SPECIAL REPORT

on

REHABILITATION OF HANDICAPPED PERSONS

in

SASKATCHEWAN

Prepared by

the

Provincial Co-ordinator of Rehabilitation of Disabled Persons

for Presentation to

ADVISORY PLANNING COMMITTEE ON MEDICAL CARE

July, 1960

1. THE REHABILITATION CONCEPT

The most typical concept of a rehabilitation service is the specialized centre, for example, the Physical Restoration Centre in Regina. The essential ingredient is a staff--a concentration of personnel and equipment that constitutes the "rehabilitation team". The members of the "team" vary, but usually involve some or all of the following:

1. Family doctor
2. Physical medicine specialist (physiatrist)
3. Nurse (or rehabilitation nurse)
4. Gerontologist
5. Clinical psychologist
6. Occupational, Physical, and Speech Therapists
7. Social Worker and/or Rehabilitation Officer
8. Regular or Special Education Teacher
9. Placement Officer

An additional component is special equipment designed for, or adapted to meet, the peculiar needs of each case.

However, the rehabilitation process is not limited to specialized centres or programs, but involve other community resources, such as the general hospital, the school, the special treatment hospitals (mental and tuberculosis), and other welfare and health services. For example, hospitalized accident, cardiovascular, orthopedic, and rheumatic cases require (in addition to the medical and nursing care that the hospital renders) physical and occupational therapy and frequently psychological and social casework. Similarly, the mentally ill cases need social and vocational guidance and support before and after discharge from psychiatric care, necessitating rehabilitation staff both in the treatment institution and in the community.

(a) Definition of Rehabilitation

Ideally, it can be argued that for any disability, injury, or illness that occurs, restoration of every person towards optimum function is desirable. The rehabilitation process cannot, therefore, be divorced from the regular health, welfare, and educational services of the community, since it plays a role in the recovery of the person during the primary and secondary stages of the illness or injury.

For practical purposes, it becomes necessary to consider the rehabilitation process in a more narrowly defined way, recognizing such realistic limits as finances, facilities, personnel supply, public demand and potential recovery of the individual in relation to the effort expended.

Consequently, the term "rehabilitation" as used herein is understood to mean the judicious use of professional skills and community resources to help handicapped people achieve the optimum function of which they are capable. It may also include assistance to the handicapped in achieving adjustment to disability. In general, a functional goal would seem to be the restoration of handicapped persons to a level adequate for them to maintain their place in society with minimal dependence on others.

Early application of the skills and resources used in the rehabilitation process not only augments recovery, but may prevent development of deformity. (This is applicable to acute and chronic disease conditions and with the aged.) The aim of rehabilitation is not only improvement in physical condition, but also realization of optimum social, educational, psychological, and vocational independence for those handicapped who are potentially capable of such independence.

(b) Who Needs Rehabilitation?

The disability of an individual may be physical or mental. The cause may be injury, accident, or a consequence of disease. There are several categories of conditions requiring rehabilitation. These include:

1. Those persons with residual, physical impairment for whom a relatively complete program is necessary.

   (a) Disabling arthritis
   (b) Accidents and burns causing disfigurement and permanent injury
   (c) Amputation (major)
   (d) Cerebral palsy
   (e) Poliomyelitis
   (f) Miscellaneous orthopaedic deformities
   (g) Blindness
   (h) Cerebrovascular disease (strokes)
   (i) Visual impairments
   (j) Auditory impairments
   (k) Speech disorders
   (l) Heart disease

2. Those persons or groups who suffer from conditions not primarily physical, and for whom specialized care is already available, but whose development towards desirable independence would be augmented by providing an element of rehabilitation. These include:

(a) Persons with alcholic conditions
(b) (Certain) mentally ill or post-treatment cases
(c) Mentally retarded
(d) Persons subject to epileptic attacks

3. Those persons whose condition causes disablement, but for whom early application of rehabilitation methods can often prevent the development of deformity or deterioration of function due to contractures, etc. These include:

(a) Arthritis
(b) Visual impairments
(c) Cerebrovascular disease
(d) Chronic illness and premature, physical deterioration of the aged

(c) The Importance of Rehabilitation

Rehabilitation has received almost universal public recognition and support, as indicated by the number of organizations and departments involved in rehabilitation programs. Such development is attributed to the following:

1. There is unequivocal evidence of the effectiveness of rehabilitation services in preventing disablement, restoring physical function, and teaching substitute methods to compensate for irrecoverable functional loss.

2. Restoration of the individual to full or partial independence saves money for society. The individual becomes an economic asset rather than a drain on resources.

3. There is a growing recognition that adequate health and welfare services must include a comprehensive rehabilitation service for the handicapped.

4. Society has accepted moral responsibility to help the handicapped achieve their potential for normal living.

A complete range of services is, in a sense, a minimum requirement. For instance, the benefits of existing medical and psychiatric restorative services are diminished or dissipated without the complementary support (psychological, social, educational, and vocational) required by the disabled to achieve maximum independence. Successful treatment of persons suffering from psychosis, for example, is of questionable value without sufficient skilled social and vocational staff to rehabilitate the patient into the community. Similar arguments apply to physical disablement; the benefits of good medical care may not be fully realized (and may even be negated) without the appropriate application of a range of auxiliary services.

2. PRESENT PROGRAM OF REHABILITATION IN SASKATCHEWAN

(a) Organizations concerned with Rehabilitation

A list of Saskatchewan organizations concerned with rehabilitation is contained in Appendix 1.

(b) Services Available

Unlike the traditional pattern of predominately voluntary agency leadership in the development of many health and welfare services, rehabilitation has been pioneered jointly under governmental and non-governmental sponsorship.

Rehabilitation programs within the Province emerged under the stimulus of private agencies and provincial and federal departments of government. Development has been sporadic, often conflicting and unco-ordinated. Most programs currently suffer from serious gaps which, at times, prevent full utilization of existing facilities. Although the adequacy of services varies greatly with areas, a certain provincial organizational pattern has evolved, providing both a generalized service within the existing resources in the province, and a specialized service, located at strategic points; for example, certain rehabilitation personnel may be attached to community health and welfare services, while certain others are concentrated in separate facilities such as the rehabilitation centres.

Specifically, these services are provided at three levels--local, regional, and central:

(a) Local Community Level:

Apart from the family doctor, the public health nurse, the Social Welfare representative, there are no formal rehabilitation resources in the local communities in the province. Exceptions are non-regional hospitals in Rosetown and Shaunavon (and part-time in Wilkie) which have physical therapy and in a few communities which are visited by travelling Canadian Arthritis and Rheumatism Society physiotherapists. Most cases requiring special attention are referred to the regional programs.

(b) Regional Services

The following rehabilitation resources are currently available on the regional level:

i. Casefinding, diagnosis, limited treatment, and social casework for crippled children and adults is attempted through mobile clinics in ten regional points sponsored by the Saskatchewan Council for Crippled Children and Adults, and the Department of Public Health. The Canadian Arthritis and Rheumatism Society operates a similar, but more limited, service for arthritics.

Hospitals in North Battleford (2), Prince Albert (1), Moose Jaw (3), Yorkton (1), Estevan (1), Swift Current (2), and Lloydminster (1) have physical therapy staff,

(the number being indicated in parentheses). A visiting Physical Medicine Specialist (Physiatrist) services the North Battleford hospitals as consultant. Moose Jaw Hospital employs a medical social worker.

ii. Special schools for the severely mentally retarded are located in Saskatoon (John Dolan School) and Regina (Harrow DeGroot School). These are primarily special educational institutions (but aim in the future to extend their work into vocational activities such as vocational training and sheltered work). Opportunity classes for the less severely involved (slow learners) are part of the regular, public school system and not considered in the report. Special classrooms for the severely mentally retarded are located in Moose Jaw, North Battleford, Yorkton, Prince Albert, Melfort and Moose Jaw. Classes for crippled children are located in Saskatoon, Regina, and Prince Albert, (including classes operated by the Regina (4) and Saskatoon (2) Physical Restoration Centres). Pre-school classes for deaf children are operating in Regina and Saskatoon.

iii. The Rehabilitation Branch of the Department of Social Welfare and Rehabilitation has two full time rehabilitation officers in Regina; one and one-half in Saskatoon; and half-time workers in North Battleford, Moose Jaw and Prince Albert. Their function is primarily evaluation and guidance of adult handicapped persons who apply for vocational rehabilitation service.

The Indian Affairs Branch of the Department of National Health and Welfare also employs one provincial special placement (Rehabilitation) Officer in Saskatoon.

iv. Alcoholics Anonymous groups, of which there are about 75 in Saskatchewan, aid in the recovery and re-establishment of the alcoholic into the community. These groups may be classed as both local and regional

v. There are full-time National Employment Services special placement officers in Regina (1) and Saskatoon (2) for the handicapped. In seven other regional points, this task is assigned to one of the regular placement officers.

(c) Central Services (Regina and Saskatoon)

Central services in this province include:

i. Two Physical Restoration Centres (Regina and Saskatoon)

ii. A Rehabilitation Medicine Department (University Hospital)

iii. The four general hospitals in Regina and Saskatoon have physical therapists on staff. Two have a medical social work department.

iv. Three geriatric centres. It is intended to extend rehabilitation as part of institutional services to Regina, Saskatoon and Melfort. Another centre is under construction at Swift Current.

v. One Vocational Rehabilitation Centre (evaluation, conditioning, sheltered and homebound

employment) in Saskatoon, operated by the Saskatchewan Council for Crippled Children and Adults, and a second one being developed in Regina.

vi. Two brace shops (Regina and Saskatoon). A limited limb fitting and manufacturing service is provided to civilians by the Department of Veterans Affairs Prosthetics Shop in Regina.

vii. A camping program at Watrous, operated by the Saskatchewan Council of Crippled Children and Adults, extends its facilities to orthopaedically and mentally handicapped and diabetics. Also a camp at Long Lake for patients of the Saskatchewan Training School (Moose Jaw), for the mentally retarded.

viii. Recreational and social club rooms at Saskatoon, Regina and Swift Current, operated by the Canadian Mental Health Association, offer a partial, recreational and re-adjustment program for post-treatment cases.

ix. Tuberculosis Sanatoria. No rehabilitation staff but some intra-mural education is provided.

x. A School for the Deaf in Saskatoon providing a reasonably complete program.

xi. Institutes for the Blind in Regina and Saskatoon, operated by the Canadian National Institute for the Blind. Education for the blind is by arrangement with the Brantford (Ontario) School for the Blind (Department of Education).

xii. The Bureau on Alcoholism of the Department of Social Welfare and Rehabilitation operates a referral and guidance centre in Regina, employing a lay counsellor, a nurse counsellor and a medical consultant.

3. REFERRAL AND FOLLOW-UP PROCEDURES

All rehabilitation agencies follow the principle that referrals for further medical and therapy services should be made by the patient's family doctor or, in the case of educational, psychological, social and vocational services by the responsible social agency. The family doctor or agency making the referral is generally advised of progress when treatment is prolonged. The patient is referred back to the referring doctor or agency, following consultative service, or treatment.

The need for a good liaison between the family doctor (or agency) and the rehabilitation service is well recognized, yet this is frequently a week point in present programming. Work loads, staff shortages, distance factors all seem to add to the breakdown in communication.

4. FINANCING OF REHABILITATION SERVICES

The sources of funds for financing current rehabilitation programs are from Federal and provincial governments, and voluntary organizations. Briefly, the distribution is:

(a) Expenditure of voluntary funds for the physical and mentally handicapped, through:

(1) The Saskatchewan Council for Crippled Children and Adults, which operates: transportation services (9 or 10 busses in Regina, Saskatoon, Moose Jaw and

Prince Albert), a summer camp for the handicapped; two vocational rehabilitation centres; prosthetic services; mobile diagnostic and treatment clinics.

(2) The Canadian Arthritis and Rheumatism Society, operates: mobile diagnostic and treatment clinics, and two in-patient "treatment centres" in Regina and Saskatoon hospitals.

(3) The Canadian Mental Health Association provides recreation and social adjustment programs and a limited support of classes for the mentally retarded.

(4) The Saskatchewan Association for Retarded Children has promoted and given auxiliary support to classes for severely retarded children, programs for patients and promotion of services for the young adult retarded.

(5) The services for the Canadian National Institute for the Blind include: residential units in Regina and Saskatoon; home-teaching; social and recreational activity; vocational assessment; training; special placement and employment.

(6) Other organizations provide important services. For example, the Canadian Junior Red Cross and the Shrine Clubs (Crippled Children); the Handicapped Civilians' Association (recreational and social needs of adults); Victorian Order of Nurses (home-care rehabilitation nursing). See Appendix 1 for a more complete list of organizations and services.

The total annual expenditure of these agencies amounts to approximately $500,000. About 25 per cent of this amount is derived from local and provincial government sources.

(b) Expenditure of Government Funds

Expenditures on behalf of Federal-provincial governments for formal physical and vocational rehabilitation is currently at the rate of approximately $750,000 a year. This covers the operation of the two physical restoration centres; the Department of Rehabilitation Medicine, University Hospital; Vocational assessment; counselling; and training of handicapped (Department of Social Welfare and Schedule "R"), medical services to poliomyelitic and paraplegic patients, Bureau on Alcholism, and grants to voluntary organizations. The amount excludes the support of special education programs for the severely retarded (e.g. special schools) the re-establishment of persons with physical and mental handicaps by means of

on-going treatment services (e.g. General and Special hospitals providing social work and therapy staff), restoration of compensible injured workmen, psychiatric services, or the work of public health nurses and social welfare field staff in case-finding and follow up, and special placement services of the National Employment Service.

In summary, it is impossible to extract precise expenditure date on rehabilitation, because much of "rehabilitation" is an integral aspect of services rendered to the non-handicapped, within the social, educational, and health services of the Province. It would appear that a total of about $1.5 million is expended annually in the provision of special services to the handicapped; voluntary funds and efforts provide approximately one-third of this amount.

Most of the aforementioned expenditure is for staff remuneration, and nearly all rehabilitation staff is on salary, the exception being medical staff. All the voluntary organizations use a fee-for-service or honorarium basis of payment for medical staff. Government operated rehabilitation programs employ salaried medical staff, where possible, for overall direction, but use many part-time specialists (usually on an honorarium basis) as consultants. In general, both Voluntary and Government organizations provide services without charge to the patient, with such exceptions as surgery and prosthetics. However, these special and additional services may also be provided from available voluntary and governmental funds in cases of indigency.

5. UNMET NEEDS IN REHABILITATION

(1) Program Gaps on the Regional Level

(a) There are currently no physical medicine departments in any of the ten regional general hospitals, including the general hospitals in the cities of Regina and Saskatoon, (although the Moose Jaw Union Hospital has space provision for a department). Some are considering establishing units. This is being encouraged by the Department of Public Health and the Saskatchewan Hospital Services Plan, which will underwrite certain costs of operation.

(b) Inadequate medical, psychological, and vocational assessment services

in all regional areas except Saskatoon. Regina refers many cases to Saskatoon for psychological and vocational assessment. (The Saskatchewan Council for Crippled Children and Adults is developing vocational assessment facilities in Regina; some workconditioning is also done in the occupational shop at Regina P. R. C.)

(c) Guidance and support to post-psychotic cases, necessary for adjustment into the community, are almost non-existent.

(d) Special placement services of the National Employment Service are not adequate to meet the demand.

(e) Arrangements for regional general hospital out-patient rehabilitation services are insignificant, (restricted to limited funds for treatment of certain poliomyelitis cases), although physical medicine care is generally of long duration, and usually does not necessitate intramural accommodation beyond a relatively brief period. Resources for regular and continuous follow-up care in the region are vital for positive permanent benefit.

(2) Program Gaps in Central Services

(a) Shortage of Facilities:

Excluding accommodation for in-patient facilities, the major building and equipment needs are:

(1) Improved and expanded physical restoration facilities in Saskatoon.

(2) A vocational rehabilitation centre in Regina, to serve mentally and physically handicapped post-treatment cases.

(3) Receiving or accommodation units for out-of-city cases requiring short term assessment and treatment in Regina and Saskatoon.

Note: (Consideration of extension of the Moose Jaw Training School facilities for custodial care of severaly mentally retarted is excluded from this brief; an estimated waiting list of 500 cases is reported by the Moose Jaw Training School.)

(4) A complete prosthetic service and training centre located either in Regina or Saskatoon.

(5) Active Geriatric rehabilitative services.

(b) Personnel Shortages:

Lack of sufficient trained personnel is the most critical problem. Current facilities are chronically understaffed. The shortage adversely affects existing programs in that working standards are often relaxed in order to retain staff. Moreover, supervisory positions are held by individuals with limited experience and often supervision of new staff is inadequate or non-existent. These conditions have made it difficult to maintain desirable standards even within current program services.

Experience in Saskatchewan has revealed that stability and adequacy in staffing is more often attained with recruiting and training of residents of the province. There are no provincial training resources for any of the disciplines that constitute the rehabilitation team (aside from special education courses, and medical and nursing education).

6. COMPREHENSIVE PLANNING AND COORDINATION OF REHABILITATION SERVICES

(a) The Need for Co-ordination of Rehabilitation Activities

The developmental pattern for rehabilitation services in voluntary agencies has been according to specific disease conditions, with separate organizations being formed in the interests of cerebral palsy, poliomyelitis, blindness, arthritis, or muscular dystrophy; each organization has been attempting to provide as broad a program as possible for its particular group.

Within government, rehabilitation services developed under a number of departments, usually along health, education, and welfare lines. Hence, the rehabilitation program in Saskatchewan and elsewhere has become a very complex structure, involving not only a diverse group of professions but an even greater variation of administrative and program organizations.

This pattern of development works well in areas with very concentrated populations where numerically large numbers of cases warrant separate facilities and personnel for each disease condition. In sparsely populated areas, however, as is characteristic of Saskatchewan, this multifaceted approach, while showing commendable results in helping to initiate program services for many groups almost concurrently, also creates undesirable problems. The benefits to be gained from

ungoverned, spontaneous growth are, at times, cancelled out by undesirable consequences.

The problems pertaining to both voluntary organizations and departments of government are varied. Two serious aspects are: duplication of effort, and, conversely, mal-distribution of limited staff and resources. Some specific problems which have arisen, and sometimes still exist, include the following:

(i) several agencies providing essentially the same services resulting in more than ample funds for certain groups of disabled and a dearth of funds for others; or

(ii) several agencies functioning autonomously in the interests of a common problem, but with diverse views about the proper method of approach and solution;

(iii) failure to make full use of some of the existing rehabilitation facilities because of staff shortages, due in part to the manner in which available staff has been distributed among government departments and private agencies;

(iv) several agencies attempting to serve individual disease conditions in rural areas with independent staffs and physical facilities -- resulting in expensive and inefficient use of resources.

(v) failure to achieve a comprehensive service because of interdepartmental and/or inter-agency conflict in policies.

(vi) lack of information among agency personnel as to available or potential resources;

(vii) public confusion and resentment at the manner in which the voluntary and tax dollar is spent.

(b) Development of Co-ordinated Action in Saskatchewan

(1) The Inter-departmental Co-ordinating Committee on Rehabilitation

The need to coordinate the work of rehabilitation agencies has been apparent to some leaders for a long time. Some ten years ago, the Departments of Health, Welfare, and Education met as an informal interdepartmental discussion group

to consider such problems as overlapping of activities, unmet needs, and more efficient use of funds and staff.

By 1952, the Federal Government appointed a National Co-ordinator of Rehabilitation to encourage provincial governments to help establish co-ordinators on a provincial level. In August, 1953, the Co-ordination of Rehabilitation of Disabled Persons Agreement was signed between the federal and provincial governments. This arrangement has continued and currently provides for the Government of Canada to share equally with the Provincial Government the costs of maintaining the office of the Provincial Co-ordinator of Rehabilitation.

(2) The Secretariat

The work of the Provincial Co-ordinator (appointed on a full time basis in 1957) is guided by an Interdepartmental Co-ordinating Committee on Rehabilitation, composed of representatives of the Departments of Health, Education, Welfare, Labour, Provincial Treasury, and the Workmen's Compensation Board. The function of the Committee and the Co-ordinator is to facilitate co-ordination of the several departmental rehabilitation activities and to advise government on rehabilitation matters.

(3) The Co-ordinating Council on Rehabilitation

Voluntary rehabilitation organizations and the Saskatchewan College of Physicians and Surgeons, had for some years urged the development of a broader co-ordinating and planning media for rehabilitation than the Interdepartmental Committee. Actually, the latter expanded the duties of the Co-ordinator by authorizing him to establish ad hoc committees outside government when necessary for the solution of special problems and a working relationship evolved with non-governmental agencies.

In 1959, a co-ordinating agency was formed, known as the Co-ordinating Council on Rehabilitation (Saskatchewan), consisting of all governmental and non-governmental rehabilitation organizations (35 in total). The Provincial Co-ordinator's office serves as the secretariat, and the Provincial Co-ordinator as Executive Officer of the Council.

The purposes of the Council are:

(i) to act as a "clearing house" for information.

(ii) to serve as a medium through which agencies can plan and arbitrate conjointly.

(iii) to operate certain services designed to strengthen agency services to the handicapped.

The Council is composed of a Board of Directors and 5 Divisional Chairmen. Each of the Divisional Chairmen is responsible for one of the 5 major program areas -- Medical Rehabilitation, Psycho-Social-Vocational Rehabilitation, Special Education and Training Division, Research-Consultation Division and General Administration Division.

All committees and sub-committees of the Co-ordinating Council on Rehabilitation (Saskatchewan) must be formally constituted by the Board of Directors, to whom they are responsible for their terms of reference through the appropriate Division. Some of these committees will be "standing" ones, others will be ad hoc ones according to current and foreseeable needs; certain committees are already at work on pertinent problem areas, while others will become active in the near future.

Funds for financing the Council are derived from two sources.

(i) The major expense - that of staff - is borne by the provincial and federal governments through the loan of the services of the office of the Co-ordinator to the Council for the first year.

(ii) Non-governmental agencies pay membership scaled from $10.00 - $100.00 according to the size of their rehabilitation budget.

7. SCOPE OF THE CO-ORDINATION ACTIVITY

As indicated in the definition of the term rehabilitation, the process is complex; yet the organization of pertinent resources is even more involved. For this reason, the approach to co-ordination of services has been divided, into the aforementioned five major divisions; The following outline indicates the specific nature of these various problems.

(1) Medical Rehabilitation

(a) Development of Physical Medicine Services in general hospitals, special hospitals, chronic illness and geriatric institutions.

(b) Specialized Physical Restoration Services.

(c) Adequate Prosthetic and Orthotic Services.

(d) Special groups, viz;, Speech, Visual and Auditory Defects, Cleft Palate.

(e) Home-care, Out-patient, Mobile Clinic and other Paramedical services.

(f) Workmen's compensation Board cases.

(2) Psycho-Social-Vocational Rehabilitation

(a) Case-finding and reporting.

(b) Evaluation - psychometric and social.

(c) Social casework, psychological and psychiatric treatment.

(d) Recreation for the handicapped.

(e) Work tolerance, conditioning and development of work habits.

(f) Vocational training.

(g) Special placement.

(h) Sheltered employment.

(i) Accommodation for the disabled.

(j) Financial assistance and wages to the handicapped.

(3) Research

(a) Medical and paramedical research dealing with the prevention of disabling conditions.

(b) Statistical research providing data regarding incidence, prevalence, successes and failures in treatment of cases (resulting in evaluation of current rehabilitation programs) and determination of future or current needs; the provision of Registries of Disabled Children and Adults and the use of Rehabilitation Closure forms as a data-collecting device also comes into this area.

(c) Vocational research in matters of physical capacity, job-demand and job availability for the handicapped.

(d) Consultation and advisory services, upon request, to:

(i) member agencies on matters concerning their problems and programs

(ii) the other divisions of the Council.

(4) Special Education and Training

(a) Integration of certain handicapped children into the regular cl assroom.

(b) Provision of adequate and suitable special classes.

(c) Special arrangements involving classes for the handicapped operated by private boards, institutions and specialized facilities.

(d) Development of curricula guides and adaptations for teachers of the handicapped.

(e) Methods of testing and evaluation of exceptional children.

(f) Training and selection of teachers of exceptional children.

(g) Pre-vocational and vocational training, academic up-grading and guidance for adolescent and adult handicapped.

(5) Other On-going Services to Agencies Provided through the Co-ordination Program

(a) The Professional Personnel Development Program

This program attempts to alleviate the acute shortage of rehabilitation staff via:

(i) Careers in Rehabilitation Project -- designed to provide information and counselling on careers in the rehabilitation disciplines to students.

(ii) Rehabilitation Personnel Bureau -- giving service to both employer and employee by referring registered personnel seeking employment to appropriate vacancies listed with the Bureau.

(b) Technical and General Information Services

(i) Library -- provides books, pamphlets, papers, etc.

(ii) Extracting -- specific interest items forwarded to appropriate agencies and/or individuals.

(iii) Directory -- development of a comprehensive listing of health, welfare, special education, and rehabilitation services.

(iv) Newsletter -- rehabilitation personnel are kept informed of developments in the field via regular issues of the Newsletter.

(c) Consultation Services

These services are of a less specific and formalized nature than many of the others, but include:

(i) Meeting individual and agency request on matters of rehabilitation

(ii) Provision of technical and professional information to individuals or groups.

(iii) Advising on program development

(iv) Making referrals to appropriate agencies and advising as to availability of services.

APPENDIX I

LIST OF SASKATCHEWAN REHABILITATION ORGANIZATIONS

1. Agencies Operating or Actively Promoting Rehabilitation Programs

   (a) Government Departments and Agencies:

   (1) Public Health
   (2) Social Welfare and Rehabilitation
   (3) Education
   (4) Labour
   (5) Workmen's Compensation Board
   (6) Veterans' Affairs
   (7) Indian Affairs
   (8) National Employment Service

   (b) Private Agencies and Organizations:

   (1) Canadian Arthritis and Rheumatism Society
   (2) Handicapped Civilians Association
   (3) Canadian Junior Red Cross
   (4) Saskatchewan Council for Crippled Children and Adults
   (5) University Hospital (Physical Medicine)
   (6) Canadian Mental Health Association
   (7) Saskatchewan Association for Mentally Retarded
   (8) Canadian National Institute for the Blind
   (9) Saskatchewan Conference of Alcoholics Anonymous
   (10) Shrine Clubs
   (11) Multiple Sclerosis Society
   (12) Muscular Dystrophy Association
   (13) Anti-Tuberculosis League
   (14) Federation of the Blind

2. Organizations Interested in Rehabilitation

   (a) College of Physicians and Surgeons
   (b) Saskatchewan Hospital Association
   (c) Canadian Cancer Society
   (d) Victorian Order of Nurses
   (e) Canadian Diabetic Association
   (f) Canadian Heart Association
   (g) University of Saskatchewan Education Department
   (h) Saskatchewan Registered Nurses Association
   (i) Society for the Chronically Ill
   (j) Organization for Old Age and Nursing Homes (pending)
   (k) The Therapy Associations (Physical, Occupational and Speech)

3. Other Organizations Concerned with Development of Rehabilitation Services

   (a) Old Age Pensioner Associations
   (b) Urban and Rural Municipalities
   (c) Welfare Councils
   (d) Family Service Organizations
   (e) Salvation Army
   (f) Canadian Public Health Association (Saskatchewan)

1. THE REHABILITATION CONCEPT

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An additional component is special equipment designed for, or adapted to meet, the peculiar needs for each case.

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(d) Chronic illness and premature, physical deterioration of the aged

(c) The Importance of Rehabilitation

Rehabilitation has received almost universal public recognition and support, as indicated by the number of organizations and departments involved in rehabilitation programs. Such development is attributed to the following:

1. There is unequivocal evidence of the effectiveness of rehabilitation services in preventing disablement, restoring physical function, and teaching substitute methods to compensate for irrecoverable functional loss.
2. Restoration of the individual to full or partial independence saves money for society. The individual becomes an economic asset rather than a drain on resources.
3. There is a growing recognition that adequate health and welfare services must include comprehensive rehabilitation service for the handicapped.
4. Society has accepted moral responsibility to help the handicapped achieve their potential for normal living.

A complete range of service is, in a sense, a minimum requirement. For instance, the benefits of existing medical and psychiatric restorative services are diminished or dissipated without the complementary support (psychological, social, educational, and vocational) required by the disabled to achieve maximum independence. Successful treatment of persons suffering from psychosis, for example, is of questionable value without sufficient skilled social and vocational staff to rehabilitate the patient into the community. Similar arguments apply to physical disablement; the benefits of good medical care may not be fully realized (and may even be negated) without the appropriate application of a range of auxiliary services.

2. PRESENT PROGRAM OF REHABILITATION IN SASKATCHEWAN

(a) Organizations concerned with Rehabilitation

A list of Saskatchewan organizations concerned with rehabilitation is contained in Appendix 1.

(b) Services Available

Unlike the traditional pattern of predominately voluntary agency leadership in the development of many health and welfare services, rehabilitation has been pioneered jointly under governmental and non-governmental sponsorship.

Rehabilitation programs within the Province emerged under the stimulus of private agencies and provincial and federal departments of government. Development has been sporadic, often conflicting and unco-ordinated. Most programs currently suffer from serious gaps which, at times, prevent full utilization of existing facilities. Although the adequacy of services varies greatly with areas, a certain provincial organizational pattern has evolved, providing both a generalized services within the existing resources in the province, and a specialized service, located at strategic points; for example, certain rehabilitation personnel may be attached to community health and welfare services, while certain others are concentrated in separate facilities such as the rehabilitation centres.

Specifically, these services are provided at three levels – local, regional, and central:

(a) Local Community Level:

Apart from the family doctor, the public health nurse, the Social Welfare representative, there are no formal rehabilitation resources in the local communities in the province. Exceptions are non-regional hospitals in Rosetown and Shaunavon (and part-time in Wilkie) which have physical therapy and in a few communities which are visited

by travelling Canadian Arthritis and Rheumatism Society physiotherapists. Most cases requiring special attention are referred to the regional programs.

(b) Regional Services

The following rehabilitation resources are currently available on the regional level:

i. Casefinding, diagnosis, limited treatment, and social casework for crippled children and adults is attempted through mobile clinics in ten regional points sponsored by the Saskatchewan Council for Crippled Children and Adults, and the Department of Public Health. The Canadian Arthritis and Rheumatism Society operates a similar, but more limited, service for arthritics.

Hospitals in North Battleford (2), Prince Albert (1), Moose Jaw (3), Yorkton (1), Estevan (1), Swift Current (2), and Lloydminster (1) have physical therapy staff, (the number being indicated in parentheses). A visiting Physical Medicine Specialist (Physiatrist) services the North Battleford hospitals as consultant. Moose Jaw Hospital employs a medical social worker.

ii. Special schools for the severely mentally retarded are located in Saskatoon (John Dolan School) and Regina (Harrow DeGroot School). These are primarily special educational institutions (but aim in the future to extend their work into vocational activities such as vocational training and sheltered work). Opportunity classes for the less severely involved (slow learners) are part of the regular, public school system and not considered in the report. Special classrooms for the severely mentally retarded are located in Moose Jaw, North Battleford, Yorkton, Prince Albert, Melfort and Moose Jaw. Classes for crippled children are located in Saskatoon, Regina, and Prince Albert, (including

classes operated by the Regina (4) and Saskatoon (2) Physical Restoration Centres). Pre-school classes for deaf children are operating in Regina and Saskatoon.

iii. The Rehabilitation Branch of the Department of Social Welfare and Rehabilitation has two full time rehabilitation officers in Regina; one and one-half in Saskatoon; and half-time workers in North Battleford, Moose Jaw and Prince Albert. Their function is primarily evaluation and guidance of adult handicapped persons who apply for vocational rehabilitation service.

The Indian Affairs Branch of the Department of National Health and Welfare also employs one provincial special placement (Rehabilitation) Officer in Saskatoon

iv. Alcoholics Anonymous groups, of which there are about 75 in Saskatchewan, aid in the recovery and re-establishment of the alcoholic into the community. These groups may be classed as both local and regional

v. There are full-time National Employment Services special placement officers in Regina (1) and Saskatoon (2) for the handicapped. In seven other regional points, this task is assigned to one of the regular placement officers.

(c) Central Services (Regina and Saskatoon)

Central services in this province include:

i. Two Physical Restoration Centres (Regina and Saskatoon)

ii. A Rehabilitation Medicine Department (University Hospital)

iii. The four general hospitals in Regina and Saskatoon have physical therapists on staff. Two have a medical social work department.

iv. Three geriatric centres. It is intended to extend rehabilitation as part of institutional services to Regina, Saskatoon and Melfort. Another centre is under construction at Swift current.

v. One Vocational Rehabilitation Centre (evaluation, conditioning, sheltered and homebound employment) in Saskatoon, operated by the Saskatchewan Council for Crippled Children and Adults, and a second one being developed in Regina.

vi. Two brace shops (Regina and Saskatoon). A limited limb fitting ad manufacturing service is provided to civilians by the Department of Veterans Affairs Prosthetics Shop in Regina.

vii. A campaign program at Watrous, operated by the Saskatchewan Council of Crippled Children and Adults, extends its facilities to orthopedically and mentally handicapped and diabetics. Also a camp at Long Lake for patients of the Saskatchewan Training School (Moose Jaw), for the mentally retarded.

viii. Recreational and social club rooms at Saskatoon, Regina and Swift Current, operated by the Canadian Mental Health Association, offer a partial, recreational and re-adjustment program for post-treatment cases.

ix. Tuberculosis Sanatoria. No rehabilitation staff but some intra-mural education is provided.

x. A school for the Deaf in Saskatoon providing a reasonably complete program.

xi. Institutes for the Bling in Regina and Saskatoon, operated by the Canadian National Institute for the Blind. Education for the blind is by arrangement with the Brantford (Ontario) School for the Blind (Department of Education).

xii. The Bureau on Alcoholism of the Department of Social Welfare and Rehabilitation operates a referral and guidance centre in Regina, employing a lay counsellor, a nurse counsellor and a medical consultant.

3. REFERRAL AND FOLLOW-UP PROCEDURES

All rehabilitation agencies follow the principle that referrals for further medical and therapy services should be made by the patient's family doctor or, in the case of educational, psychological, social and vocational services by the responsible social agency. The family doctor or agency making the referral is generally advised of progress when treatment is prolonged. The patient is referred back to the referring doctor or agency, following consultative service, or treatment.

The need for a good liaison between the family doctor (or agency) and the rehabilitation service is well recognized, yet this is frequently a week point in present programming. Work loads, staff shortages, distance factors all seem to add to the breakdown in communication.

4. FINANCING OF REHABILITATION SERVICES

The sources of funds for financing current rehabilitation programs are from Federal and provincial governments, and voluntary organizations. Briefly, the distribution is:

(a)Expenditure of voluntary funds for the physical and mentally handicapped, through:

(1) The Saskatchewan Council for Crippled Children and Adults, which operates: transportation services (9 or 10 busses in Regina, Saskatoon, Moose Jaw an Prince Albert), a summer camp for the handicapped; two vocational rehabilitation centres; prosthetic services; mobile diagnostic and treatment clinics.

(2) The Canadian Arthritis and Rheumatism Society, operates: mobile diagnostic and treatment clinics, and two in-patient "treatment centres" in Regina and Saskatoon hospitals.

(3) The Canadian Mental Health Association provides recreation and social adjustment programs and a limited support of classes for the mentally retarded.

(4) The Saskatchewan Association for Retarded Children has promoted and given auxiliary support to classes for severely retarded children, programs for patients and promotion of services for the young adult retarded.

(5) The services for the Canadian National Institute for the Blind include: residential units in Regina and Saskatoon; home-teaching; social and recreational activity; vocational assessment; training; special placement and employment.

(6) Other organizations provide important services. For example, the Canadian Junior Red Cross and the Shrine Clubs (Crippled Children); the Handicapped Civilians' Association (recreational and social needs of adults); Victorian Order of Nurses (home-care rehabilitation nursing). See appendix 1 for a more complete list of organizations and services.

The total annual expenditure of these agencies amounts to approximately $500,000. About 25 per cent of this amount is derived from local and provincial government sources.

(b) Expenditure of Government Funds

Expenditures on behalf of Federal-provincial governments for formal physical and vocational rehabilitation is currently at the rate of approximately $750,000 a year. This covers the operation of the two physical restoration centres; the Department of

Rehabilitation Medicine, University Hospital; Vocational assessment; counselling; and training of handicapped (Department of Social Welfare and Schedule "R"), medical services to poliomyelitic and paraplegic patients, Bureau on Alcoholism, and grants to voluntary organizations. The amount excludes the support of special education programs for the severely retarded (e.g. special schools) the re-establishment of persons with physical and mental handicaps by means of on-going treatment services (e.g. General and Special hospitals providing social work and therapy staff), restoration of compensable injured workmen, psychiatric services, or the work of public health nurses and social welfare field staff in case-finding and follow up, and special placement services of the National Employment Service.

In summary, it is impossible to extract precise expenditure date on rehabilitation, because much of "rehabilitation" is an integral aspect of services rendered to the non-handicapped, within the social, educational, and health services of the Province. It would appear that a total of about $1.5 million is expended annually in the provision of special services to the handicapped; voluntary funds and efforts provide approximately one-third of this amount.

Most of the aforementioned expenditure is for staff remuneration, and nearly all rehabilitation staff is on salary, the exception being medical staff. All the voluntary organizations use a fee-for-service or honorarium basis of payment for medical staff. Government operated rehabilitation programs employ salaried medical staff, where possible, for overall direction, but use many part-time specialists (usually on an honorarium basis) as consultants. In general, both Voluntary and Government organizations provide services without charge to the patient, with such exceptions as

surgery and prosthetics. However, these special and additional services may also be provided from available voluntary and governmental funds in cases of indigency.

5. UNMET NEEDS IN REHABILITATION

(1) Program Gaps on the Regional Level

(a) There are currently no physical medicine departments in any of the ten regional general hospitals, including the general hospitals in the cities of Regina and Saskatoon, (although the Moose Jaw Union Hospital has space provision for a department). Some are considering establishing units. This is being encouraged by the Department of Public Health and the Saskatchewan Hospital Services Plan, which will underwrite certain costs of operation.

(b) Inadequate medical, psychological, and vocational assessment services in all regional areas except Saskatoon. Regina refers many cases to Saskatoon for psychological and vocational assessment. (The Saskatchewan Council for Crippled Children and Adults is developing vocational assessment facilities in Regina; some work conditioning is also done in the occupational shop at Regina P. R. C.)

(c) Guidance and support to post-psychotic cases, necessary for adjustment into the community, are almost non-existent.

(d) Special placement services of the National Employment Service are not adequate to meet the demand.

(e) Arrangements for regional general hospital out-patient rehabilitation services are insignificant, (restricted to limited funds for treatment of certain poliomyelitis cases), although physical medicine care is generally of long duration, and usually does not necessitate intramural accommodation beyond a relatively brief period. Resources for

regular and continuous follow-up care in the region are vital for positive permanent benefit.

(2) Program Gaps in Central Services

(a) Shortage of Facilities:

Excluding accommodation for in-patient facilities, the major building and equipment needs are:

(1) Improved and expanded physical restoration facilities in Saskatoon.

(2) A vocational rehabilitation centre in Regina, to serve mentally and physically handicapped post-treatment cases.

(3) Receiving or accommodation units for out-of-city cases requiring short term assessment and treatment in Regina and Saskatoon. Note: (Consideration of extension of the Moose Jaw Training School facilities for custodial care of severely mentally retarded is excluded from this brief; an estimated waiting list of 500 cases is reported by the Moose Jaw Training School.)

(4) A complete prosthetic service and training centre located either in Regina or Saskatoon.

(5) Active Geriatric rehabilitative services.

(c) Personnel Shortages:

Lack of sufficient trained personnel is the most critical problem. Current facilities are chronically understaffed. The shortage adversely affects existing programs in that working standards are often relaxed in order to retain staff. Moreover, supervisory positions are held by individuals with limited experience and often supervision of new

staff is inadequate or non-existent. These conditions have made it difficult to maintain desirable standards even within current program services.

Experience in Saskatchewan has revealed that stability and adequacy in staffing is more often attained with recruiting and training of residents of the province. There are no provincial training resources for any of the disciplines that constitute the rehabilitation team (aside from special education courses, and medical and nursing education).

6. COMPREHENSIVE PLANNING AND COORDINATION OF REHABILITATION SERVICES

(a) The Need for Co-ordination of Rehabilitation Activities

The development pattern for rehabilitation services in voluntary agencies has been according to specific disease conditions, with separate organizations being formed in the interests of cerebral palsy, poliomyelitis, blindness, arthritis, or muscular dystrophy; each organization has been attempting to provide as broad a program as possible for its particular group.

Within government, rehabilitation services developed under a number of departments, usually along health, education, and welfare lines. Hence, the rehabilitation program in Saskatchewan and elsewhere has become a very complex structure, involving not only a diverse group of professions but an even greater variation of administrative and program organizations.

This pattern of development works well in areas with very concentrated populations where numerically large numbers of cases warrant separate facilities and personnel for each disease condition. In sparsely populated areas, however, as is characteristic of Saskatchewan, this multifaceted approach, while showing commendable

results in helping to initiate program services for many groups almost concurrently, also creates undesirable problems. The benefits to be gained from ungoverned, spontaneous growth are, at times, cancelled out by undesirable consequences.

The problems pertaining to both voluntary organizations and departments of government are varied. Two serious aspects are: duplication of effort, and, conversely, mal-distribution of limited staff and resources. Some specific problems which have arisen, and sometimes still exist, include the following:

(i) several agencies providing essentially the same services resulting in more than ample funds for certain groups of disabled and a dearth of funds for others; or

(ii) several agencies functioning autonomously in the interests of a common problem, but with diverse views about the proper method of approach and solution;

(iii) failure to make full use of some of the existing rehabilitation facilities because of staff shortages, due in part to the manner in which available staff has been disturbed among government departments and private agencies;

(iv) several agencies attempting to serve individual disease conditions in rural areas with independent staffs and physical facilities – resulting in expensive and inefficient use of resources.

(v) failure to achieve a comprehensive service because of interdepartmental and/or inter-agency conflict in politics.

(vi) lack of information among agency personnel as to available or potential resources;

(vii) public confusion and resentment at the manner in which the voluntary and tax dollar is spent.

(b) Development of Co-ordinated Action in Saskatchewan

(1) The Inter-departmental Co-ordinating Committee on Rehabilitation

The need to coordinate the work of rehabilitation agencies has been apparent to some leaders for a long time. Some ten years ago, the Department of Health, Welfare, and Education met as an informal interdepartmental discussion group to consider such problems as overlapping of activities, unmet needs, and more efficient use of funds and staff.

By 1952, the Federal Government appointed a National Co-ordinator of Rehabilitation to encourage provincial governments to help establish co-ordinators on a provincial level. In August, 1953, the Co-ordination of Rehabilitation of Disabled Persons Agreement was signed between the federal and provincial governments. This arrangement has continued and currently provides for the Government of Canada to share equally with the Provincial Government the costs of maintaining the office of the Provincial Co-ordinator of Rehabilitation.

(2) The Secretariat

The work of the Provincial Co-ordinator (appointed on a full time basis in 1957) is guided by and Interdepartmental Co-ordinating Committee on Rehabilitation, composed of representatives of the Departments of Health, Education, Welfare, Labour, Provincial Treasury, and the Workmen’s Compensation Board. The function of the Committee and

the Co-ordinator is to facilitate co-ordination of the several departmental rehabilitation activities and to advise government on rehabilitation matters.

(3) The Co-ordinating Council on Rehabilitation

Voluntary rehabilitation organizations and the Saskatchewan College of Physicians and Surgeons, had for some years urged the development of a broader co-ordinating and planning media for rehabilitation than the Interdepartmental Committee. Actually, the latter expanded the duties of the Co-ordinator by authorizing him to establish ad hoe committees outside government when necessary for the solution of special problems and a working relationship evolved with non-governmental agencies.

In 1959, a co-ordinating agency was formed, known as the Co-ordinating Council on Rehabilitation (Saskatchewan), consisting of all governmental and non-governmental rehabilitation organizations (35 in total). The Provincial Co-ordinator's office serves as the secretariat, and the Provincial Co-ordinator as Executive Officer of the Council.

The purposes of the Council are:

(i) to act as a "clearing house" for information

(ii) to serve as a medium through which agencies can plan and arbitrate conjointly.

(iii) to operate certain services designed to strengthen agency services to the handicapped.

The Council is composed of a Board of Directors and 5 Divisional Chairmen. Each of the Divisional Chairmen is responsible for one of the 5 major program areas – Medical Rehabilitation, Psycho-Social-Vocational Rehabilitation, Special Education

and Training Division, Research-Consultation Division and General Administration Division.

All committees and sub-committees of the Co-ordinating Council on Rehabilitation (Saskatchewan) must be formally constituted by the Board of Directors, to whom they are responsible for their terms of reference through the appropriate Division. Some of these committees will be "standing" ones, others will be ad hoe ones according to current and foreseeable needs; certain committees are already at work on pertinent problem areas, while others will become active in the near future.

Funds for the financing Council are derived from two sources.

(i) The major expense – that of staff – is borne by the provincial and federal governments through the loan of the services of the office of the Co-ordinator to the Council for the first year.

(ii) Non-governmental agencies pay membership scaled from $10.00-$100.00 according to the size of their rehabilitation budget.

7. SCOPE OF THE CO-ORDINATION ACTIVITY

As indicated in the definition of the term rehabilitation, the process is complex; yet the organization of pertinent resources is even more involved. For this reason, the approach to co-ordination of services has been divided, into the aforementioned five major divisions; The following outline indicates the specific nature of these various problems.

(1) Medical Rehabilitation

(a) Development of Physical Medicine Services in general hospitals, special hospitals, chronic illness and geriatric institutions.

(b) Specialized Physical Restoration Services.

(c) Adequate Prosthetic and Orthotic Services.

(d) Special groups, viz;, Speech, Visual and Auditory Defects, Cleft Palate.

(e) Home-care, Out-patient, Mobile Clinic and other Paramedical services.

(f) Workmen's compensation Board cases.

(2) Psycho-Social-Vocational Rehabilitation

(a) Case-finding and reporting.

(b) Evaluation – psychometric and social.

(c) Social casework, psychological and psychiatric treatment.

(d) Recreation for the handicapped

(e) Work tolerance, conditioning and development of work habits.

(f) Vocational training.

(g) Special placement.

(h) Sheltered employment.

(i) Accommodation for the disabled.

(j) Financial assistance and wages to the handicapped.

(3) Research

(a) Medical and paramedical research dealing with the prevention of disabling conditions.

(b) Statistical research providing data regarding incidence, prevalence, successes and failures in treatment of cases (resulting in evaluation of current

rehabilitation programs) and determination of future or current needs; the provision of Registries of Disabled Children and Adults and the use of Rehabilitation Closure forms as a data-collecting device also comes into this area.

(c) Vocational research in matters of physical capacity, job-demand and job availability for the handicapped.

(d) Consultation and advisory services, upon request, to:

(i) member agencies on matters concerning their problems and programs

(ii) the other divisions of the Council

(4) Special Education and Training

(a) Integration of certain handicapped children into the regular classroom.

(b) Provision of adequate and suitable special classes.

(c) Special arrangements involving classes for the handicapped operated by the private boards, institutions and specialized facilities.

(d) Development of curricula guides and adaptations for teachers of the handicapped.

(e) Methods of testing and evaluation of exceptional children.

(f) Training and selection of teachers of exceptional children.

(g) Pre-vocational and vocational training, academic up-grading and guidance for adolescent and adult handicapped.

(5) Other On-going Services to Agencies Provided through the Co-ordination Program

(a) The Professional Personnel Development Program

This program attempts to alleviate the acute shortage of rehabilitation staff via:

(i) Careers in Rehabilitation Project – designed to provide information and counselling on careers in the rehabilitation disciplines to students.

(ii) Rehabilitation Personnel Bureau – giving service to both employer and employee by referring registered personnel seeking employment to appropriate vacancies listed with the Bureau.

(b) Technical and General Information Services

(i) Library – provides books, pamphlets, papers, etc.

(ii) Extracting – specific interest items forwarded to appropriate agencies and/or individuals.

(iii) Directory – development of a comprehensive listing of health, welfare, special education, and rehabilitation services.

(iv) Newsletter – rehabilitation personnel are kept informed of developments in the field via regular issues of the Newsletter.

(c) Consultation Services

These services are of a less specific and formalized nature than many of the others, but include:

(i) Meeting individual and agency request on matters of rehabilitation

(ii) Provision of technical and professional information to individuals or groups

(iii) Advising on program development

(iv) Making referrals to appropriate agencies and advising as to availability of services.

APPENDIX 1

LIST OF SASKATCHEWAN REHABILITATION ORGANIZATIONS

1. Agencies Operating or Actively Promoting Rehabilitation Programs

   (a) Government Departments and Agencies:

      (1) Public Health
      (2) Social Welfare and Rehabilitation
      (3) Education
      (4) Labour
      (5) Workmen's Compensation Board
      (6) Veteran's Affairs
      (7) Indian Affairs
      (8) National Employment Services

   (b) Private Agencies and Organizations:

      (1) Canadian Arthritis and Rheumatism Society
      (2) Handicapped Civilians Association
      (3) Canadian Junior Red Cross
      (4) Saskatchewan Council for Crippled Children and Adults
      (5) University Hospital (Physical Medicine)
      (6) Canadian Mental Health Association
      (7) Saskatchewan Association for Mentally Retarded
      (8) Canadian National Institute for the Blind
      (9) Saskatchewan Conference of Alcoholics Anonymous
      (10) Shrine Clubs
      (11) Multiple Sclerosis Society
      (12) Muscular Dystrophy Association
      (13) Anti-Tuberculosis League
      (14) Federation of the Blind

2. Organizations Interested in Rehabilitation

   (a) College of Physicians and Surgeons
   (b) Saskatchewan Hospital Association
   (c) Canadian Cancer Society
   (d) Victorian Order of Nurses
   (e) Canadian Diabetic Association
   (f) Canadian Heart Association
   (g) University of Saskatchewan Education Department
   (h) Saskatchewan Registered Nurses Association
   (i) Society for the Chronically Ill
   (j) Organization for Old Age and Nursing Homes (pending)

(k) The Therapy Associations (Physical, Occupational and Speech)

3. Other Organizations Concerned with Development of Rehabilitation Services

(a) Old Age Pensioner Associations
(b) Urban and Rural Municipalities
(c) Welfare Councils
(d) Family Service Organizations
(e) Salvation Army
(f) Canadian Public Health Association (Saskatchewan)