

Comparatively little systematic work has been carried out in the United Kingdom to establish the total numbers of handicapped children of different kinds, and to establish their family and social situations and needs. Although the poverty survey was insufficient in scale to discover large numbers and allow a full picture to be given, it does, in certain respects, provide a more accurate estimate of numbers and proportion in the population and a preliminary account, for different types of handicap, of standards of life and circumstances.

The government's survey of the handicapped in 1968-9 excluded children under the age of 16. There are at least three independent sources of information.¹ First, the Department of Health estimates the number cautiously at 150,000,² and Table 21.1 gives the numbers of handicapped on local-authority registers and receiving certain types of service. But there are a number of deficiencies in these statistics. Some children are counted twice - for example, some of those in the care of local-authority mental-health services and those awaiting admission to special schools. A few small groups of physically handicapped and chronic sick children in ordinary schools and in hospitals are not separately identified. And there are wide variations in the numbers registered in different regions and areas. These variations have been shown by research and special administrative measures to be due more to laxity of administration in registering children than to variations in prevalence. Many handicapped children are not known to any service. More strenuous efforts have been made in Scotland than in England to locate the handicapped, and though the Scottish Home and Health Department admitted in 1973 that there was still some way to go, far more physically handicapped children have been registered there than in England although the latter had nearly ten times the population. According to Scottish experience there should be 80,000 to 100,000 handicapped children,

¹ There have been a series of studies of illness and handicap among children in Britain, but these have not attempted to measure the duration and degree of handicap of different types of condition. See, for example, Spence, J., *et al.*, *A Thousand Families in Newcastle-upon-Tyne*, Oxford University Press, 1954, and Miller, F. J. W., *et al.*, *Growing Up in Newcastle-upon-Tyne*, Oxford University Press, 1960.

² Report of the Committee on Local Authority and Allied Personal Social Services (The Seebohm Report), Cmnd 3703, HMSO, London, 1968.

excluding children who are mentally handicapped, deaf, blind or partially sighted, on the English local registers. In 1971 there were fewer than 6,000.¹ Even if the Department of Health and Social Security total is revised conservatively on the basis of that experience, the numbers of handicapped children must be considerably in excess of 200,000.

Table 21.1. *Numbers of handicapped children in the United Kingdom estimated from official sources.*^a

Number of mentally handicapped children in hospital	7,100
Registered blind	2,300
Registered partially sighted	3,300
Registered deaf and partially deaf	6,300
Handicapped (general classes) on local authority registers	15,700
Number physically handicapped and delicate children in special schools	19,500
Number of educationally subnormal children in special schools	59,000
Additional number attending special schools, formerly training centres	21,400
Number educationally subnormal children awaiting admission to special schools, and those receiving education in their own homes	10,400 ^b
Numbers in care of local-authority mental-health services	31,300

NOTES: ^aEstimates have in some instances been made in proportion to the population of children, for Northern Ireland and also Wales.

^bEngland and Wales only.

SOURCES: *Census of Mentally Handicapped Patients in Hospital in England and Wales at the end of 1970*, HMSO, London, 1972; *Digest of Health Statistics 1970*, HMSO, London, 1971; DHSS, Annual Report for 1971, HMSO, London, 1972; *Health of the School Child 1966-68*, HMSO, London, 1969.

Secondly, the National Children's Bureau found in a survey of 7-year-olds that 2.6 per cent were congenitally handicapped and another 1.6 per cent had been injured after accidents, had progressively disabling illnesses, were severely or partially deaf or were otherwise in need of special educational treatment.² If these two percentages are applied to children of all ages, a total in the United Kingdom of more than 500,000 children is reached. However, some will be only slightly handicapped, for the National Child Development Study, as the bureau's follow-up survey is called, includes medical examinations but does not establish functional effects.

Thirdly, a major survey in 1964 and 1965 of the education, health and behaviour of 9- to 12-year-old children living in the Isle of Wight, undertaken with extensive cooperation of the medical and local authorities, offers an alternative source of

¹ DHSS, *Annual Report for 1971*, HMSO, London, 1972, p. 240.

² Davie, R., *et al*, *From Birth to Seven*, Longmans, Green, London, 1972.

estimation. Among the total population on that island of children aged 10-12, 5.7 per cent were identified as having physical disorders, including (in order of prevalence) asthma (2.3 per cent); eczema (1.0 per cent); epilepsy (0.6 per cent); cerebral palsy (0.5 per cent); other brain disorders (0.4 per cent); orthopaedic conditions (0.3 per cent); heart disease (0.2 per cent); severe deafness (0.2 per cent); diabetes (0.1 per cent); neuromuscular disorders (0.1 per cent); and miscellaneous disorders (0.4 per cent).¹ However, some of these, especially with transient asthmatic attacks, had no difficulty with everyday activities. The authors classified the children according to severity of handicap : after allowances are made for incomplete information, it seems that 1.1 per cent were moderately, severely or extremely handicapped, in the sense that they had difficulty or discomfort or restriction or inability to perform ordinary activities, or needed substantial regular help with dressing, washing, bathing or feeding, or needed help with all or nearly all ordinary activities; a further 2.2 per cent were slightly handicapped, in the sense that while they had no difficulty with everyday activities, they did have difficulty or discomfort or restriction in performing any strenuous activities, or had a limp or wore surgical shoes or other aids, or had dietary restrictions; and finally, 2.4 per cent who had a chronic condition but, except for transient episodes, no limitation of daily or even strenuous activities.² These proportions apply, of course, only to children aged 10-12, and children living on the Isle of Wight. If they are applied to all children aged under 16 in the United Kingdom, they would produce population totals of 157,000, 314,000 and 343,000 in the three categories respectively.

This evidence leads to the conclusion that there must be at least 400,000 children in the United Kingdom whose activities are restricted because of handicap, 150,000 of them substantially or seriously.³ But, by the nature of the evidence, this conclusion must be imprecise, and there is an obvious need for more comprehensive work which identifies the incapacitating effect of the different types of handicap, and goes on to show what financial and social needs arise as a consequence.

Different Forms of Handicap

There were 1,543 persons, or 25 per cent, in the present sample who were aged under 15. A variety of questions sought to show how many had any trouble from ill-health, injury or disablement and, in particular, how many had a marked handicap.

¹ Rutter, M., Tizard, J., and Whitmore, K., *Education, Health and Behaviour*, Longman, Green, London, 1970, pp. 285-96.

² In *ibid.*, chronic handicap is defined a little inconsistently (compare, for example, the emphasis on pp. 275-8 on conditions lasting twelve months with the emphasis on p. 288 on inability to undertake ordinary or strenuous activities). The totals allocated to degrees of handicap in Table 18.3 (p. 289) were aggregated and adjusted in terms of information on p. 286 about children with asthma and eczema. See *ibid.*, pp. 288-91.

³ A review of previous evidence will also be found in Bradshaw, J., *The Financial Needs of Disabled Children*, Disability Alliance, London, 1975, pp. 2-5.

Table 21.2 lists the percentages and estimated numbers in the population with a disablement condition who were handicapped in various other senses.

Over 5 per cent, representing 780,000 in the total population, had a disablement condition giving trouble. Over a third had trouble with chest or lungs, several of whom had asthma, and about a quarter had trouble with speech, hearing or eyesight. About a tenth were specifically said to have a mental handicap other than nerves, the equivalent rate in fact being 5 per 1,000 for all children under 15, in fact slightly higher for children under 10 and slightly lower for children aged 10-14. Others had a range of different conditions, including spinal trouble, trouble with joints, diabetes and mental illness. Three children suffered from a kidney disorder, including one with four kidneys.

The numbers in the sample with differing disabling conditions correspond closely with estimates derived from other sources. For example, the rate per 1,000 produced by children found to be having trouble with chest or lungs is 22, and the corresponding rate for children aged 5-15 with asthma, published in the Seeborn Report, was 23,¹ and for children aged 7 in the National Child Development Study was 27.² The rate per 1,000 for the mentally handicapped was 6, compared with rates for the 'severely subnormal' of 3.5 and 2.7 respectively.³

The parents of the children were also asked one or more questions to check whether the condition had a restricting effect on activity (see also pages 688-91 above). When they answered positively, this was counted as confirming the existence of a disablement condition. This procedure gives a *minimum* estimate of those in fact having a disablement condition which has a marked or specific restriction on activity. Had there been time to ask further questions, other forms of restriction on activity might have been established. Altogether, 2 per cent of children were so identified, representing 265,000 in the total population. Here, as elsewhere in this chapter, the small numbers on which our estimates are based are subject to considerable sampling errors. We have chosen to put forward the estimates, however, on two grounds: first, that the sample has been shown to correspond very closely in its structure to the structure of the population, as demonstrable from the census and other sources; and secondly, that there is a lack of reliable information about handicapped children.

Questions about incapacity were asked of children aged 10-14 but not of younger children. An entirely different set of questions would have been required for very young children, and we were aware that the questions that were used for active older

¹ Packman, J., and Power, M., 'Children in Need and the Help they Receive', Appendix Q in the Report of the Committee on Local Authorities and Allied Personal Social Services, HMSO, London, 1968.

² Younghusband, E., *et al.* (eds.), *Living with Handicap*, National Children's Bureau, London, 1970, p. 82.

³ *ibid.*

Table 21.2. Percentages and estimated number of children aged under 15 who had different forms of handicap.

<i>Characteristic</i>	<i>%</i>	<i>Estimated number in non-institutionalized population (000s)</i>
1. Health said by parent to be poor for age	1.1	155
2. (a) Having trouble with a disablement condition	5.4	780
(b) Having a disablement condition with marked or specific restriction of activity	1.8	265
3. Ill off school and/or at home or in bed for 10 weeks or more	0.2	30
4. (a) Normally confined to bed	0.2	35
(b) Not confined to bed but cannot walk unaided	0.2	35
5. (a) Attending training centre	0.2	35
(b) Attending special school	0.3	65
6. (a) <i>Of those aged 10-14</i> slight incapacity	0.6	25
some incapacity	0.9	35
appreciable or severe	1.3	55

NOTE: The figures are subject to considerable sampling errors and are put forward for reasons given in the text.

children and adults would have had to be modified for children aged, say, 7-9. Otherwise incapacity might merely have been equated with immaturity. But the problem is deeper even than this, because children do not all develop at the same pace in conformity with their chronological age.¹ Previous research on handicap among young children shows how difficult it is to assume that differences among children can be measured simply by varying sets of questions to children according to their chronological age. Slow development can be mistaken for incapacity and vice versa, as parents of mentally handicapped children have found.² In principle, measures for the very young (and perhaps very old) either have to be related to modal behaviour at that age or to standard adult activity. Agreed research procedures which apply functional criteria to young children are likely to be important explanatory tools and also devices for the allocation in policy of services and other benefits.

¹ Further research between 1974 and 1976 financed by the DHSS, on functional assessment scales, including research on children, was undertaken by Alan Walker at the University of Essex.

² Jaehnig, W., *Mentally Handicapped Children and Their Families*, unpublished Ph.D. thesis, University of Essex, 1974.

Among children aged 10-14, relatively few were found to have incapacity: 0.6 per cent slight (representing 25,000), 0.9 per cent some incapacity (35,000) and 1.3 per cent appreciable or severe incapacity (55,000).

Parents were reluctant to say that the health of their children was generally poor for their age, and only just over 1 per cent did so. These included a disproportionately high number of children with disabling conditions, but not all. Again, the combined numbers of children found to be attending special schools and training centres, of just under 100,000 compared fairly closely with annual totals produced by central and local departments.¹

In order to examine standards of living of households in which there was a handicapped child, we employed strict criteria of handicap. We included the *immobile*, those who were normally confined to bed or to the house or off school for at least ten weeks; the long-term ill, those confined to bed or to the house or off school for at least ten weeks; those with a *marked disablement condition* (epilepsy, mental handicap, deafness, blindness, etc.); those *attending a special school, training centre, day or occupational centre, outpatients' department, etc.*, for reason of long-term illness or handicap. No child was counted as having a disablement condition without also being said to suffer some specific impairment of function (i.e. becoming breathless; having fits of coughing; or having difficulty in moving freely or in moving hands, hearing ordinary conversation; joining in ordinary conversation outside the family; reading ordinary print, even with glasses) or, in the case of a psychiatric condition, being known to be receiving treatment by a doctor or believed to require such treatment.

Poverty among Handicapped Children

Twenty-eight children were so identified, living in twenty-six households comprising a total of eighty-three people in the total sample of 6,098. The numbers are small, and for this reason any comparison between their distribution among different income groups and that of the rest of the population must be regarded as provisional only. However, if twenty-eight children found to be handicapped among 1,500 is representative, then there are 250,000 in the United Kingdom. The proportion in any particular income group is, of course, subject to substantial sampling error. But, for the reasons given above (page 743), we believe it right to put forward the figures. Table 21.3 suggests that substantially more people in such households are in poverty, and fewer have relatively high incomes. About half in the sample were in, or on the margins of, poverty by the supplementary benefit standard. Nearly a third were in poverty by the deprivation standard.

A supplementary measure was of incapacity among children aged 10-14. Nearly twice as many children living in income units in which at least one of the children

¹ For example, 19,955 children were in junior training centres in 1968 and 57,000 day pupils in special schools, in England and Wales. Department of Education and Science, *Statistics of Education, 1968*, vol. 1, HMSO, London, 1969.

Table 21.3. Percentages of people in households with a handicapped child, other people, and all children, who are in poverty.

%	<i>Net disposable income last year As % of supplementary benefits scale plus housing cost</i>			<i>As % deprivation standard of poverty</i>			
	<i>People in households with handicapped child</i>	<i>People in other households</i>	<i>All children with</i>	<i>People in households handicapped child</i>	<i>People in other</i>	<i>All children</i>	
Under 100	25	6	7	} 55	23	29	
100-39	25	22	27		36	57	57
140-99	25	29	40				
200+	24	43	26		100	100	100
Total	100	100	100	100	100	100	
Number	83	5,076	1,332	5,063	1,263	1,355	

had a score on the incapacity index of 1 or more as other children were in or on the margins of poverty (Table A.87, Appendix Eight, page 1059). But their numbers in the sample were small.

Over three quarters of the families were working class, dividing equally between parents with skilled manual and those with partly skilled manual and unskilled manual jobs, thus suggesting the likelihood of a higher proportion in these less numerous classes. Three of the families were professional or managerial, and the remainder other non-manual classes.

The children belonged to a range of different types of families: nine in households with parents and one, two or three children, five in households with parents and four or more children, twelve in households with three adults and children, and the remainder in other types of household.

Illustrations of Families with a Handicapped Child

1. Tom

Tom, 11, lives with his mother and father, in their late thirties, and three younger brothers of 8, 2 and 1, in a four-roomed flat above an unoccupied shop in a northern city (rent £2.50). There is no garden. He has asthma and a hole in the heart and he cannot run about or climb stairs without becoming breathless. He attends a special school. Two of his brothers also have chest troubles. The family live in poverty, having an income less than 90 per cent of the supplementary benefit standard. Their

income consists of £10 sickness benefit plus £2.90 family allowances. They were not receiving supplementary benefit. They had no assets, and although the home was very clean, there was little furniture. They had only one of the durables (a television set) on our list. The flat was structurally damp and they felt overcrowded. Tom's father has not worked for two years and was previously a clothing cutter. He has had a series of stomach operations and had part of his stomach removed. He has spent a period of twenty-six days in hospital this year and has spasms of acute pain. He has applied to go on a government resettlement course, but will not be accepted until declared fit. His wife has anaemia and finds the demands of sick husband and children a strain. Until the birth of her two youngest children, she had worked as an auxiliary nurse. The family have not had a holiday and had not had an evening out lately, though the mother and two of the children go regularly to a Catholic church. Rarely do they eat fresh meat, except for the two older children who have free meals at school. At the time of interview (January), husband and wife were going to bed early to save fuel 'for next day when the children would be up'. She said her husband gave her the entire £10. 'He scarcely spends any money on himself - five shillings a week. Newspapers, that's all.' They felt poor 'all the time. We haven't two pennies to rub together.'

2. Gillian

Gillian, aged 13, had acute rheumatic fever three years earlier and has to be watched carefully. She is delicate, had had twenty-eight days' illness in bed in the previous twelve months, and is in frequent regular contact with the G P. She has difficulty in performing everyday activities such as washing, bending down, stretching, going up and down stairs and running. Her parents are in their mid forties and also have an older son of 16, who is at a Government Training Centre, and two younger daughters. The father works for the Electricity Board as a patrolman and earned £11.95 after deductions the previous week. The house is terraced in a village in Scotland, and has no WC indoors. Both husband and wife's parents live locally and see the family daily. Even allowing for the 16-year-old's low earnings (after expenses), the family's income is on the margins of the state poverty line.

3. Vivien

Vivien is 4, the youngest of a young family consisting of husband and wife and five children all under 10. They live on the margins of the state poverty line on a wage of £15 in a council house in Norwich. Vivien is mentally handicapped and has a speech defect. She has been given a place in an ordinary nursery class because she is backward. Vivien had been to see a doctor at the hospital twelve times in the year prior to interview, and had been visited once by the children's officer in the same

period. She had not been on holiday or away from home in the past twelve months, although the family does go on picnics sometimes.

4. Ann

There are two daughters aged 8 and 6, the eldest of whom, Ann, has been in bed for sixteen weeks after an operation to her back and is encased in plaster, except for her head and legs. Ann suffers from spina bifida, and her hearing and speech are impaired. She normally attends a special school. Her parents, 34 and 32, were among the most prosperous parents with a handicapped child in the survey. They own a semi-detached house worth £3,500 in Gloucestershire, with all amenities except central heating, and had spent £400 improving it in the last twelve months. The father is an electrician and his wife a nurse working two nights a week at a mental hospital. His take-home pay in the previous week was £17 (for a short week), but he normally earns about £25 a week. His wife earns about £33 a month. They have a car and are paying a substantial sum for furniture in hire purchase. Except for her night work at hospital, when her husband can, of course, look after their daughter, the wife does not go out and their social life is severely restricted.

5. Michael

Michael, 10, lives in a semi-detached council house with a small garden, in a Midlands city, with his parents in their forties and five older brothers and sisters. He has a weak heart and also a chest complaint and spent twenty-one days in hospital this year. He is taken to an out-patients' department for a check every few months, and has difficulty in joining in ordinary activities, including climbing stairs and running. He attends a special school. His father is a Post Office sorter, earning a low wage, but three of the older children are at work and contribute to household expenses. The chief problem is that the mother is frequently ill, has St Vitus's Dance, migraine, arthritis and is mentally unstable. She sleeps badly and says she weeps from depression all the time. She has been in mental hospital for a fortnight this year, has also had twenty-four days altogether ill in bed and attends an out-patients' department regularly for treatment.

6. Tony

Tony is 10. He lives with his mother and father, older sister and grandfather. His father, a maintenance worker with a water-softener firm, has take-home earnings of about £17. They had moved as owner-occupiers into a six-roomed detached house in mid Wales only six weeks previously, and extensive repairs remain to be undertaken. Tony has a spinal disablement, such that he has difficulty in moving

freely and using his hands. He also has kidney trouble for which he needs to have frequent injections, and to see the doctor regularly. He experiences difficulty in, for example, reaching overhead and bending down, say, to cut his toenails. Also he finds it impossible to run anywhere and to carry a light load in each hand. He attends the local state primary school, but comes home to dinners because his mother prefers it. He had spent six nights in hospital in the year prior to the interview, visited the hospital doctor three times, and been to his own doctor's surgery seven times. Although he had not been away from home in the past twelve months, or out in the evening in the past two weeks, Tony has friends in to play and there is a garden.

7. Jenny

Jenny, 12, has a condition affecting her joints and cannot move freely. She cannot carry a shopping basket or run to catch a bus, and has difficulty climbing stairs, washing down and engaging in other activities. Her brother of 11 is mentally backward and attends a special school. Their parents are in their forties and have a third child, a daughter of 4. In addition to the two handicapped children, the mother has the care of her father, 76, who is severely incapacitated with arteriosclerosis. The family occupies a modern five-roomed council house with a substantial garden (Bristol), and the father has net earnings of about £20 a week as a sales representative.

8. Joan

Joan is 13 and has a brother of 15 and a twin sister. Her father is a shop assistant earning about £13 a week, and her mother has cleaning work in a factory for £6 a week. The family lives in a self-contained flat in London on the second floor of a large council block (there is a lift). Joan has four kidneys; consequently she is a delicate child and frequently ill. Because of her condition she must regularly attend hospital for check-ups, and had spent ten days there during the twelve months prior to interview. She had also spent a total of fifty-six days at home in bed due to illness, being visited by the doctor each day. She had been to the doctor's surgery a further twelve times. Joan had been dancing with her sister in the previous fortnight and had a friend at home to play.

9. Mary

Mary, 12, has attended a boarding school for the mentally handicapped since she was five. She sees her parents and older brother of 15 at home during school holidays. Her father is a miner, working underground for about £18.50 a week. Her mother is a canteen assistant, earning £10 a week, and her brother is a shop assistant,

earning £5. According to her father, Mary has some sort of muscular disease, but he does not know what it is. Mary is severely handicapped because she is completely unable to reach overhead, tie a knot, cut her toenails or carry light loads, and finds it hard to wash herself and go up and down stairs.

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In the four area samples surveyed in Belfast, Neath, Glasgow and Salford, there were twenty-nine households in which there was a handicapped child (following the same definition as that given above). Five of these had a net disposable income in the previous year of below the state's poverty standard, and another eleven of less than 40 per cent above that standard - amounting to more than half the families altogether. Only two of these families had an income of more than twice the poverty standard.

Summary and Conclusion

The data obtained in the poverty survey about handicapped children were limited but, first, help to confirm that the number of handicapped children is much larger than is officially estimated, and secondly, suggest that disproportionately large numbers of the families affected are in, or on the margins of, poverty - whether defined according to the deprivation standard or whether by the state.

The chapter also suggests how urgent it is to obtain *comprehensive* evidence about all children, on a national basis. It must be comprehensive in the sense that it is restricted neither to a particular cohort nor to particular types of disability, must identify *degrees* of incapacity and changes in degree over time, and must show the various family and social problems to which handicap give rise. Little is known about numbers with different degrees of handicap. Some children may be only mildly handicapped and require little more parental supervision and care than children who are not handicapped. Others place severe psychological, physical and financial demands on their parents. Some need special aids, frequent replacements of shoes and clothing, a special diet, a specially designed home environment, or regular subsidies for transport.¹

One reason why a comprehensive approach is urgent is that the pattern of handicap is changing and therefore shaping the need for a new grouping of treatments and services in adulthood as well as childhood. During the past fifty years, cerebral palsy and spina bifida have begun to replace poliomyelitis and heart disease as principal causes of handicap. The change is, of course, based largely on the development of new drugs and methods of surgery, but also on the acceptance by

¹ These have been discussed more fully in Bradshaw, *Financial Needs of Disabled Children*, pp. 5-7. Also see Baldwin, S., 'The Financial Problems of Families with Handicapped Children: An Evaluation of the Attendance Allowance', Family Fund Project Paper, November 1974; and Baldwin S., *Disabled Children - Counting the Costs*, Disability Alliance, London, 1977.

more of the medical profession and of the public of malformation, at least among children. The numbers of handicapped children who survive the critical weeks after birth is likely to increase.

A working party on children with special needs, under the chairmanship of Dame Eileen Younghusband, concluded:

Overall national planning of services and provision for handicapped children - and adults - is at the present time conspicuous by its absence ... There is an urgent need for effective machinery for co-ordinated appraisal, clarification of priorities and policy determination in relation to the total well-being of handicapped children.¹

Another reason why a comprehensive approach is urgent is that while such an approach to a maternity service has been achieved within the National Health Service, nothing comparable has yet been devised for children. This will involve new forms of organization and training for doctors² and unification of educational and community services for children. There have been a number of recent studies and pressures questioning the policy of placing many handicapped children in special schools.³ There is illustrative evidence that the educational content of that experience is sometimes neglected⁴ and its emotional and social content limited.⁵ The transfer of junior training centres for mentally handicapped children to education authorities makes acute the balance of choice between ordinary and special school. And the fragmented and inadequate methods of registering handicapped children implies the need for the new social service departments of local councils to replan the services they can provide for families.

Some progress has been made in outlining successive stages of child development in statistical terms, but attempts to understand handicap must be based in large measure on estimates of incapacity at successive ages. Prediction of handicap is very restricted, especially for mental handicap.⁶ The most remarkable discovery from the many longitudinal studies of children now completed is the variability in the pattern of individual development. Some children develop at a steady rate, others show large fluctuations from year to year.⁷ The course taken in handicap needs to be

¹ Younghusband, E., *et al.* (eds.), *Living with Handicap*, National Children's Bureau, London, 1970, p.23.

² Chamberlain, R. N., 'Children in the Integrated National Health Service', *Lancet*, 4 November 1972.

³ For example, Eckstein, H. B., and Macnab, G. H., *Lancet*, (i) 1966, p. 842; and 'The Handicapped Child at School', editorial note in *Lancet*, 11 March 1967.

⁴ See Rawlings, H. E., 'The Handicapped Child at School', *Lancet*, 15 April 1967.

⁵ Hunt, P. (ed.), *Stigma*, Chapman, London, 1966.

⁶ See, for example, Yarrow, L., in Glass, D. C. (ed.), *Environmental Influences*, New York, 1968.

⁷ See the review of 'Influences in Child Development', *Lancet*, 4 November 1972.

traced and can be classified as static non-adaptable, static adaptable, degenerative, regenerative or intermittent. If the relative importance of these types of handicap are to be elucidated, base-lines have to be established from some kind of cross-sectional study at a preliminary stage of research.

Some major disabilities are not in practice identified in early infancy and only come to light, or develop, much later. Muscular dystrophy, for example, may not become apparent until a child begins to walk, and severe mental handicap may not be diagnosed among children under 5, or even under 10. The reported incidence is only 0.5 per 1,000 under 5 years of age, compared with 3.5 per 1,000 at 15-19. As the Tunbridge Committee stated in a recent report on *Rehabilitation*: 'Disability in children is rarely easy to analyse in the early years. The early identification of disability is best achieved by a periodic developmental assessment for all children.'¹

Finally, a comprehensive approach is required if the different financial needs of families are to be properly compared and explained, and a government policy to be formulated to meet those needs and remedy the situation found in this survey. In 1972, public interest was aroused on behalf of 400 Thalidomide children and pressure put on the Distiller's Company to provide adequate compensation. The government also announced the allocation of £3 million in the first instance, to be administered by the Joseph Rowntree Memorial Trust on behalf of severely congenitally disabled children, including the Thalidomide children. But the latter comprise only about 1 in 1,000 handicapped children, and the group which the government was indirectly helping with limited grants was also only a small minority.² Moreover, the attendance allowance which had been introduced in 1970 had by 1973 been taken up by only 2,000 of the parents with severely handicapped children, and parents of infants under the age of 2 are not eligible. Any attempt to consider all handicapped children must imply a more rational approach to a state system of allowances, and one with a better-ordered sense of priorities. Such a system will need to include a principal system of maintenance allowances, perhaps on the model of family allowances, though related as a percentage of a maximum allowance according to degree of incapacity, supplemented by different grades of attendance allowance (there are four rates of attendance allowance in the war pension scheme), special allowances for the expenses of extra clothing, transport and services, and a more equitable system of compensation (following the report of the Pearson Commission).

¹ DHSS, Central Health Services Council, *Rehabilitation*, Report of a Sub-committee of the Standing Medical Advisory Committee, HMSO, London, 1972, p. 55.

² In October 1974, a further allocation of £3 million was made. By 1975, about £4 million had been distributed to 17,000 families as lump-sum grants for items ranging from adaptations and cars to clothing grants.