because of fiscal restraint.

The practice of the late 1960's and 1970's reflects a focus on specific problem areas and "target groups".

It seems that the failure of Bill C57 (The Social Services Act of 1977) gave licence to the peripheral, ie., agencies, service providers, and government departments, other consumer or parent organizations to explore and innovate new relationships with community and individuals. In Manitoba, for instance, the Secretary of State became involved with giving seed money to consumer organizations to try out their ideas at the time the social services review was taking place. This probably would not have happened had it not been recognized that the VRDP Act was

outdated and that the Health Department could not fund the type of projects that were being proposed under the VRDP Act. It was through this seed money and the work of the consumer movement that new services emerged to meet the new needs that old structures could not handle. This evolution did not come easily; it required people to be in different roles to make it happen.¹

End-In-View Not Being Met

In a report (Rothney, et. al., 1977) of labour market implications for handicapped Manitobans, it was noted that of those people who had gone through the rehabilitation and/or manpower services in the province and were placement candidates, 54.7% were unemployed. This in spite of the fact that handicapped people are consistently exempted from minimum wage laws.

The goal of full employment was not being reached.

Repercussions on Agency Services

Nineteen thousand Manitobans aged 16 years and over were in rehabilitation programs with physiological impairments (Rothney, et. al., 1977). Therefore one of the main issues facing the Board of Directors of the Society for Crippled Children and Adults over the last few years has been centered on whether or not all physically disabled

¹Personal conversation with Violet Rushowick, Social Development Officer, Citizenship Branch of the Secretary of State, and Frank Rogesezenski, Vice-President, MLPH, 1981

people can be employed (May, 1971, Minutes of Board Meeting). Similarly, the services for group work, centered on avocational goals, have grown in the last few years. Now the Society is faced with the task of either enlarging its mandate to include avocational training and/or moving the program into another agency and/or reassessing program and goals (Minutes of Board Meeting, 1981).

Thus we see in 1981, that the agency is beginning to grapple with their position on a micro level. This was similar to what had already taken place at the national level in the 1960's and 1970's.

Services and Stances

In the SCCA we can also view a different stance between Children's Services and Adults' Services.

For instance, in the Children's division, Bliss symbols and computers are being used by people who have oral communication problems. It has been found that the children are building their own vocabularies through creating their own symbols and synthesizing old ones. They are in the process of teaching their teachers new words and sentence phrases (Zdrilick, 1981).

The end-in-view is often multi-dimensional with emphasis on living in the community and taking social responsibility after treatment is completed.

In the adult services, however, the end-in-view is often uni-dimensional--that of employment. The program at

the Employment Preparation Centre is based on employment "conditioning" rather than learning about work and how to work (SCCA, 1980 Brochure).

In Canada, and Manitoba specifically, the ends-in-view of most rehabilitative services appear to be remunerative employment. It has been assumed that those people who are not employable are also not able to live independently. Training, therefore, has focused on "life skills" and/or employment traits. Training here means to prepare people (or objects) for a specific task.

Education, on the other hand, seems to have the connotation of understanding and illuminating inherent values of people and society. However, in the field of rehabilitation, the level of education achieved may have been viewed as another way of ascertaining employable traits. The focus is often on readily available employment potential, ie., how many resources can be exploited for use to potential employers rather than the opportunity to do purposeful work.

The criteria for success of training creates a shift from value of person-being-useful to value being related to being economically viable. If a person is economically viable, he is seen to be of worth. If not economically viable, to have no worth. Consequently, people are perceived as objects to be manipulated.

Work-Employment

We now see that persons are not valued but the conditions leading to work or employment skills are of primary importance. For example, the ability to type becomes more important than the typist. Consequently, the typing skill of 40 words per minute is valued regardless of who has the skill; in fact the skill and its underlying condition is disembodied from the person. His/her purpose and own perception of value or capacity is of no consequence. Therefore, persons with specific skills are seen to be interchangeable commodities with any other person who possesses the same skill.

The consequence of this stance for the physically disabled person become readily apparent. When persons are seen as interchangeable, the economic advantage for the employer will rest with the employee who can do more than one activity or who makes fewer supplementary demands. For example, the deaf person who is a draftsman but cannot answer the phone, or the typist in a wheelchair who needs special facilities in the washroom will be at a disadvantage.

An alternative approach to work as employment can be seen in Schumacher² (1979) who suggests that work has the following characteristics:

²Schumacher was also one of the major architects of the Beveridge Report.

1. Work is to provide necessary and useful goods and services.
2. Work is to enable everyone of us to use and thereby perfect our gifts like good stewards.
3. To do so in service to, and in co-operation with, others so as to liberate ourselves from our inborn egocentricity.

Schumacher's understanding of work gives us an opportunity to expand our perception of rehabilitation. The ideological argument of the use of people as resources is reframed to stress social responsibility and interdependence.

Social reality is different from physical reality, because people are co-creating their own relationships and therefore their own meaning. Schumacher also stresses that useful goods and services may not be the same goods and services used yesterday or today. This thereby, allows for the opportunity to develop different capacities to meet new relationships.

Schumacher in his study on work gives a good deal of attention to the proper place of technology. He sees technology as ideally aiding people in getting things done. Technology should support social relationships.

When the social environment is equated with the physical environment the tendency to see and utilize people as objects is accentuated.

If a person is seen as useful and economically productive he is viewed as independent and valueable.

However, an independent person is also an isolated person, and therefore this negates the social reality.

In the rehabilitation field we have a number of technologies coming together. There are technologies from medicine, education, the work-place and the rehabilitation field itself. In view of the previously identified goals of employment and independence it is not surprising that the technology has reflected these ends-in-view rather than facilitating social relationships and social responsibility.

Need and Service

We have seen a number of changes; handicapped people had greater expectations of social participation; the programs and services of the Society which had originally centered on medical intervention became more peripheral; and programs centered on social integration and employment became more central to the organizational functions.

For instance, in Winnipeg (and Toronto) there was a growing realization that because of extended hospitalization, young adolescents were growing up with a distorted view of their bodies and the right to privacy. It was around this perceived problem that adolescent programs evolved. The programs consisted of learning about such social skills as sexual awareness, dating, human rights. These gradually evolved to focus on a number of other social skills.

In Manitoba there was a shift in the late 1960's and early 1970's, in the housing area, from nursing-chronic care housing to concepts such as Ten Ten Sinclair (where people could live in a residential setting with a degree of freedom and responsibility to learn the rudiments of living independently). With this program in place, it became clear there was a need for integrated apartment dwellings, thus the emergence of Focus (in which there are a number of apartments built to accommodate wheelchairs and trained life assistance personnel are available on call for a specified number of hours.)

These shifts in program caused definite shifts in service delivery. With greater numbers of people living in the community, there is and was an increased demand on community services, (homemakers, meals on wheels, etc.). Homemakers could no longer be simply an untrained housekeeper but also had to become aware of different life-support systems and what was required to keep the life-support system operable and safely connected to the person.

As more and more people live in the community with the aid of technical independent living aids, the initial concern for medical palliative services is shifted to a concern for the co-ordination of technical equipment and operative education.

The fact that a person can co-ordinate his/her own life-support services is in direct contrast to the medical

view of caring for people.

As social conditions change, the ramifications of those changes spread to the rehabilitation field. For instance, as the population grows older, physical impairment increases! This leads to the social realization that "all of us at one time or another are handicapped." This reinforces fears on the one hand, and on the other, it forces the public to realize the similarities between themselves and the handicapped.

Ramifications for Rehabilitation

This insight has ramifications for policy and social responsibility dilemmas. Fund raising and charity drives are suddenly suspect. "The cute kid with braces" syndrome may, in fact, denigrate both the giver and the receiver of money or charity.

Giving to the image of "a kid in braces" isolates people from the community and the interdependency of each with the other (Titmuss, 1971, Chapter XIV). The United Way Campaign on the other hand, reflects a stance of a "community responsible for itself." The we/they syndrome is kept to a minimum and the public message is that all people are seen as part of the whole community. This reflects a leaning away from concepts of charity as "good works" and sickness and disability as sin wrapped up in isolation and misunderstanding. This concern for social integration and participation has been a major concern of

the consumer movement.

However, both the consumer movement and the movement toward "normalization" have the end-in-view of independence and employment. Therefore the service delivery system they are advocating is essentially the same as currently exists.

In terms of the social service worker relationship to the consumer, the end-in-view may be quite task orientated. Knowledge of the process and methods used can be shared and utilized, thus the consumer organization has adopted the stance that the tasks should be fully articulated and fully delineated, and contracts drawn up between "producer" and "consumer" services.

This stance views the relationship of knowledge and services and people as objective, rational, and scientific, and therefore physically maleable.

It seems the relationships are based upon economic-physical reality of scarce resources. The struggle is viewed as who is going to be made adaptable--consumer, producer, or environment. Who has the greater power to make people and conditions adapt to their world view. Who will influence the distribution of resources.

As Mr. Henry Enns (who is now Chairperson of the World Coalition of the Physically Handicapped) states:

It has been said that the wheel that squeaks the loudest gets the grease. This has been proven over and over again by the MLPH and other groups in the community. Public pressure forces governments to take action and, in fact, it appears that public pressure is the one

thing the the Conservatives will react to in this time of restraint. Self-help groups are in an enviable position. Because they know what they want, their advocacy role is extremely powerful, more powerful, in fact, than social workers because they are not faced with a conflict of interests. (Manitoba Social Worker, Vol. 13, No. 6, March 1979, page 2).

What consumers are advocating is that rehabilitation should be considered first as a medical problem--to stabilize conditions, to maintain and enhance physical resources by therapy, and/or technical equipment. Then secondly to move from there to community social services centered on housing, transportation, and education. They want in this way to by-pass such rehabilitation services as the SCCA.

Relationships Mismatched With Present Ends-In-View

In the Report of the Special Committee of the Disabled and the Handicapped, called Obstacles (1981), there appears to be a trend towards integrating rehabilitation policies into other policies of general concern--housing, transportation, education, hospitalization, Pension Plans, and Unemployment Insurance, etc.

Of the 130 recommendations, most have been covered under Option C of the Social Services Review recommendations. For example, community support systems, guaranteed annual income, etc. Those areas that would not have been covered under Option C are part of the process whereby the new problem of attitudes is dealt with. This includes concerns centered around Human and Civil Rights, independent living, consumerism, changing attitudes, international perspectives

and new concepts of funding and implementation.

The central theme is centered around independent living. Independent Living Services are defined as "those services which are uniquely required by the physically disabled person in order to maintain an independent life-style in the community. Such services may include a personal care attendant or an intervenor." The report focuses on the process of "social relevance" to save economic costs rather than on "social reconstruction" to create more human social development. This is indicated in the following statement:

Central Theme: Throughout the Committee's hearings across Canada, the concept of "independent living" emerged as a central theme. As an idea it services to counteract the myth of "helpless victim" which plagues disabled persons wherever they go. As a daily reality, it enables disabled persons to care for themselves in ways that no institution could ever match. As federal government policy, independent living makes remarkable economic sense.

\$22,000 Saved: Based on American experiences, there is a remarkable difference in the average annual costs of keeping a disabled person institutionalized compared with assisting him or her to live independently in the community. Institutionalization costs \$30,000, independent living \$8,000. A potential yearly saving of \$20,000 is possible each time a disabled person can make the transition from hospital to community. The Multiple Sclerosis Society of Canada has found that the difference of caring for a person in a nursing home is \$11,900 per year. The same service--2 hours per day--in a private home costs \$5,730 per year. Wherever the cost of institutionalization and independent living can be compared directly, it is clear that independent living is significantly less expensive. These facts alone justify major government initiative to promote independent living.³

³However as larger numbers of severely disabled people

Helping Families: Another alternative to institutionalization is to make it possible for the disabled person to live with his or her family. Experience has shown, however, that families who care for a disabled dependent often suffer from "burn out." This means that they become physically and emotionally exhausted from the continual responsibility of responding to the special needs of the disabled person. "Burn out" frequently creates the conditions for divorce, child abuse, and mental breakdown. Community support services, respite care, temporary attendant services, and counselling must be provided so that families can be freed periodically from their responsibilities.

Involvement Crucial: Disabled persons themselves must play a key role in the development and management of these independent living programs. The success of existing programs depends greatly upon the sense of ownership felt and communicated by the disabled persons who helped to develop them.

People with physical disabilities are now supposed to "look after themselves." They should have a sense of ownership, but implicit in this phrase is the lack of sense of responsibility and capacity to share. The report continues this line of thinking by stating "parents should be relieved of their responsibility," rather than having support systems allowing persons to share their social responsibility. We are again reminded of Marsh's view of relieving people of responsibility and the primary concern about economics. We are again faced with a policy that isolates and tears down community and denegrates human beings to manipulated objects.

We may be seeing other disturbing trends taking

move into independent living situations, the costs of support services may more nearly equal or even surpass the costs of institutional care.

place in the consumer movement. In the early stages of the movement, the people who were advocating for consumer participation were primarily highly educated, middle-class citizens. Most worked in the federal or provincial governments in related departments, or worked in the rehabilitation field (Pacquette, 1980, page 26). They were directly involved with decision making and were highly articulate people. As the movement grew, there was a need for structure and organization. Thus the consumer movement became consumer organizations.

Within a few short years we were now faced with consumer organizations which have all of the dilemmas of any modern North American organization. Leaders are still making decisions with little input from members. Members are feeling isolated from leadership. Responsibility is not delegated to members as paid staff are making decisions that the board and respective committees should be carrying out. With each new issue there are new committees formed. These committees are in competition for members who are already involved with sorting out previously identified issues. Thus, there exists an insufficient number of persons able to fill all the committee positions. All of these observations have been levied against similar organizations such as the CNIB, by other self help groups (Perceptions, Sept./Oct., 1981, page 27).

The Manitoba League of the Physically Handicapped is going through similar phases. The first focus for

action was the transportation system. After seven years of operation, consumers are still involved with the transportation issue, with issues like Human Rights and Education taking a back seat. It is recognized that transportation is of major importance. The organization's main objective was to advocate for an accessible transportation system in order to increase community participation. It is interesting to note, however, that a large percentage of the rides are to and from work, hospitals, and League functions. One might ask, "Is this community participation?".

There is also a growing recognition that the greatest problem to be solved in North America is that of public attitudes toward the handicapped.

Our methods and goals are mismatched with our new understanding of the "attitudinal problem." We are still using outmoded tools and objectives centered around the problem of economic inequality. The solution is seen as more equal distribution of the pie. However, as Schumacher indicates, we need to recognize individuality and community.

There is a gradual realization that people are responsible for our relationships. Our relationships are based upon our ability to develop a larger knowledge base about ourselves and the world around us. It is important to recognize the assumption that knowledge of self will influence both our perceptions of our community and our stances toward service.

More and more people are perceiving their own

capacities to influence and create their own social reality. These capacities have three levels of implementation:

1. possessing recognized capabilities,
 2. knowing consciously or unconsciously that one has these capacities, and
 3. having or creating or being forced into a situation where one exercises these capacities, thereby strengthening them or expanding them and realizing them, making them more real to oneself and to others
- (Schumacher and Gillingham, 1977, page 170).

Gillingham observes:

Looking at the available evidence, much of the past seems a time when most people have the first characteristic to some degree, lacked the second, and had the third only in times of stress such as war or disaster. By contrast, much of the present makes sense as a time when more and more people have the first and second characteristics but lack the third (Schumacher and Gillingham, 1977, page 171).

The awareness of the "attitudinal problem" seems to indicate an affirmation of the need to create situations where one can exercise these capacities, or to be able to share gifts in the process of co-creating a new social reality.

The rehabilitation literature reaffirms that people have capacities to become self-actualized. Even children are learning to communicate through the use of computers and are using their creative power to create new meanings by making new symbols out of old ones.

A larger number of people are becoming active

participants in their communities in a variety of roles. It seems that more people are recognizing their capabilities to become socially responsible. However, the existing social structures are impeding the acknowledgement that people are capable of creating their own social reality. Thus frustration and alienation are apparent.

Three Relational Frameworks

In attitudinal studies (Yuker, 1974) and in my own research, it seems that clients of rehabilitation services fall within three groupings of stance and conditions. These groupings are not to be seen as dead-end capsulizations of people, but rather as a tool in which one can view the whole. It seems there are some people who, because of the socialization process, hold a world view which is centered on the custodial-care framework and which limits their recognition of their own and other capacities. These people are usually older or living in rural areas with little input or chance to relate to others. Often they need extended care and have a strong family network.

To put these people into an independent living process would be to invite mental, emotional, and spiritual breakdown. They need the kind of environment which gives them inter-relationships, structure, and programs which are open-ended so that as they become more aware of themselves they may progress to other communities and lifestyles.

The second group are those people who recognize that they do have certain capacities but need a great deal

of support and time, energy, and commitment to fulfill their potential. Thus they need contact with others and a growing sense of awareness of their own contributions. The third group challenges and builds situations in which its capacities can be utilized, or they find themselves capable when they are forced into situations.

Some would argue that there are more people who could move into the third group than there are perceived in the present structure. This may be true, however, in order to make this happen there may be need for different services, different methods, and different perspectives in order to fulfill the ideal starting place for social work, that is "starting where the client is." The dilemma is how do we find the starting point and move towards mutually-acknowledged future possibilities and ends-in-view.

More and more professionals are called to work with people rather than on or for them (Schien, 1978). This requires a new perspective based on the realization that physical reality is a different order or level than social reality (Schumacher, 1971).

This new awareness is reflected in consumer demands for greater participation in their treatment plans and service delivery structure. This may be threatening to professionals who are tied to methods rather than purpose.

Chapter 5

PRACTICE PERSPECTIVES IN THE REHABILITATION FIELD

What is required is a way of ordering the stated dilemmas regarding stance in the last two chapters. It is assumed that only through encompassing the whole rather than dividing the dilemmas in isolation from each other that we are going to be able to understand, illuminate, and grapple with new, emerging, and divergent issues centered on attitudinal change and human rights and obligations. This will hopefully move us toward an integrated and just service delivery system.

May, Lacomte, and Schumacher offer a perspective that may aid in the accomplishment of our task. May has identified in the historical overview that policies and people have always been in a push-pull dilemma. The push as May suggests, is our historical, biological selves. Those who focus on history see man as an adaptive animal meeting conditions. People are pushed along an evolutionary scale, always reacting to the past.

This has been readily apparent in the policy statements of the rehabilitation field. The VRDP Act seems to be a reaction against the Depression of the Thirties and the overwhelming numbers of people to be

looked after at the end of the war, followed by the polio epidemic and the thalidomide crisis.

To focus on the historical is to be concerned about probable outcomes. All problems are seen on a convergent basis. It is this preoccupation with probable futures that denegrates people to be manipulated objects to fit an economic forecast or employment trends.

On the other hand, May states that we are also being pulled by possible ends-in-view or possible futures. This can be seen in our hopes for the future and in our preventive capacities. (It is interesting to note that preventive services run a very poor second place in our priorities.)

To be pulled by future possibilities requires a sense of purpose and a search for future development. Development, as Erickson (1959) suggests, requires a grappling with issues and a discovery of equilibrium between the divergent aspects.

Schumacher (1977, page 1977) suggests that to be working with divergent problems requires one to seek relationships with others because of the nature of the task. In his view work with convergent problems leads to isolation and atomization. A convergent focus leads to a single solution. A divergent approach provides the possibility of a multi-ended future.

Lacomte (1979), however, has identified an approach for social work practice which rests on working with both

the convergent problems to be solved and divergent issues to be resolved. He identifies that the divergent and convergent are both together in the same structure at the same time and in the same place. While clients and practitioners will often begin with the convergent, there is also a need to address the divergent.

If we recall our original list of dilemmas in the rehabilitation field we may find here some insight into how these may be addressed.

As we have explored the policies and practice of the rehabilitation field we have encountered a number of incongruencies in the stance or underlying assumptions.

In review these places of incongruencies we can note the following clusters:

custody	training	productivity	employment
X	X	X	X
education	education	responsibility	work
	rehabilitation	worth	
	X	X	
	habilitation	value	

All of these affect the client, parents, the consumer, the practitioner, the administrator, the policy maker, the agency, and policy.

To understand these incongruencies we need to appreciate both the ends-in-view and relationship. One can note that those terms on the top are primarily concerned with seeing people as individuals or objects--who can be

expected to meet societal goals ie., financial independence and employment. Those terms on the bottom view people as persons and responsible community members.

Historically the physically handicapped have been perceived first as non-entities--then as dependent subjects for charity. Through the awareness of their employment possibilities they became viewed as independent objects (both consumers and employers take this view). The place of interdependence has not yet been recognized except in insolated cases.

Ten Guidelines of Practice

The following principles of practice has the interdependence relational framework as their basis.

1. Social reality is a co-creative adventure.
2. Physical reality is what we work with in order to affirm our social responsibility. Physical reality gives us the ability to respond with each other.
3. Professionals have a message to give. This message is centered on hope, trust, truth, and justice that become the roots of creative reality and new ways.
4. Rules can change.
5. Conditions can change.
6. People change and also stay true to their pattern of capacities.
7. The person one is connected with through relationship building is more than likely searching for another stance or worldview in which to make sense of and

therefore co-create a new social reality.

8. Community is built on differences and respect for differences.
9. Social development and individual development are mirror images of each other,--identical and yet in a complete reverse order.
10. Life is a dynamic struggle. Struggling adds dignity when the pain and the joy of the struggle is shared and respected.

Implications for Practice

The kind of thinking and perceptions gained in this paper have direct implications for practice. It must first be stated that the implications addressed are ones of perceptions and insights, not methods or procedures.

This thesis was a response to my perception of clients being viewed as isolated adaptive animals--responding to environmental conditions. The search was to affirm the belief that human beings were creative beings. The practitioner and client are both learners and teachers, each building and being responsible to a community, based upon relationships that are created not just adapted to.

The process of living is an on going process. Ends-in-view are only beginnings of another process, or a continuation of ones life.

To put this on a practical level requires one to first of all view agency, and policy structure as one possibility out of many. It requires one to perceive, to

reflect that out of all of the universal possibilities one person or one group of people or one community has come to you as a practitioner. A person with knowledge, a person with insight and vision to relate their life story, to somehow gain, regain or revise their own purpose and vision.

The relational framework in which both people are working will influence the process and ends-in-view selected and maintained.

For instance, a social service practitioner who works with the assumption that disabled people must be protected because of his/her differences will probably lean towards custodial care and institutional living. The same holds true for the person with the physical disability.

If a person who is practicing in the social services sees the person as adaptable and his/her services geared towards finding conditions that will help the adapting process than the second relational framework is probably being used. The person who is physically disabled in this framework also views him/her self as being able to meet the demands of society on its terms given the necessary resources.

The third relational framework, however, goes one step beyond. The social service worker in this framework perceives the person as different, but not maladaptive or sick or disabled.

The difference can be viewed as problematic or as a new interesting path to follow, understand and encourage.

The difference is seen as having potential for further growth and development of not only the individual person and immediate family but for the whole community. The question that needs to be asked is: "Is the person malformed or formed differently?"

This then leads one into possibility thinking. If one is formed differently then the process becomes centered on finding purpose for those differences and how those differences can be shared in order to create community.

For example: A rehabilitation worker was given a case of an eighteen year old woman with cerebral palsy (anthetoid). The person has already gone through a vocational assessment which resulted in a job as a clerk-typist in a personnel office at the local hospital. The assessment itself focused on motor skills and the ability to adapt to the office routine. The person was assessed as intelligent, prompt, patient, and friendly, all of the requirements needed to adapt to the workforce as a clerk-typist. However, the assessment's end-in-view did not reflect the desires or ends-in-view of the client. The client was interested in learning and working with people creatively. Utilizing her skills in thinking, writing, and analysing, it was a waste of energy in her framework to try to adapt to office routine and not be able to use her capacities to the fullest in a meaningful way. (Meaningful way--is a phrase that is inherently personal and community building at the same time.)

After ten months of employment where it was realized her capacities as clerk-typist would never be competitively useful the person was demanding a reassessment so that she could continue her education and career plans. (This would indicate the person was working in the third relational framework).

During the first interview the practitioner asked:

"What would you like to do and how do you see us getting there?"

This one question elicited a relationship of building a partnership in the work to be done with shared responsibility.

Through further discussion the problem was viewed not as inherent in the person or the system, but the intermeshing of both. In order to utilize the useful services (for personal and community development) of the VRS system the assessment procedure had to indicate that through further education there would be greater employment opportunities that would best utilize the person's capacities for the good of the community and self.

Thus we may see where the major incongruency occurs. Most, if not all of our ideal principles for direct practice reflects our concern for individual and community development. However, our policies, our service delivery systems, the way we perceive them reflect a concern for fit and adaptation, rather than development and growth of the person and the valued membership in his/her community.

Our policies reflect a relational framework of custodial or adaptive relationships, but not a creative relationship based on truth, trust, and justice.

We may need to view policy practice as another more inclusive way of direct intervention, and of relationship building. With any relationship that is valued the purposes of the relationship need to be explored and the underlying stance need to be examined.

The future of the rehabilitation field is a kaleidoscope of change and possibilities.

CONCLUSIONS

This thesis examined some of the underlying assumptions--stances and ends-in-view in the rehabilitation field. Through the historical analysis it was found that the Canadian policies since the '40's have been influenced by a stance focused on productivity, custody, training, worth, and rehabilitation. The British Beveridge Report on the other hand seems to put emphasis on responsibility, education, value and habilitation. It has been noted that there is a need for both stance clusters in our policies affecting the rehabilitation field. It has been noted that the end-in-view of full employment was not being met and therefore there has been a growing awareness of incongruencies in the field.

It has also been noted that there are three relational frameworks that will influence our perception of ends-in-view.

It has been noted that the implications for ones perspective on practice will be influenced by which stance and clusters of underlying assumptions is emphasized.

This thesis is an exploration and illumination process, not a process of verification.

It is hoped that the illumination of underlying assumptions and an understanding of the multi-ended

ends-in-view will give a basis of ordering methods and procedures of intervention in the rehabilitation field.

Although this paper did not begin the difficult process of ordering methods and process it did reflect a pattern of perspectives that will lead into an ordering of methods and practice experiences in the future.

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APPENDIX A

The original aims of the Society for Crippled Children of Manitoba were as follows:

1. No crippled child in Manitoba shall suffer through the inability or refusal of the parent to pay for adequate care.
2. All necessary services, personnel, and equipment to meet all the special needs which arise out of crippling conditions in children shall be available.
3. The public shall be educated on the problems, care, and prevention of crippling conditions.
4. Research shall take place on the problems, care, and prevention of crippling conditions.
5. All activities on behalf of crippled children may be co-ordinated and co-operative so that working relations may exist between all groups and persons concerned.

The first objective of the Society relating the initial concerns prevention at that time included:

1. Appointment of a medical team of pediatricians, psychiatrists, orthopedic surgeon and neurologists.
2. Appointment of a social worker to act as a co-ordinator.
3. Provision of brace-making facilities.
4. Make petitions to educational facilities for further professional personnel--such as physiotherapists.

5. Expansion of Cerebral Palsy nursery at Winnipeg Children's Hospital.
6. Increased educational facilities for the children.