



WHITE PAPER ON REHABILITATION

EQUAL OPPORTUNITIES AND FULL PARTICIPATION :

A BETTER TOMORROW FOR ALL

May 1995

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FOREWORD

The Green Paper on Rehabilitation was published for public consultation in March 1992. We received a wide range of useful and constructive comments from members of the public. In the light of their views and the advice of the Rehabilitation Development Co-ordinating Committee (RDCC), we determined the priority for the major recommendations in the Green Paper. Later in 1992, we secured the funds needed to implement by 1997 all the recommendations for expanding day and residential services for adults with a disability. We are also taking other major recommendations forward such as improving the accessibility of our public transport system, strengthening employment opportunities, stepping up public education efforts, reviewing the Mental Health Ordinance, and, in May this year, introducing the Disability Discrimination Bill into the Legislative Council. These measures will go a long way towards bringing people with a disability more fully into our community.

The White Paper is a comprehensive policy document which provides extensive reference material for those working in the field of rehabilitation; more than this, we hope it will also play a key role in public education.

The significant progress which has been made since the publication of the Green Paper and the successful completion of the White Paper are due largely to the tireless efforts of a wide range of people dedicated to the goal of integrating people with a disability into our society. I must single out for special mention the Working Party on Rehabilitation Policies and Services and its three sub-committees, the RDCC for its invaluable guidance and the Governor for his strong personal support for the improvement of rehabilitation services.

In the White Paper, we have a blueprint to provide equal opportunities and full participation for people with a disability; in implementing it we shall, I am sure, provide a better tomorrow for all.



Mrs Katherine Fok
Secretary for Health and Welfare

May 1995

CHAPTER 1

INTRODUCTION

1.1 Policies on rehabilitation were previously based on the 1977 White Paper : "Integrating the Disabled into the Community : A United Effort". From that first White Paper came the Rehabilitation Programme Plan. This Plan, which is reviewed every three years, presents a comprehensive picture of the current and projected provision of rehabilitation services. The White Paper also introduced the Rehabilitation Development Co-ordinating Committee, which is consulted on all important aspects of rehabilitation.

1.2 In January 1991, Government appointed a Working Party on Rehabilitation Policies and Services under the chairmanship of the Secretary for Health and Welfare. Its Terms of Reference are at Appendix A. It was charged with reviewing policies and services for people with a disability and with producing a Green Paper which would set out proposals for the way ahead. The majority of the members of the Working Party were non-officials, drawn either from organizations and institutions involved in rehabilitation services, including organizations of people with a disability, or from the business community. Details of membership are at Appendix B. To support the Working Party, three sub-committees were established, each dealing with particular service areas or subjects. Membership lists of the sub-committees are at Appendix C. The Secretariat of the Working Party and its sub-committees was based in the Rehabilitation Division of the Health and Welfare Branch, Government Secretariat. The majority of discussion papers considered by the Working Party were drawn up by the Secretariat, although valuable submissions were also made by Working Party members as well as concerned members of the public.

1.3 The timing of the Green Paper's publication coincided with the end of the United Nations Decade of Disabled Persons (1983-92). The guiding principles with which the United Nations promoted concepts, programmes and services during the decade are embodied in the document called "World Program of Action Concerning Disabled Persons" which served as a useful reference in the drawing up of the Green Paper.

1.4 The review encompassed the rehabilitation services co-ordinated by the Commissioner for Rehabilitation. These included not only the services falling under the purview of the Secretary for Health and Welfare, for example, medical and social rehabilitation, and special education, but also subjects such as access, transport, vocational training and employment, and legislative measures for people with a disability, as well as their advocacy role. The Working Party did not consider the subvention systems, the disability allowance, or other forms of social security payments, as these particular areas had already been covered in the White Paper on Social Welfare into the 1990's and Beyond.

1.5 The Working Party met formally on 15 occasions and considered 64 papers. The three sub-committees held a total of 16 meetings and considered 94 papers. Having commenced its deliberations in early February 1991, the Working Party completed its task in early December 1991 when it endorsed the issue of a Green Paper for public comment.

1.6 The Green Paper was published for public consultation in March 1992. Government gave extensive publicity to the Green Paper to solicit comments from as wide a section of the community as possible. During the three-month consultation period, the Paper generated lively discussions and debate in the Legislative Council, District Boards, and the community at large.

1.7 A total of 553 written submissions were received. These submissions came from diverse sources, including self-help organizations, parents, non-governmental organizations, district and professional bodies. The vast majority of these submissions, which represented the interests of different sectors of the community, expressed firm support for the basic principles and objectives of the Green Paper. Many submissions also focused on the need to secure additional resources for the further development of rehabilitation services, to meet shortfalls in service provision in particular. A summary of these submissions by source is at Appendix D. The public comments are summarised at Appendix E.

1.8 We examined carefully views expressed in the written submissions and consulted the Rehabilitation Development

Co-ordinating Committee on key submissions. The Committee was asked to advise, among other things, which areas covered in the Green Paper should be accorded early priority. A set of criteria for prioritisation was drawn up to guide us in our bid for additional resources. The most important criteria were the extent of service shortfalls and the degree of hardship experienced by people with a disability and their families.

1.9 In response to public calls and in accordance with the above criteria, the Governor pledged in his 1992 Policy Address that funds would be made available for meeting in full the targets in the Green Paper over the following four years, instead of ten years as recommended in the Green Paper. The Governor also pledged that these targets would be regularly updated to ensure that they matched the changing needs and circumstances of the various groups of clients. This firm commitment to improving rehabilitation services has been warmly welcomed by the community, particularly those concerned about the well-being of people with a disability.

1.10 In the light of developments and changes on the rehabilitation front since early 1992, we have revised and updated, where necessary, the Green Paper. This White Paper sets out Government's policy decisions on the further development of rehabilitation services over the next decade and beyond. To make the White Paper more accessible to a wider audience, we have published separately an Executive Summary of this document.

1.11 A glossary of special terms referred to in the text and an index are at the end of this White Paper.

CHAPTER 2

LOCAL AND REGIONAL DEVELOPMENTS IN THE FIELD OF REHABILITATION

2.1 In the past, people with a disability were perceived generally by the public as invalids who had lost their ability to work and to care for themselves, and who depended for survival upon their families or upon the community. Society's responsibility for them, however, was limited to basic humanitarian assistance and relief. People with a disability were expected to be recipients of charity or welfare, and there was no concept of their having a role to play in the day to day life of society. Many of them felt segregated from society since they did not have the opportunity to participate fully in the community and to receive the same opportunities as their able-bodied peers.

2.2 Most societies now recognize that there is a need to move towards the goals of full participation and equalization of opportunities. How far these goals can be achieved depends on the attitude of the public towards people with a disability as well as the extent to which traditional physical and social barriers facing people with a disability are eradicated.

Definitions

2.3 Rehabilitation has been defined in the United Nations World Programme of Action Concerning Disabled Persons as "a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing him with the tools to change his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment". Rehabilitation includes medical, educational, vocational and social rehabilitation services. It also touches on other relevant subjects such as access and transport, housing and public education. Equalization of opportunities is defined in the same Programme as "the process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational

facilities, are made accessible to all". Internationally, there is a trend towards legislating to provide for equalization of opportunities, for example, through legislation which bars discrimination, or requires companies to employ people with a disability.

2.4 A clear distinction between impairment, disability and handicap is made by the World Health Organization as follows -

Impairment : Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Disability : Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap : A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors, for that individual.

Handicap is therefore a function of the relationship between people with a disability and their environment. It occurs when they encounter cultural, physical or social barriers which prevent their access to the various systems of society that are available to other citizens. Thus, handicap is the loss or limitation of opportunities to take part in the life of the community on an equal level with others. With these definitions in mind, the principle of rehabilitation is to maximize capability in the presence of impairments, and to maximize the degree of ability in the presence of disabilities.

Categories of Disability

2.5 We have reviewed the categories of disability and decided to adopt the following -

- Hearing impairment
- Autism
- Mental handicap
- Maladjustment
- Physical handicap

- Visual impairment
- Mental illness
- Visceral disability*
- Speech impairment

2.6 Visceral disability and speech impairment are new categories of disability. They have been included to meet the changing needs and aspirations of people with a disability. Learning difficulties have been deleted from the above classification because pupils with learning difficulties do not typically have an impairment. They are amenable not to rehabilitation services, but to educational services. The question of whether maladjustment should be retained or deleted is being considered jointly by the Education Department and Social Welfare Department. Further discussion of the issues involved is set out in Chapter 6. The detailed definition for each of these categories of disability can be found in the 1994 Rehabilitation Programme Plan, to be published in 1995.

The Regional Scene

2.7 In December 1971, the United Nations adopted the Declaration on the Rights of Mentally Retarded Persons, to be followed four years later by the Declaration on the Rights of Disabled Persons. National and international action was called for to ensure that this Declaration would provide a basis for the full integration of people with a disability into the community. In December 1976, believing that a concerted effort was needed to achieve the goal of integration, the United Nations General Assembly proclaimed 1981 as the International Year of Disabled Persons (IYDP). The aim of the Year was to encourage the rehabilitation of an estimated 500 million people who suffered from physical or mental disability. The theme for the Year was "Full Participation and Equality". It aimed at promoting the participation of people with a disability in social development and letting them enjoy a standard of living equivalent to that of their non-disabled peers. The General Assembly invited all member states and concerned organizations to establish measures and programmes to implement the objectives of the IYDP.

* Visceral disability : a disability resulting from disease or its treatment, its nature not being limited to locomotor functions, and which constitutes a disadvantage or restriction in one or more aspects of daily living activities, including work.

2.8 In 1980, Rehabilitation International produced the "Charter for the 80's" as their major contribution to the IYDP. The Charter recognized the need for every government to accept basic responsibility for the rehabilitation of people with a disability, and called for measures to protect and nurture the rights and responsibilities both of disabled and non-disabled persons.

2.9 In 1982, following the success of the IYDP, the United Nations proclaimed 1983-1992 as the United Nations Decade of Disabled Persons. Concrete objectives were set out in the World Programme of Action Concerning Disabled Persons, which was adopted by the United Nations General Assembly in December 1982 to mark the beginning of the Decade. The objectives of the Programme were to promote effective measures for the prevention of disability, for rehabilitation and for the realization of the goals of full participation and equalization of opportunities. This is in keeping with the realization that rehabilitation services are no longer a matter of charity, but that they require a spirit of sharing, growing out of feelings of empathy and the desire to promote human dignity and self-esteem, as well as from the recognition that social issues can only be resolved effectively through pragmatic and collective action.

2.10 The United Nations Decade of Disabled Persons ended in 1992. The achievements in the Decade were reviewed by international leaders in the rehabilitation field in September 1992 in Nairobi, Kenya at the 17th World Congress of Rehabilitation International. They concluded that significant improvements in the quality of life of people with a disability had been achieved in most parts of the world. However, it was also recognized that continuing effort by all was essential to achieve the goals of equalization of opportunities and full participation.

2.11 To sustain the momentum generated during the United Nations Decade of Disabled Persons and to add fresh impetus to promoting the well-being of people with a disability in the Asian Pacific Region, the United Nations Economic and Social Commission of Asia and the Pacific (ESCAP) declared the period from 1993 to 2002 as the Asian and Pacific Decade for Disabled Persons. Hong Kong, as an associate member of ESCAP, is one of the signatories of the resolution proclaiming this new Decade. The purpose of the Decade is to further

promote the rights of people with a disability in the region and their equal opportunities and full participation.

2.12 Hong Kong is also a signatory to 49 International Labour Organization conventions which relate directly or indirectly to rehabilitation services.

2.13 On the international level, Hong Kong participates extensively in conferences on rehabilitation issues, both at the government and non-governmental organization level. It is through such international meetings and gatherings that Hong Kong is able to acquire knowledge and skills to benefit people with a disability in the territory and contribute to other countries. Hong Kong is also active in regional collaboration. The MacLehose Medical Rehabilitation Centre has been designated by the World Health Organization (WHO) as a Collaborating Centre. The Centre runs applied rehabilitation courses at Tongji Medical University, Wuhan, which will train 1 000 rehabilitation personnel in China by the year 2000, and provide attachment programmes for doctors and therapists from countries nearby. Through affiliation to the Rehabilitation International, Hong Kong is also contributing significantly to the development of community-based rehabilitation projects in Asia and the Pacific region. In August 1991, Hong Kong hosted the 3rd International Abilympics, a major international event to promote the work, living and leisure skills of people with a disability, and to mark the end of the United Nations Decade of Disabled Persons.

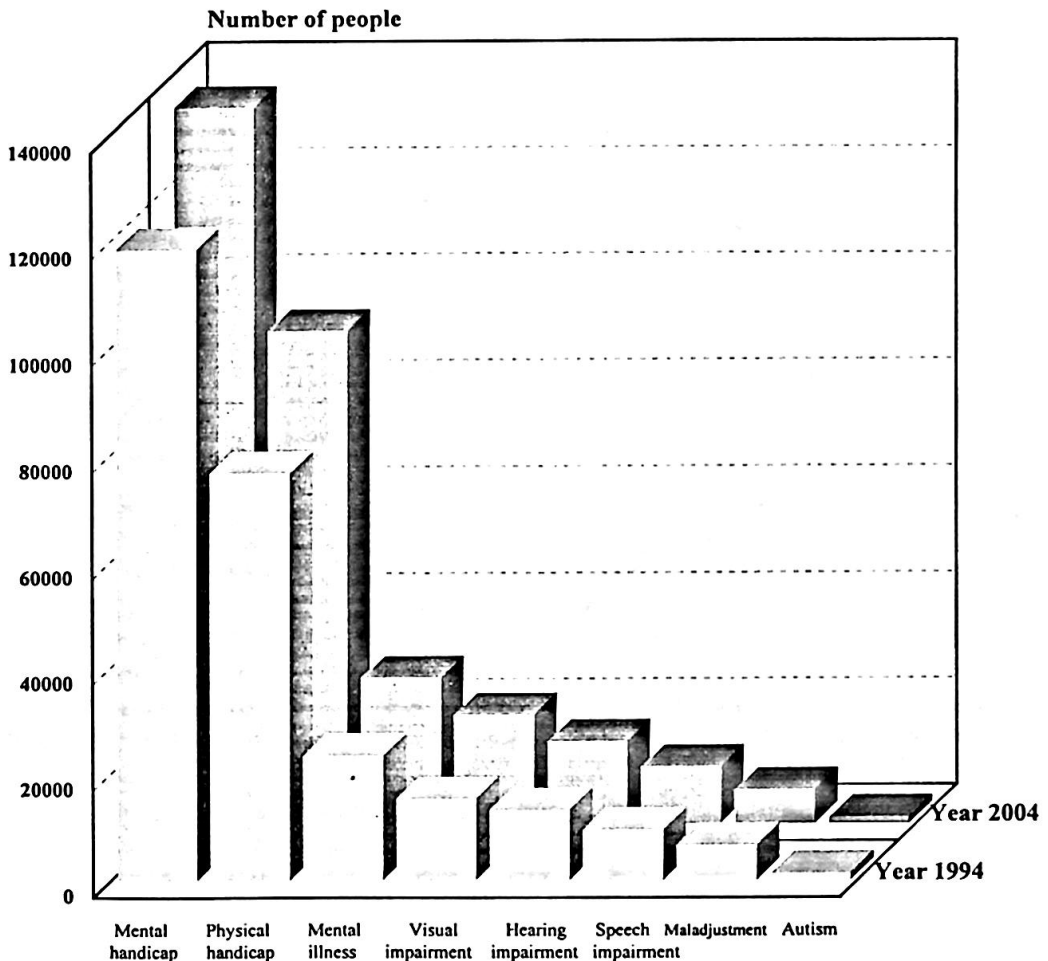
Number of People with a Disability

2.14 For the purpose of rehabilitation services planning, the number of people with a disability is estimated to be 264 000 in 1994, as shown in Chart 1. The estimated number in each disability group is illustrated in Chart 2. The major groups of people with a disability are mentally handicapped (44.9%) and physically handicapped (29.0%). It is projected that up to the year 2004, the total number of people with a disability will increase to about 310 000, mainly due to the growth in population, with both the mentally handicapped and physically handicapped still forming the major groups.

2.15 In March 1993, the number of in-patient admissions for people with a visceral disability amounted to 189 701. However, this

Chart 1

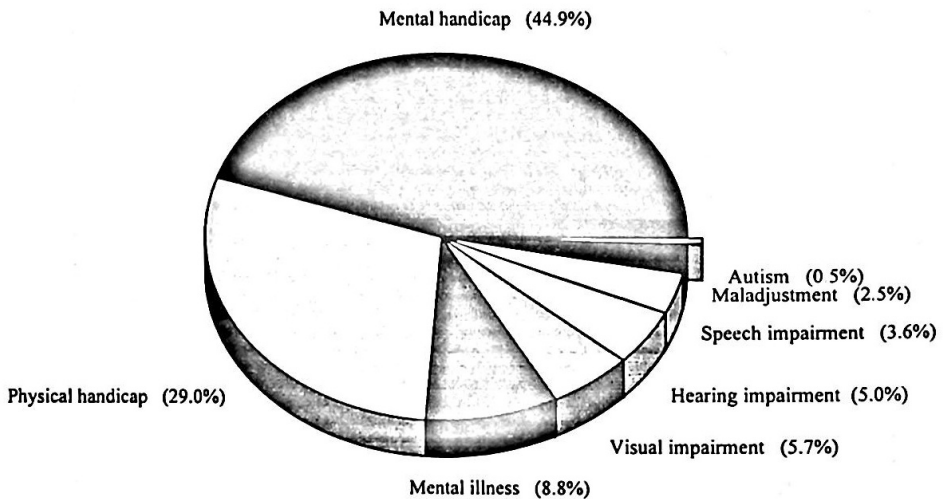
Estimated Number of People with a Disability in 1994 and 2004 by Type of Disability for Rehabilitation Services Planning



Source : Rehabilitation Division, Health and Welfare Branch. These figures, which take into account local population projections, have been estimated on the basis of data in the Central Registry for Rehabilitation and overseas prevalence rates.

Chart 2

**Estimated Number of People with a Disability in 1994
by Type of Disability for Rehabilitation Services Planning**
(Total number of people as at June 1994 : 264 000)



Source : Rehabilitation Division, Health and Welfare Branch. These figures, which take into account local population projections, have been estimated on the basis of data in the Central Registry for Rehabilitation and overseas prevalence rates.

figure relates to the frequency of in-patients admitted, hence, not the actual number of people with visceral disability. It would be unrealistic, therefore, to estimate the number of people with visceral disability on the basis of in-patient admissions, as different types of patients may have varying re-admission rates. Besides, not all of them are in need of rehabilitation services. To facilitate future planning of rehabilitation services for those with a visceral disability, we will start collecting and collating the relevant data through the Central Registry for Rehabilitation, which is discussed in Chapter 4.

2.16 There are approximately 9 400 people with speech impairment. These include voice patients and school-age as well as pre-school children with a speech impairment. Data on the number of cancer and stroke patients with a speech impairment are not available. The Central Registry for Rehabilitation will build up a database on people with speech impairment.

Local Developments

2.17 There have been rehabilitation services in Hong Kong for more than 128 years. From the middle of the last century to the Second World War, development continued on a modest scale, with the establishment of a home for the blind, a school for the deaf, a camp offering temporary accommodation and relief for people with a disability. Medical rehabilitation services were provided in hospitals and clinics as these were established. Post-war years witnessed an increase in the pace of development, with the introduction of specialist services, while the 1960's and early 1970's saw great advances in areas such as special education.

2.18 By 1976, Hong Kong had acquired a solid foundation of rehabilitation services, including identification and assessment, medical treatment and rehabilitation facilities, educational, training, social welfare services, and financial assistance. In July 1976, a Programme Plan for Rehabilitation Services covering a 10-year period from 1975 was prepared by an inter-departmental Working Group. A summary of the main findings and recommendations in the Programme Plan was tabled in the Legislative Council in October 1976 as a Green Paper entitled "The Further Development of Rehabilitation Services in Hong Kong". In October 1977, after considering public comments and

suggestions on the Green Paper, Government published a White Paper on Rehabilitation entitled "Integrating the Disabled into the Community : A United Effort".

2.19 Eighteen years have passed since the publication of the first White Paper on Rehabilitation. Many services have been established or improved, for example, the Comprehensive Observation Scheme, introduced in 1978 for all children from birth to the age of five; the establishment of services for people with a mental handicap such as day activity centres, sports associations, recreational centres and social clubs, as well as home-based training and respite care; the expansion of the Rehabus service; subvention of parent resource centres; the setting up of various multi-disciplinary teams for medical rehabilitation; the strengthening of public education on rehabilitation; improvement of employment opportunities and access.

2.20 In Hong Kong, there are many self-help organizations, with the oldest one formed in 1964 by a group of people with visual impairment. These organizations promote the rights of people with a disability, conduct public education campaigns, carry out research to identify their needs, make recommendations to Government on policy matters, express their views to service organizations and carry out consciousness-raising campaigns. They play a positive role in promoting awareness of the needs of people with a disability and improving on service delivery. We will continue to strengthen these organizations and their relationship with non-governmental organizations and Government. Currently, the welfare sector in general recognizes the importance of client participation in service delivery. Involvement of self-help organizations in the government policy-making mechanisms will therefore continue to be enhanced.

2.21 Social security benefits under the Comprehensive Social Security Assistance Scheme are available to all persons, disabled or not, who meet the eligibility criteria. Under the Social Security Allowance Scheme, Disability Allowance and Higher Disability Allowance are given to people with a disability who meet the relevant criteria.

2.22 While rehabilitation services have greatly contributed to the well-being of people with a disability, more should benefit from the concept of integration as promulgated in the 1977 White Paper. Certain

people with a disability, such as the mentally handicapped and the mentally ill, are neither understood nor, for the most part, accepted by many in the community. While special school places may be available for those who need them, integration into ordinary schools is not always possible, because of access problems or inadequate support. We are working with employers to increase employment opportunities for people with a disability but there are still many who are unemployed, or employed in positions which do not match their qualifications. We believe that Hong Kong has a strong foundation of services, but more needs to be done to enhance integration of people with a disability into the community.

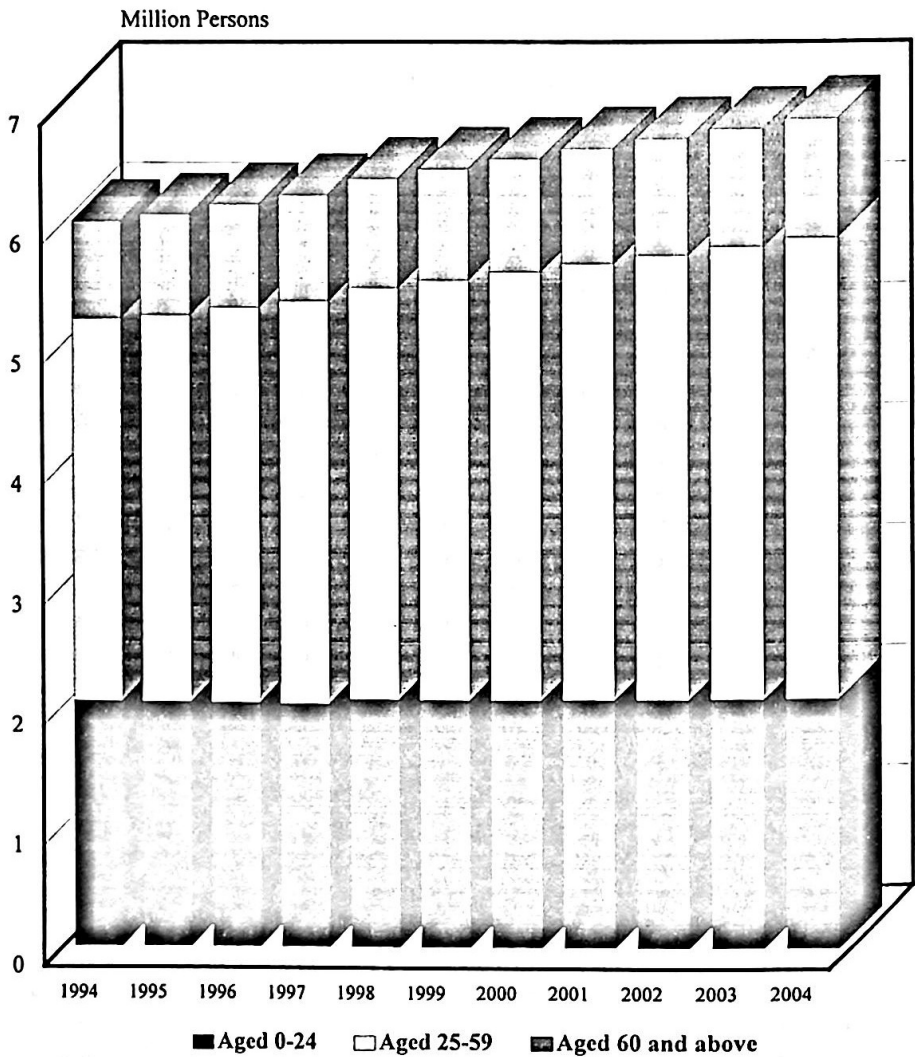
Social and Demographic Factors

2.23 In the last few years, demand for labour has outstripped supply. This had led to improved opportunities for employment for some people with a disability, at least in numerical terms. However, the transition to a service-based economy, with many manufacturing jobs being moved off-shore, has led to a need for employees in Hong Kong to be better educated and trained. This frequently works against people with a more severe disability. A further consequence of the demand for labour is that the number of females in the labour force has increased by 15.6% between 1983 and 1993, and the number of ever-married females in the labour force increased by 20.8% during the same period. Although this has increased family income, it has also increased the need for the expansion of support services, as the responsibility for caring for disabled children, or other family members, usually lies with the wife or mother. This problem is particularly critical in respect of families with severely disabled children of school leaving age, where the young person may not have a place to go after graduation, thus requiring the mother to give up employment to take care of him or her.

2.24 Life expectancy, which was estimated to be 75.2 for males and 80.7 for females in 1993, is expected to rise to 76.7 for males and 82.2 for females by the year 2001. These changes will increase the proportion of the population aged 60 or over from 13% in 1993 to about 14% in 2001 as shown in Chart 3. In terms of numbers, the increase is from 785 000 in 1993 to 956 000 in 2001. Better health generally, better preventive measures and improved treatment of serious health problems have helped to reduce the incidence of disabilities and infirmities

Chart 3

Mid-year Population Projections by Age Group for 1994-2004



Source : Census and Statistics Department

associated with old age. Nevertheless, the same factors, together with advances in medical technology and rehabilitation engineering, will mean that people with a disability will also live longer, thus creating a potentially greater demand for services.

Economic Factors

2.25 The Hong Kong economy has operated close to capacity and showed remarkable growth in output during the past ten years. Measured by the gross domestic product (GDP), the Hong Kong economy achieved an average annual growth rate of 6.4% in real terms between 1983 and 1993. In terms of per capita GDP, the corresponding growth rate in real terms was 5.3% per annum. Meanwhile, the expenditure on rehabilitation has also increased rapidly, by an average of about 10% in real terms per annum. With a tight labour market, the unemployment rate of the overall economy has remained at around 2% or below since 1987. It is generally expected that the current near-full employment situation will continue to prevail in the coming years.

2.26 Over the past decade, Hong Kong has continued to develop as a service centre. The contribution to the GDP of the tertiary services sector as a whole (comprising the wholesale, retail and import/export trades, restaurants and hotels; transport, storage and communications; finance, insurance, real estate and business services; and community, social and personal services) has increased continuously since the early 1980s, from 62% in 1983 to 76% in 1992. With regard to employment, the share of the tertiary services sector in the employed workforce has also increased from 54% in 1983 to 69% in 1993. It is expected that this trend will continue, albeit possibly at a less rapid pace than in the past two decades. An increased share of the economic contribution by the service sector has a stabilizing effect on the economy, since the labour intensiveness of the service industries helps to maintain high employment. In order that people with a disability can benefit from the shift to service industry, vocational training must be more sensitive to changes in employment pattern and market trends.

Political Factors

2.27 Significant political changes are taking place in this decade, not least of which being the transfer of sovereignty in 1997. Local

anxieties over the future have increased, and mobility, which has always been a characteristic of Hong Kong's population, has developed since 1985 to a substantial level. It is estimated that about 62 000 people emigrated in 1994, many being productive and relatively young nuclear families. It is anticipated that the number will fall to a range between 40 000 and 50 000 in the coming few years. Dual residence in Hong Kong and overseas, and occupational exchanges with other territories or countries have caused considerable adjustment problems for the families involved. The natural growth in population due mainly to births by local residents and immigration from China has increased, and will continue to increase, the demand for rehabilitation and other services.

2.28 The increasingly educated population of Hong Kong and its evolving economic and social development have given rise to growing needs and expectations in society, including those of people with a disability, their parents, and workers in the field of rehabilitation.

Technological Factors

2.29 In the field of disability prevention and rehabilitation, scientific and technological advancement is very important. For instance, in the area of telecommunications, hearing impaired persons in Hong Kong can now communicate with other people with the aid of facsimile machines or pagers. With the aid of computer and information technology, visually impaired persons can read messages and newspapers, while physically handicapped or persons with cerebral palsy persons can find remunerative jobs in desk top publishing.

2.30 The development of modern technical devices helps solve problems of everyday life and facilitates the full participation of the individual in the community. Yet it remains an unfortunate fact that many such technological devices are unavailable in Hong Kong, or have to be imported at a price beyond the reach of many disabled persons. This area is discussed in Chapter 14.

Targets in the Green Paper on Rehabilitation

2.31 Government's commitment to meeting in full the targets in the Green Paper on Rehabilitation by 1997 was briefly described in Chapter 1. These targets are broken down as follows -

<u>Type of Services</u>	<u>Original Target Provision of Extra Places</u>	<u>Extra Places Achieved by 1994</u>	<u>Extra Places to be Achieved by 1997</u>
Day Services			
Day Activity Centres (% of target)	1 650	582 (35%)	1 408 (85%)
Sheltered Workshops (% of target)	2 110	760 (36%)	2 160 (102%)
Residential Services (% of target)	3 929	1 023 (26%)	4 237 (108%)
Total	<u>7 689</u>	<u>2 365</u>	<u>7 805</u>

2.32 We have updated the original targets to take account of changing needs and circumstances of the various groups of clients. Funds earmarked for the provision of a particular service which has a smaller projected demand have been redeployed to meet the growing demand for other rehabilitation services covered by the targets. The targets for day activity centres, sheltered workshops and individual residential services have been reviewed as follows -

Day Activity Centres

- (a) the demand for this service has recently been reviewed by the Rehabilitation Programme Plan Review Committee which decided that the planning targets for day activity centres should be reduced and resources for the balance of 242 places (1 650 - 1 408) be redeployed to other rehabilitation services for mentally handicapped people;

Sheltered Workshops

- (b) a Working Group, chaired by the Director of Social Welfare consisting of representatives from the non-governmental sector, has been set up to look for further ways to enhance training and employment services for people with a disability. The Working Group considers that resources are better used on providing supported employment places rather than ever increasing the number of sheltered workshop places. Accordingly, funds earmarked for some sheltered workshops have been retargeted to providing 330 supported employment places which became available in March 1995. The 2 160 extra places which will be provided by 1997 include these 330 supported employment places and some more places in future years through redeployment of funds; and

Residential Services

- (c) within the overall target provision of 3 929 places, we have revised some individual targets to take into account the changing needs of our clients.

Details of the targets and planned provision are set out in Appendix F I.

2.33 Access remains a major problem for many people with a disability, be it access to buildings, to transport, or to information. These deficiencies can create barriers which impede people with a disability from participating in work, education, training and social activities - all essential elements of an independent life. There is also a significant cost to society if people with a disability cannot move freely : assistance has to be provided to bring basic goods and services to them - either by family and friends, or by government funded social services. Only a few modes of public transport have been made accessible to cater for the needs of people with a disability with walking difficulties. Many people with a physical disability cannot be integrated into the mainstream education system since most of the normal schools have access problems to them. Because of access and transport problems, many people with a disability have difficulties in getting open employment or in receiving mainstream welfare services. Mobility and adequate access are

necessary for the overall objectives of equalization of opportunities and full participation to be met.

2.34 People with a disability usually find it difficult to get the opportunity to work, even if they are well-qualified. For those who do find employment, there is always the risk of being made redundant because of improved technology, or of being laid off first in times of economic down-turn. Training and re-training programmes need to keep up with employment trends, which is not always the case.

2.35 There are shortages of professional staff in several areas of rehabilitation, including clinical psychologists, speech therapists, physiotherapists, occupational therapists and special education teachers. As regards public education, further efforts are required to promote positive attitudes towards people with a disability and a better understanding of the nature of their disability.

Meeting New Demand

2.36 A new formula for projecting the demand for social rehabilitation services was endorsed by the Rehabilitation Development Co-ordinating Committee (RDCC) in January 1994. This demand formula, which adopts an accounting flow method and takes into account variables such as annual new applications and discharges, is capable of projecting service requirements more accurately. The new demand formula shows that there will be additional requirements for the provision of pre-school, sheltered workshop and residential services for people with a disability even after the revised targets in the Green Paper on Rehabilitation have been fully met. It also shows that the demand for pre-school services will be higher than previously forecast. We have already secured funds to provide over 700 extra places in pre-school centres over the next four years to help meet this increased demand.

2.37 Although there is still a lot of work to be done to ensure that the existing targets are achieved in full by 1997, we have already started planning the provision of additional services. We will bid for the necessary resources and identify suitable premises with a view to meeting the additional demand as soon as possible.

2.38 The provision of and demand for other rehabilitation services are shown at Appendix F II. The measures which are being or will be taken to tackle the new demands are discussed in greater depth in the following Chapters.

Innovative Service Designs

2.39 Since the 1977 White Paper, a variety of new service models and designs have been brought into use to meet the needs or alleviate the problems of people with a disability. These include rehabilitation engineering, the aim of which is to design and construct artificial body replacements or reinforcements so as to effectively restore normal functional performance. The Environmental Advisory Service advises on the design and accessibility of buildings to ensure that they are barrier-free for people with a disability. Conductive education is a combined therapeutic and educational approach for children and adults with neurological and physical/multiple impairments to achieve rehabilitative/educational goals.

2.40 A Rehabus full-day Dial-A-Ride Service came into operation in July 1989 to provide territory-wide door-to-door transport service for people with physical disabilities for their social functions, leisure, recreational activities and so on.

2.41 To meet the residential needs of school-age children with a mild mental handicap, a foster care service was piloted in April 1988 and a special small group home was established in April 1989.

2.42 A 2-year project called the "Gateway Movement" started in 1989 which aims to integrate people with a mental handicap into the community through participation in leisure and recreational activities so as to promote their emotional development and social adjustment.

Community-based Rehabilitation

2.43 Community-based rehabilitation (CBR) means having resources for rehabilitation available in the community. Knowledge about disabilities and their prevention, and of skills in rehabilitation, can be transferred to people with a disability, their families, and members of the community. There is community involvement in the planning,

decision making and evaluation of CBR. This is an area where volunteers are very important. CBR is discussed in detail in Chapter 9.

CHAPTER 3

BASIC PRINCIPLES AND POLICY OBJECTIVE

Introduction

3.1 With rising standards of education and growing expectations of equal rights and obligations, people with a disability in Hong Kong want to achieve the goals of "equalization of opportunities" and "full participation" to the greatest extent and as soon as possible. We have introduced the Disability Discrimination Bill to give people the legal weapons to fight for equal opportunities and to fight against discrimination and harassment. Details of the Bill are set out in Chapter 15.

3.2 To achieve the above goals, people with a disability are given equal opportunities to enjoy and exercise the same basic rights as other members of the community, and have equal rights to speak and represent themselves. Essential concepts of participation by people with a disability, self-help and parental involvement have been developed and promulgated. More details are given in subsequent Chapters.

Basic Principles

3.3 In developing a policy objective for rehabilitation, the following basic principles have been observed -

- (a) the right of people with a disability to live their lives with dignity should be recognized as being inviolable;
- (b) all members of the community, with or without disabilities, should have equal opportunities to enjoy their rights as citizens;
- (c) society should ensure that people with a disability are not excluded as a result of their disabilities from full participation in the community;

- (d) appropriate rehabilitation services, support and assistance should be provided for people with a disability, and their families, so as to reduce the adverse effect of disability on their lives with the aim of letting each person play a constructive role in society;
- (e) it should be recognized that people with a disability have abilities and can make a valuable contribution to society;
- (f) public education should be conducted to develop positive attitudes in the community towards people with a disability; and
- (g) the general planning process and the administrative structure should ensure that the benefits of societal development programmes can reach people with a disability.

Policy Objective

3.4 Bearing the above basic principles in mind, the overall policy objective for rehabilitation is as follows -

To promote and provide such comprehensive and effective measures as are necessary for the prevention of disability, the development of the physical, mental and social capabilities of people with a disability, and the realization of a physical and social environment conducive to meeting the goals of their full participation in social life and development, and of equalization of opportunities.

CHAPTER 4

PREVENTION, IDENTIFICATION AND ASSESSMENT

Principles and Policy Objectives

4.1 The following points made by the United Nations World Programme of Action are adopted as principles in respect of the prevention of disablement -

- (a) disability does not necessarily give rise to handicap. Failure to apply simple remedies very often increases disability, and the attitudes and institutional arrangements of society increase the chance of disability placing people at a disadvantage. Sustained education is needed, both of the public and of professionals; and
- (b) avoidable disability is a prime cause of economic waste and human deprivation. The technology to control or prevent most disablement is available and is improving. What is needed is commitment by society to overcome the problems.

The aim must be to prevent impairments or to ensure that impairments do not escalate into more limiting disabilities.

Importance of Prevention

4.2 Preventive services can be categorised into three levels -

- (a) first-level prevention : is equivalent to "primary prevention" and includes measures aimed at reducing the occurrence of impairment;
- (b) second-level prevention : prevents the development of disability once an impairment has occurred. It includes what is usually termed "secondary prevention" and involves social intervention and the prevention of additional impairments; and

- (c) third-level prevention : prevents the transition of a disability which has occurred and is found to be irreversible into a handicap. It includes "tertiary prevention", plus a wide range of social intervention.

4.3 The objective of all preventive measures is to reduce the incidence of disability. This is carried out in Hong Kong at present by -

- (a) arousing public awareness through health education;
- (b) providing screening services for early detection of disabilities;
- (c) conducting immunisation programmes;
- (d) adopting measures to reduce accidents at work, on the road, at home, or during recreational activities;
- (e) preventing occupational diseases and promoting occupational health;
- (f) identifying areas where legislative or planning controls can assist in the prevention of disabilities;
- (g) promoting the health of the population; and
- (h) minimising the occurrence of disabilities arising from medical illness or accidents by providing appropriate medical services.

Major Causes of Disabilities

4.4 Disabilities can be caused by various factors and may appear at different stages of life : embryogenesis, birth, infancy, childhood, adulthood and old age. They may arise from genetic or bio-chemical disorders, from infectious diseases, for example, poliomyelitis or rubella, or from accidents on the road, in the home or in the workplace.

4.5 There have been changes in the pattern of disabilities, as a result of medical advances, improvements in industrial safety as well as

the increasing percentage of elderly people in the community. In addition, in an industrialised city like Hong Kong, many disabling diseases like cardiovascular diseases, diabetes mellitus, etc. are caused, in part, by unhealthy lifestyles.

Preventive Measures During Pregnancy, Infancy, and Childhood

4.6 The two major components of clinical genetic service are assessment and counselling. These are now provided by paediatric units in public hospitals managed by the Hospital Authority, and the Clinical Genetic Service of the Department of Health. A pre-natal diagnostic service is also available in a number of public hospitals.

4.7 Genetic counselling and health education can discourage practices which may increase the chance of genetic disorders, such as inter-marriage and child bearing after the age of 35. The incidence of hereditary disabilities can be reduced by strengthening the provision of genetic counselling, health education and pre-natal diagnosis. Every effort is made to make the community aware of these facilities, and those who are at risk are encouraged to consult a doctor. It is also important to ensure that adequate services are available to meet demand.

4.8 Perinatal care plays an important role in the prevention of perinatal disorders which may lead to mental handicap, cerebral palsy and other disabilities. It is provided both in hospitals and maternity homes. High risk pregnancies are referred to hospitals with adequate resources for perinatal care.

4.9 Neonatal examinations screen the baby for physical abnormalities, as well as detecting conditions which may lead to irreversible brain damage.

4.10 Neonatal screening tests are carried out routinely for G6PD deficiency and congenital hypothyroidism.

4.11 The present immunisation programme in Hong Kong protects children against nine common childhood infectious diseases, namely, tuberculosis, measles, mumps, rubella, hepatitis B, diphtheria, pertussis, poliomyelitis and tetanus. These diseases may lead to severe and permanent health problems.

4.12 Health education plays a vital role in the prevention of disease and disability, both physical and mental. The Working Party on Primary Health Care made a number of recommendations to enhance health education and promotion as well as community participation. The vast majority of these recommendations has already been implemented.

4.13 Although the remaining preventive measures as described below are considered effective, the policy on prevention is kept under review so that any advances in preventive measures and changes in major causes of disability may be taken into account.

Industrial and Occupational Safety

4.14 Improvements in safety and health standards of workers and the progressive reduction of industrial accidents are conducive to the prevention of disabilities. There are laws to promote occupational health and industrial safety. The Labour Department is considering the feasibility of introducing legislation to require the setting up of safety committees in large industrial establishments.

4.15 In 1994, there were 44 164 industrial accidents, of which 67 were fatal. Various steps have been taken to review and reinforce safety standards. One of the effective means in the long run is public education. The Labour Department has organized a number of industrial safety training courses and education campaigns to increase understanding of the need for safety measures on the part of workers, employers and members of the public.

Accidents

4.16 Accidents, whether in the home or on the road, can lead to disability. Home safety and road safety have been targets of major government publicity campaigns and will continue to be so in the future. Injuries caused by the lack of seat belts for rear seat passengers and those in the middle front seat of vehicles give rise to particular concern. Proposed legislative amendments on rear seat belts for private cars and middle front seat belts for private cars, taxis, light buses and goods vehicles are currently being drafted. In addition, every effort is made to enforce other road safety measures.

Environmental Controls

4.17 A White Paper on Pollution was published in June 1989. Any environmental measures which assist in preventing disability, for example, reducing the high level of noise which might otherwise affect hearing, are to be encouraged. The Second Review of the 1989 White Paper, published in November 1993, set out the progress of environmental protection programmes. As far as noise pollution is concerned, noisy activities and products are controlled through the enforcement of noise control legislation; noise mitigation measures are incorporated in new projects at the planning stage; and control measures are implemented to abate existing noise problems.

Identification

4.18 Disabilities are usually identified in children and in adults through -

- (a) contacts with clinics, out-patients and emergency units of hospitals;
- (b) contacts with medical practitioners;
- (c) neonatal examinations;
- (d) the Comprehensive Observation Scheme;
- (e) contacts with the Special Education Services Centres;
- (f) the Combined Screening Programme; and
- (g) contacts with social workers, psychologists or allied health staff.

Parents, teachers and general practitioners all play a key role in the identification of disabilities. They are encouraged to acquire the necessary knowledge to assist them in identification. In addition, community-based rehabilitation is an effective means of identifying persons with disabilities. This subject is discussed in Chapter 9.

4.19 Physical examinations of all new-born babies are carried out in public and private hospitals and maternity homes within the first 24 hours to identify physical abnormalities. Children with abnormalities will be referred, if necessary, to specialists for follow-up treatment. Parents who give birth to infants with a disability are, where necessary, immediately referred to medical social workers for counselling. Upon discharge, they can be referred to parent resource centres for support services and guidance.

4.20 The Comprehensive Observation Scheme provides developmental screening for all children from birth to the age of five. Screening is performed in maternal and child health centres for children aged 10 weeks, 9 months and 3 years. It aims to ensure that all congenital defects or those acquired after birth are discovered so that remedial action may be taken as early as possible.

4.21 To improve preventive care, the Working Party on Primary Health Care also made recommendations in respect of the need to develop a comprehensive screening programme for students under the new Student Health Service and opportunistic screening for certain common diseases among elderly people attending general out-patient clinics. The first Elderly Health Centre was set up in May 1994. Six more centres will be set up by 1997. As regards the Student Health Service, it will come into operation in the 1995-96 academic year.

4.22 The Special Education Services Centres of the Education Department provide a wide range of services for school-age children and pre-school children with a disability. They accept referrals from the Department of Health under the Comprehensive Observation Scheme, non-governmental organizations providing rehabilitation services, as well as direct applications from parents.

4.23 The Combined Screening Programme, which covers all Primary 1 pupils in ordinary schools, identifies children with moderate or severe problems and refers them for full assessment. It may also identify those children who are at risk of acquiring visual, hearing or speech or learning problems and provide advice to the schools they attend.

Assessment Services for Children

4.24 After an abnormality is detected in a child, he is given a comprehensive assessment so that appropriate treatment can be given or referral for placement can be made. The Child Assessment Centres of the Department of Health provide multi-disciplinary teams to undertake assessment.

4.25 Children identified through the Education Department's Combined Screening Programme as having eye-sight problems are referred to the appropriate clinics for ophthalmic or optometric assessment. Their parents may also consult ophthalmologists in private practice.

4.26 Children identified as having hearing difficulties receive audiological assessment and, where necessary, remedial treatment. The results of the assessment with appropriate recommendations are given to their heads of schools and parents. Children requiring ear, nose, throat (ENT) treatment are referred to government ENT specialists. Appropriate assistance such as the making of special seating arrangements in the classroom, the provision of hearing aids, access to peripatetic advisory service, and placement in special education classes or special schools can then be given.

4.27 Children identified as having speech problems are referred for speech and language assessment and remedial services where required.

4.28 For mentally handicapped children, as well as those with learning or behavioural problems, the Services Division of the Education Department provides the following services -

- (a) individual assessments of the degree of mental handicap, learning problems, emotional or behavioural difficulties;
- (b) follow-up support for children with learning difficulties, emotional and behavioural problems; and

- (c) advice to teachers and parents on the handling and placement of children with learning, emotional and behavioural problems.

Child Assessment Service

4.29 The main concern for the Child Assessment Service is the long waiting time for detailed assessments. The new Ha Kwai Chung Child Assessment Centre, expected to be opened in late 1996, will improve the situation.

Assessment Services for Adults

4.30 Adolescents and adults suffering from acquired disabilities are treated and initially assessed in clinics and hospitals. Further assessment and rehabilitation services are provided for them after the acute phase of their illness or injury is over. This aspect will be discussed in Chapter 5.

Classification

4.31 Hong Kong uses a broad classification system which covers visual impairment, hearing impairment, physical handicap, mental handicap and mental illness. However, different government departments and professional groups may adopt different schemes for more refined classification which serve their functions best. As recommended by the Green Paper, we explored whether the World Health Organization's "International Classification of Impairments, Disabilities, and Handicaps", which was published in 1980 as a manual of classification relating to the consequences of disease, should be adopted for common use in Hong Kong. Our conclusion is that the international classification is too detailed and may not suit local circumstances. The current broad classification system which is sufficiently flexible will continue to be used.

4.32 The Green Paper recommended that the three-tier classification system for mental handicap be replaced by a four-tier classification system (dividing the degree of handicap into mild, moderate, severe and profound). We will adopt this new system because it takes into account the individual's adaptive behaviour; helps the proper

diagnosis of the level of mental retardation and helps identify with greater precision the need for services and resources. Moreover, since it is in keeping with local trends and international practice, it will facilitate comparative research. Programmes and services will, in any case, continue to be planned according to the needs and abilities of individuals rather than their classification. Details of similar classification systems are at Appendix G.

Central Registry for Rehabilitation

4.33 The Central Registry for Rehabilitation (CRR) collects and makes available information on people with a disability in Hong Kong in order to -

- (a) provide an enquiry service for rehabilitation agencies to facilitate their provision of services, to minimize duplication of services and to assist in their reaching out to people with a disability;
- (b) obtain an accurate estimate of the number of people with a disability in Hong Kong for the planning of rehabilitation services; and
- (c) provide statistics on people with a disability to governmental departments, voluntary agencies and other organizations for research purposes.

4.34 CRR became fully operational in October 1983. The Rehabilitation Division of the Health and Welfare Branch is responsible for its day-to-day operation. At the end of April 1995, there were 136 880 people with a disability on record with CRR. Because of under-reporting, the CRR statistics are incomplete for planning purpose, and this affects the planning of rehabilitation services.

4.35 In mid-1993, we streamlined and simplified the CRR's report forms so as to encourage reporting of data. To cater for its future enhancement, new computer software and hardware were installed and migration of the CRR to the new computer system was completed in 1994. This will facilitate data retrieval and compilation of statistics.

Disability Prevalence Rates

4.36 Apart from a large scale psychiatric community survey in Shatin, no major surveys have been carried out to ascertain local prevalence rates for various disabilities. In order to obtain projections for the likely number of people with a disability, it is necessary to rely on information from a variety of sources, both in Hong Kong and overseas.

4.37 A territory-wide prevalence study would be a highly specialized area of statistical enquiry, we have concluded that it cannot be conducted in the context of the 1996 by-census. Commissioning a tertiary institution to conduct a special survey with a clinical type of approach would, however, be an enormous task whose costs in terms of time, effort and expenditure would be greater than the potential benefits. We have, therefore, decided not to pursue the idea. Overseas prevalence rates or demand formulae, where appropriate, will continue to be taken into account in the planning for rehabilitation services.

CHAPTER 5

MEDICAL REHABILITATION

Introduction

5.1 With technological advances being made and an ageing population, the morbidity pattern in Hong Kong has shifted towards chronic diseases. Many of them are disabling in nature and these patients will require long term rehabilitative care. It is most important that the planning and development of medical rehabilitation services are geared towards this and complement community rehabilitation so that patients can have equal opportunities and full participation as ordinary individuals.

Principles and Policy Objectives

5.2 The ultimate aim of medical rehabilitation is to restore patients' functional capacity to their maximum potential so that they can live independently and continue to participate in the community as far and as equally as possible. Medical rehabilitation aims to help patients overcome their structural or functional impairments, minimize the residual defects, disabilities or complications, and develop their life skills. Long term institutionalization is avoided as far as possible.

5.3 Nonetheless, it is recognized that there are patients who have little or no rehabilitation potential and who cannot be integrated into the community. They require long term accommodation, maintenance care and protection. The target for these patients is to minimize or defer further deterioration and to maintain whatever level of improvement which may be achieved.

5.4 Assessment, treatment and rehabilitation are regarded as an integrated continuum. Conducting full assessment at an early stage and choosing appropriate treatment are important pre-requisites for successful rehabilitation. As such, rehabilitation is no longer considered as starting after the acute phase of illness. Instead, it forms an integral part of the acute treatment process.

5.5 It is important to have a proper and professional multi-disciplinary assessment of the physical, mental, functional and social abilities, as well as the needs and potential of individual patients. Comprehensive, consistent, and individually tailored management/care/rehabilitation plans are being, and will continue to be, formulated and executed through well co-ordinated inter-disciplinary and/or multi-disciplinary efforts. Such a concept of rehabilitation extends beyond institutional settings into the community to form a continuum. Collaboration between medical settings, social welfare organizations and other relevant parties is needed to ensure good patient rapport and to meet the specific needs of patients. Similarly, promotion of a caring attitude among the family members and the community is encouraged.

5.6 The ways in which clients requiring medical rehabilitation are identified and referred are discussed in Chapter 4.

5.7 The Hospital Authority took over the management and control of all public hospital services on 1 December 1991. Committed to improving medical services in Hong Kong and with greater flexibility in its resource utilisation and management, the Hospital Authority will continue to improve and expand the provision of medical rehabilitation services in the years ahead, subject to availability of funds. Hospital Authority's planned improvement measures are briefly described in the following paragraphs.

Medical Rehabilitation for People with Physical Handicap

5.8 At the end of March 1995, there were 322 public hospital beds officially designated for rehabilitative purposes. Rehabilitative activities are also taking place in other settings, such as extended care hospitals including infirmaries, as an integral part of hospital services provided by the Hospital Authority.

5.9 There is a rapidly increasing demand for medical rehabilitation in most clinical disciplines. In addition to the traditional emphasis on orthopaedics and traumatology, these include rheumatology, cardiology, respiratory medicine, oncology, stroke, neurosurgery, renal medicine and the like. Under such circumstances, co-ordinators with multi-disciplinary and multi-speciality knowledge are of great help in ensuring the quality and development of medical rehabilitation services

to meet the diverse needs of patients suffering from various chronic illnesses. So far, two rehabilitation consultants have been appointed, one in Kowloon Hospital and one in Tung Wah Hospital.

5.10 The role of rehabilitation co-ordinators is to ensure appropriate utilization of resources to meet rehabilitation needs; and to ensure smooth formulation and execution of comprehensive management and of rehabilitation plans tailored for individual patients. They need to participate directly and liaise with other concerned parties in the assessment, treatment and rehabilitation process. As such, they need to have broad-based training to acquire multi-speciality and multi-disciplinary knowledge. Clinicians will be encouraged to undergo such training which is currently available overseas, for example, in Scandinavia. As a parallel development, the co-ordinating role can also be assigned to a committee comprising specialists from different disciplines. Rehabilitation is an important and long term process, and it is essential to have either a specific unit or an individual to be responsible for it.

5.11 The following measures are being, and will continue to be, taken to improve medical rehabilitation services for people with a physical handicap -

- (a) the existing services provided at the extended care hospitals will continue to be improved with a view to developing some of these hospitals into specialized centres for medical rehabilitation;
- (b) a specialization in medical rehabilitation will be established in order to cater for the diverse needs of people with a disability, for example, cardiac rehabilitation, neurological rehabilitation, respiratory rehabilitation, speech rehabilitation and cancer rehabilitation;
- (c) full time rehabilitation co-ordinators will continue to be appointed in each of the major extended care hospitals providing medical rehabilitation services to plan, develop and co-ordinate rehabilitation programmes;

- (d) in major extended care hospitals which admit a wide variety of patients, special co-ordinating committees with multi-speciality and multi-disciplinary input will be set up to support the rehabilitation co-ordinator;
- (e) a network of rehabilitation services, where day rehabilitation programmes and domiciliary services can be promoted, will be developed thereby enhancing patients' abilities to actually participate in the community;
- (f) the provision of medical rehabilitation personnel, physiotherapists, occupational therapists and prosthetists and orthotists in particular, will continue to be improved;
- (g) the training of medical rehabilitation personnel will be strengthened and upgraded;
- (h) courses for professional grades will be modified or upgraded so that they incorporate advances in the relevant technology; and
- (i) self-help groups formed by patients will be encouraged and promoted.

Psychiatric Medical Rehabilitation for People with Mental Illness

5.12 Traditionally, psychiatric practice has been predominantly hospital-centred. The two big psychiatric hospitals in Hong Kong, namely Castle Peak and Kwai Chung, are located in remote areas. On the other hand, psychiatric out-patient clinics and day hospitals are district-based. This geographical separation has greatly limited their interaction. Such inadequacy is even more significant when considering the link with aftercare services, e.g. halfway houses, which are mainly operated by the social welfare sector. The flow of patient information between hospitals, out-patient clinics, day hospitals, community psychiatric nursing service, and welfare service units is far from satisfactory and needs further improvement.

5.13 Hospital Authority has reorganized its psychiatric services into four geographic clusters, based in Castle Peak Hospital, Kwai Chung

Hospital, Queen Mary Hospital/Hong Kong Psychiatric Centre and Prince of Wales Hospital/Shatin Hospital. There has also been vertical integration of the care process across acute, extended, ambulatory and community care to improve continuity of clinical and rehabilitative care and to minimize problems arising from the physical separation between mental hospitals and other non-institutional services.

5.14 There is also a growing demand for subspecialization in psychiatric care. There are four psychogeriatrics teams, while two community psychiatric teams were set up in 1994-95. Another subspecialty service now being actively planned is child psychiatry.

5.15 Efforts to improve psychiatric rehabilitation focus on the following -

- (a) improvement of the liaison between the medical and the social welfare sectors by establishing formal communication channels at different levels to improve mutual communication and co-operation, and to co-ordinate the development and planning of psychiatric rehabilitation services;
- (b) consolidation of the development of psychogeriatrics community psychiatry and other subspecialty services; and
- (c) introduction of a clinical information system to facilitate an efficient flow of information within the medical and welfare service network so as to improve the setting of rehabilitation objectives and the evaluation of patient outcomes.

Medical Rehabilitation for People with Mental Handicap

5.16 The main feature of this service is to provide infirmary care. At the end of March 1995, there were 825 public hospital beds designated for the care of severely mentally handicapped people. The Caritas Medical Centre with 300 beds admits those below 16. It also runs a specialist clinic for pre-admission assessment and follow-up. These services now come under the Paediatrics Unit of the hospital. The Siu Lam Hospital with 300 beds and Tuen Mun Hospital with 200 beds admit those aged 16 or above. Urgent temporary placement service is

provided in the former, while respite service is being planned in the latter. Specialist clinics are also available in the Yaumatei and Violet Peel Psychiatric Centres. These services are all under the management of full-time psychiatrists. In addition, community outreach services are now being introduced with a view to supporting clients with a mental handicap who are living in other residential or community settings.

5.17 The main focus of services in these three centres is on care and protection. With intensive rehabilitative efforts, including the provision of conductive education, behavioural therapy and better control of epilepsy, it is now possible for patients to improve significantly after the appropriate professional input, and some of them are then discharged from hospital. The condition of these patients sometimes changes, and a certain degree of dynamism in service provision, especially at the interface between these centres and the residential service in the social welfare sector, is allowed for.

5.18 The introduction of units for people with a mental handicap in general hospitals, such as the Tuen Mun Hospital, will provide greater potential for better patient assessment and rehabilitation programme planning as these units will allow greater interaction with other clinical specialities and disciplines.

5.19 Specialist out-patient clinics, day hospitals and community outreach services will be further developed as channels for assessment and professional support for patients living in social welfare institutions or in the community. These will decrease significantly the need for long term institutionalisation.

Policies and Services in Respect of Autism

5.20 Autism is a developmental disorder characterized by three core handicaps, and where a variety of other handicaps frequently co-exist. Research in recent years has led to a much better understanding of autism. The Green Paper considered that policy and services for people with autism appeared outdated in the light of new findings. It recommended that a separate working group be set up to examine the provision of services for autistic persons. The Working Group on Services for Autistic Persons was set up under the auspices of Rehabilitation Division of the Health and Welfare Branch in late 1991.

Comprising representatives from concerned government departments, non-governmental organizations, professionals and parent associations, it produced a report in January 1994. The report was subsequently endorsed by the RDCC and accepted by the Secretary for Health and Welfare.

5.21 In the light of the Working Group's recommendations, people with core autism or autistic features are now collectively termed as people suffering from autistic disorders. The prevalence rate was revised from 8 : 10 000 to 10 : 10 000 which will be taken into account for the purpose of long-term service planning.

5.22 There are 18 major recommendations in the Working Group's report. Funds have been secured to implement most of them over the next four years. These include 78 additional special programme places in pre-school centres and upgrading the provision of occupational therapists and clinical psychologists for people with autism. A Hong Kong delegation comprising 12 representatives from the non-governmental sector, the Rehabilitation Development Co-ordinating Committee and concerned departments conducted an overseas study visit on autism in January 1995. The delegation visited selected service establishments in Tokyo and the Division TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children) of the University of North Carolina in the United States of America. In the light of its observations, the delegation produced a report on the study visit which was endorsed by the Rehabilitation Development Co-ordinating Committee in April 1995.

Geriatric Rehabilitation

5.23 The percentage of the population aged 60 and above has been rising, and this trend is expected to continue. The ageing process is associated with illnesses and disabilities. It is common for elderly persons with a disability to suffer from more than one disability. Many of them are incapacitated further by the lack of adequate social support. They are prone to rapid deterioration, resulting in permanent disability, if care and rehabilitation cannot be provided at the right time and in the right place. In addition, they often respond slowly to treatment and rehabilitation and require long term maintenance care.

5.24 The aim of medical rehabilitation for elderly persons is to restore the patients' functional abilities to their maximum potential so that they can live on their own and continue to participate in all aspects of community life. Long-term institutionalization of elderly persons with a disability is avoided as far as possible.

5.25 Apart from the traditional emphasis on in-patient, out-patient and day-patient services, other new initiatives have been introduced in recent years, in particular, the community geriatric assessment service and psychogeriatric service. A total of five community geriatric assessment teams and four psychogeriatric teams were established in 1994-95. These services provide early assessment and management of elderly clients in the community and enhance the caring capacity of their carers. The objective is to improve the health, functional status and quality of life of elderly persons to their maximum potential so that the chance of hospitalization and long term institutionalisation is minimized and they, as far as possible, can enjoy a normal life in the community.

The Working Group on Care for the Elderly

5.26 This working group, appointed by the Governor in 1993, conducted a general review of services for older people and formulated proposals on the objectives and future development of such services. It published its report in August 1994. There are 71 recommendations in the report. They aim to -

- (a) provide a network of care for the elderly;
- (b) assist elderly persons to live in the community with dignity for as long as possible;
- (c) provide a range of residential care for those elderly persons who cannot be cared for at home, and
- (d) provide a range of community support services for elderly persons and their carers.

5.27 The recommendations of the Working Group will be implemented in phases. One of the recommendations is the

establishment of nursing homes which are of particular pertinence to geriatric rehabilitation. Initially, the nursing homes will provide a total of 1 400 places for elderly people. This new service will be subvented by Government and run by non-governmental organizations. This type of residential care is community-oriented, as distinct from hospital or infirmary care. It provides care to elderly people outside a hospital environment, thereby reducing the number of them being admitted to hospitals and infirmaries. The first nursing home is expected to come into operation in 1997.

5.28 Geriatric rehabilitation will develop along the following lines -

- (a) the community geriatric assessment service will be strengthened to provide professional support to elderly persons living in other residential or community settings, as well as to their carers;
- (b) a geriatric service will be provided in all major acute hospitals;
- (c) the rehabilitative role of residential homes and community support services will be enhanced, and the demand for and provision of them will be reviewed;
- (d) community-based rehabilitative services, especially domiciliary occupational therapy and domiciliary physiotherapy, will be developed to promote and support the care of elderly persons in the community;
- (e) medical and social services for elderly persons will be organized into district-based networks to ensure collaboration in the provision of care and rehabilitation for elderly persons;
- (f) there will be improved staff training and education in geriatric rehabilitation;
- (g) public education on family and community responsibility towards elderly persons will be promoted;

- (h) a mechanism will be established to monitor and evaluate the standard of geriatric rehabilitative services;
- (i) healthy retired elderly persons will be encouraged to participate in the rehabilitation of those elderly persons with a serious disability; and
- (j) mutual support groups will continue to be encouraged, since group members can give psychological support and comfort to each other by sharing their experiences.

Rehabilitation Services for People with Chronic Illness

5.29 As in the case of people with a disability, chronically ill patients, including those suffering from brain injury, cancer and pneumoconiosis, need a wide range of medical, social and vocational rehabilitation services to help them live as normal a life as possible. These services are, indeed, being provided by concerned departments and authorities. As visceral disability has now been included as a new category of disability, community-based rehabilitation for people with visceral disability has been strengthened. Details are set out in Chapter 9.

5.30 It is important to enhance and support the role of patients, their families and the community as carers. There are eight patient resources centres in Queen Mary Hospital, Queen Elizabeth Hospital, Tuen Mun Hospital, Kwai Chung Hospital, Caritas Medical Centre, Grantham Hospital, Princess Margaret Hospital and Castle Peak Hospital. They act as the focal point to provide support, and to facilitate the formation of self-help groups and community linkages. Four additional patient resources centres have been planned for 1995-96.

Oral Health Care

5.31 Patients with a mental handicap or physical handicap often have difficulty in gaining access to normal oral health care, partly because of their inability to practise health care and self-care, and partly because of their own inability or unwillingness to seek proper treatment. This is particularly true for people with a severe handicap, whether

mental or physical. An additional group requiring priority dental care are those suffering from head and neck cancers.

5.32 Referral centres for special oral health needs groups will be set up in all regional hospital dental units in phases. One centre was set up in Tuen Mun Hospital in February 1995, while the other one in Pamela Youde Nethersole Eastern Hospital will be set up in July 1995.

Post-discharge Follow-up Services

5.33 A variety of services are available to assist patients who have been discharged from hospital but who still require nursing care, support or assistance. These include -

- (a) the community nursing service. This provides medical care and support for sick persons, people with a disability and elderly persons in their own homes. Patients are encouraged, with the help of their families, to participate in their own treatment and rehabilitation. The service is district-based, and operates through a network of 39 satellite centres and six hospital stations;
- (b) the domiciliary occupational therapy service. This provides advice, assistance and training to persons with various disabilities who face adaptational problems in their daily life activities at home or at work. Discharged hospital patients usually receive this service through the Hospital Authority, while special school leavers and elderly persons within the community are served through non-governmental organizations;
- (c) the Community Psychiatric Nursing Service (CPNS). This provides psychiatric nursing care and preventive nursing services for discharged mental patients. By assisting patients in their treatment programme and in their readjustment process as well as educating patients and their families on mental health, CPNS reduces the risk of relapse of the psychiatric patients, and enables many of them to be rehabilitated in the community rather than in hospitals; and

- (d) the medical social service. This aims to prevent the recurrence of social and emotional problems related to illness situation among patients and their families; to assist those patients and families with such problems when they arise; and to enable them to make the best use of medical and rehabilitative services. It also aims to strive for the promotion of health for them and the community.

5.34 All the follow-up services described above contribute to the rehabilitative process, and in many cases enable patients to be rehabilitated in the community rather than in hospitals. These services also recognize the stress imposed upon the family members of persons who have undergone medical rehabilitation, and thus are able to provide advice and counselling as appropriate. These services should not be seen in isolation as good rehabilitation services demand good multi-disciplinary collaboration. They are integrated through the multi-disciplinary team concept to provide effective and comprehensive rehabilitation services. The demand for these services is kept under review, and improvements made as required.

CHAPTER 6

EDUCATION

Principles and Policy Objectives

6.1 The "School Education in Hong Kong : A Statement of Aims", published by the Education Department in September 1993, defines education as a social process by which people may attain social competence and optimal individual development. In particular, current educational theory emphasizes the realisation of innate abilities, and sees the educational process as flexible and adapted to the needs of an individual. Special education is first and foremost education, not rehabilitation. Some rehabilitation services may be required to support, enhance or even expedite the educational programme geared to individual needs and provided by special education, but the programme itself is educational.

6.2 Special education is education which is adapted from or additional to that normally provided in the ordinary classroom and is offered to pupils whose needs are not being met fully by mainstream education. It is offered to children with a disability, maladjusted and gifted children, and children who are unmotivated or have learning difficulties. It is now generally agreed among educationalists that special education encompasses the whole range and variety of additional help wherever it is provided and whether on a full or part-time basis. Since special education is an integral part of the education system, it was recommended in the Green Paper that it should become the responsibility of the Education and Manpower Branch, while the rehabilitation services required to support special education should continue to remain the responsibility of the Health and Welfare Branch. A review of the policy responsibility for special education was, therefore, undertaken within the Government Secretariat. As a result, the Secretary for Education and Manpower took up policy responsibility for special education with effect from 1 April 1995.

6.3 The concepts of "full participation" and "equalisation of opportunities" are in line with the educational philosophy that the goals of education are the same for all children in terms of personal

development and community involvement. Every child, with or without disabilities, is a unique individual having his own rights and obligations to the community of which he forms a part. Equal opportunities are provided for all children to develop their potential to the full so that they can grow up to be active and responsible members of the community and achieve as much independence as possible. Since the 1970's, the main trend of special education has been one of helping children with a disability to integrate into the mainstream as far as possible so that they can receive an appropriate education alongside their peers. It is important that the services themselves are individualised and accessible, and offer a choice commensurate with the requirements of the community.

6.4 In accordance with the above principles, the objectives for the development of educational services are to -

- (a) provide all children with a minimum of nine years of free and compulsory general education;**
- (b) given that children with a disability may experience difficulty in learning, give them appropriate programmes to enable them to maximise their abilities;**
- (c) provide vocational and skills training beyond compulsory school age as required since such practical skills are necessary for people with a disability to live more independently and participate more fully in society;**
- (d) make available higher education to people with a disability if they are academically qualified;**
- (e) for children with a disability who cannot benefit from education in ordinary schools, provide special schools and special education classes in ordinary schools;**
- (f) give special pre-school education and training to children with special needs as early education is of particular importance to people with a disability; and**

- (g) provide opportunities for people with a disability to pursue adult education since it gives those who missed on the compulsory education the chance to receive a formal education.

Measures to Integrate Disabled Students into Ordinary Schools

6.5 Children with a disability are encouraged to receive education in ordinary schools as far as possible and as early as possible. Teachers and students in ordinary schools must learn to accept that disabled students have a right to be there. The process of integration has been expedited.

6.6 Special education is the responsibility of all teachers in the school system. To enhance teachers' understanding and acceptance of children with special educational needs, there is an element in the initial teacher training for ordinary school teachers on the education of children with special educational needs. To promote integration, the Education Department organizes regular seminars and talks for ordinary school teachers on the acceptance and handling of children with a disability. Pamphlets and leaflets promoting the understanding of disabled children are also available to teachers. The whole-school approach to guidance and the development of the school-based curriculum is being implemented. In the formal curricula for ordinary school children, there are topics relating to people with a disability at primary and secondary levels and the optional curricula at the senior secondary and sixth form levels in order to promote acceptance of the people with a disability and their integration. Apart from topics in the formal curriculum, schools are also encouraged to organize various extra-curricular activities in the civic and moral education programmes. For special schools, educational programmes for practical and cultural subjects are adapted for disabled pupils. While there are no formally adapted educational programmes for children with a disability in ordinary schools, the teachers take into consideration the children's special needs and organize appropriate programmes accordingly.

6.7 At present, special schools for the blind and for the deaf also function as resource centres for integrators. The possibility of utilising special schools for mentally handicapped children as resource centres to promote integration is being explored.

6.8 The provision of access facilities is a prerequisite for integration of physically handicapped children. Access facilities for physically handicapped children who are wheelchair-bound or who have locomotive problems will be provided in new schools scheduled for completion from 1998 onwards. Conversion of existing schools to improve accessibility will also be considered in the context of major renovation work, during which factors such as structural feasibility, and alternative provision of schools with access facilities in the district will be taken into account.

Pupils with Visual Impairment

6.9 Visually impaired children are encouraged to receive education in ordinary schools as far as possible. They receive assistance from resource teachers (from schools for the visually impaired) in the preparation of supplementary teaching materials such as braille books and notes, braille test and examination papers, embossed maps and diagrams, and training in the use of technical aids.

6.10 In addition to the services provided at school, the Hong Kong Society for the Blind and the Hong Kong Association of the Blind provide supportive educational services at their resource centres, including reading, tutoring, braille and the provision of study rooms. The Centralised Braille Production Centre of the Hong Kong Society for the Blind is subvented by the Education Department.

Pupils with a Physical Handicap

6.11 Physically handicapped pupils in ordinary schools receive remedial teaching, counselling, and advice on rehabilitation aids and resources from the Resource Help Service operated by the Education Department.

Pupils with Hearing Impairment

6.12 Children with hearing impairments who do not need places in special schools are encouraged to integrate in ordinary schools, where they can benefit from peripatetic advisory services, or special classes operated in ordinary schools. The Supportive Remedial Service, piloted by a special school for children with hearing impairments integrated into

ordinary schools, has proven an effective means to improve the performance of hearing impaired children. The service is being implemented in all primary schools and has been extended on a pilot basis to hearing impaired children attending secondary schools in 1994-95. Besides the Supportive Remedial Service, the Education Department also provides advice on the use of hearing aids, ear moulds and the special seating arrangements required in an ordinary classroom setting, as well as resource materials.

Pupils with a Mental Handicap

6.13 Mildly mentally handicapped children are encouraged to receive education in ordinary schools. Intensive remedial support services are provided by the Education Department to facilitate their integration. These services include resource classes or peripatetic teaching services, centre-based remedial support, and advisory services for teachers.

English-speaking Children with Special Education Needs

6.14 Special educational provision for English-speaking children in Hong Kong is provided in schools run by the English Schools Foundation (ESF) which receives subvention from the Government. Similar to the local sector, English-speaking children with special needs are integrated in ordinary schools with support from school-based special units. At present, the ESF operates two primary special units and two secondary units in two junior and two secondary schools. A total of 84 places are available.

6.15 For the more severely handicapped English-speaking children, education is provided in the Jockey Club Sarah Roe School of the ESF. A total of 40 places are provided.

Pre-school Education and Training

6.16 Pre-school services comprise early education and training centres, special child care centres, integrated child care centres and integrated kindergartens. As the early childhood period of rapid development is likely to be even more crucial for children with a disability, it is clear that pre-school services have a vital role to play in

rehabilitation. Not only do they prevent impairments from having a negative physical, social or psychological effect, but they also maximise the child's development potential. In the long run, they minimise the medical, educational and welfare costs to society. That is why our policy on pre-school services emphasizes the provision of equal opportunities and full participation through early intervention programmes. Families with children with a disability are supported by relevant community services, and parents are involved as full partners in making decisions which affect the development of their children.

6.17 Taking all these points into consideration, the policy objective is -

To provide a comprehensive range of pre-school services for children with a disability or children at risk of becoming disabled from birth to the age of six which enhance their physical, psychological and social development. Early intervention will reduce their developmental delay, increase their opportunities for participating in ordinary schools and daily life activities, and help their families to meet their special needs.

6.18 The provision of and demand for pre-school services for disabled pre-schoolers are shown at Appendix F II. As mentioned in Chapter 2, we will provide over 700 extra places in pre-school centres over the next four years to help meet the increased demand.

Early Education and Training Centres

6.19 The early education and training centres (EETC) provide centre-based early education and training programmes for children with a disability from birth to the age of two as well as those aged between two and five years 11 months who need EETC's service. Particular emphasis is placed on the role of their families. This is because very small children are best cared for in their homes. The primary objective is to support their parents in training and caring for them.

Special Child Care Centres

6.20 Special child care centres (SCCC), established in 1978, provide intensive training and care for moderately and severely disabled children aged between two and five years 11 months who cannot benefit from the integrated programmes in ordinary child care centres or in kindergartens. The training in SCCC aims at developing disabled children's sensory, perceptual, motor, cognitive communication, social and self-care skills. Where a child requires therapy or care services which cannot be provided either by a day SCCC or by his family, he may be given a place in a residential SCCC. Residential special child care centres also take in children with a disability who are homeless, abandoned, or whose families cannot care for them adequately.

6.21 With additional social work input, the extension of special provision for autistic children to all SCCC's and the provision of central clinical psychologists' support, the quality of the service will be substantially improved.

Integrated Child Care Centres

6.22 Integrated child care centres (ICCC) provide training and care for mildly disabled pre-schoolers between the ages of two and five years 11 months. Each participating child care centre with 100 places sets aside six places for such children, and is provided with an additional special child care worker.

6.23 Resources have been secured to provide ICCC places. The Social Welfare Department will improve occupational therapy services for ICCC subject to availability of funds, and will continue to review the need for improving physiotherapy services for ICCC.

Integrated Kindergarten Programme

6.24 The integrated kindergarten programme (I K/G) was designed for mildly disabled pre-school children in ordinary kindergartens. Started as a pilot project in 1985, it was shown to be effective in 1988 and expanded to 20 I K/G providing a total of 120 places. The I K/G programme takes in children from the age of three to five years and 11 months who are identified as being able to benefit from

education in an integrated setting. Each non-profit making kindergarten joining the programme can employ an additional trained kindergarten teacher to serve as a resource teacher and to conduct remedial programmes for up to six children. These children receive individual tuition for half an hour each day and participate the rest of the time in the same activities as their peers.

6.25 As kindergartens are not subvented, the Education Department has had to look for other ways to encourage operators to accept children with a disability. These include salary reimbursements for resource teachers, the provision of training opportunities for these teachers and the loan of resource materials and teaching aids. I K/G has evolved into a system with its own characteristics and values. It will continue to be an additional service option for disabled pre-schoolers to meet part of the demand for ICCC.

Preparatory Classes in Special Schools

6.26 Preparatory classes are provided in special schools for blind, deaf and physically handicapped children aged four to five years 11 months. In addition to their major disabilities, some of these children may also have other handicaps, for example, a mild or moderate mental handicap.

6.27 Preparatory classes ensure a smooth transition from the early years of education to primary education. The aim is to develop the children's general learning ability, language proficiency, reading and writing, concept of numbers and social and motor skills. In the 1994-95 academic year, 145 places in preparatory classes were provided in special schools. These classes will continue to be run as part of the overall provision of special school places for the different disability groups.

Primary and Secondary Education in Special Schools

6.28 Special schools are provided for children with more complex special educational needs or whose disabilities are so severe that they cannot benefit from education in ordinary schools. At present, children with a physical handicap or sensory impairments are provided with at least nine years of free general education, and mentally handicapped children are provided with ten. In addition, blind, deaf or

physically handicapped children who require a longer period of such education may receive up to three additional years of free education in the respective special schools.

6.29 We consider that students, disabled or otherwise, should be given equal opportunities to receive nine years of free general education. However, the Director of Education has the necessary flexibility to allow individual students with a disability to receive a longer period of education. Parents' requests are considered on the basis of individual merits.

6.30 Beyond the junior secondary level, diverse forms of educational facilities are also provided for children with a disability. The provision of different types of subsidised post-secondary 3 education has meant that they have access to educational facilities best suited to their capabilities and aptitudes.

6.31 For children who are capable of pursuing academic studies, senior secondary education (secondary 4 - secondary 5) is provided either in ordinary or special schools. For children who are not academically inclined, vocational training is provided.

6.32 On a territory-wide basis, there are enough special school places for all children with a disability. The provision of special school places for mentally handicapped children has been reorganized through the reprovision of existing special schools to meet higher demand in particular regions. A school bus service is being provided in most special schools. The Education Department is considering improvement to this service to cover all special schools. The provision of occupational therapists and physiotherapists has been strengthened with effect from September 1994.

Hospital Schools

6.33 The main objective of hospital schools is to ensure that the education of children who are receiving medical care in hospitals or medical rehabilitation centres is not seriously disrupted. This makes it easier for such children to resume schooling when they are discharged.

6.34 In 1994-95, classes ranging from primary to junior secondary levels were operated in 15 hospitals, catering for pupils aged six to 15 years. Some of these classes are run in psychiatric hospitals or centres for children with various kinds of psychiatric or behavioural problems including autism, hyperkinesis, schizophrenia, depression and conduct disorder.

6.35 The Education Department's current policy objective is to provide free and compulsory education to children aged six to 15 years and 11 months and up to the junior secondary level. As the suggestion for extending the hospital schools service to senior secondary levels will have implications for all other special educational services, we have decided not to pursue it further at this stage.

Boarding Facilities in Special Schools

6.36 Boarding facilities are provided for moderately, severely and profoundly mentally handicapped children, or children who are blind, deaf or physically handicapped, who have no family, who live too far away from school, who need temporary care or whose families cannot care for them adequately. The demand for boarding places, except those for moderately mentally handicapped children, has been fully met. The demand and supply of boarding places for these children are under constant review and efforts will be made to provide more boarding places. The Education Department will continue to monitor carefully the supply and demand for boarding places.

Promotion of Parent Teacher Associations in Special Schools

6.37 Schools in Hong Kong, including special schools, are encouraged to maintain close liaison with parents in the education of their children. A series of booklets on good parenting has been published by the Education Department and is extensively promoted, with the aim of improving home-school co-operation. Feedback from parents and the public has been encouraging. The booklets are distributed every year to parents of pupils newly admitted to schools.

6.38 In accordance with the recommendations of the Education Commission Report No. 5, a Committee on Home-School Co-operation was set up in February 1993. Subsequently, the Education Department

issued guidance notes to schools on the setting up of Parent Teacher Associations (PTAs) in June 1994. School circulars will also be issued every June to invite applications for project grants to set up PTAs and to implement innovative programmes in improving home-school partnership. For 1994-95, 33 special schools were provided with such project grants. The remaining special schools, though they have not applied for the grants, have routinely carried out home-school liaison work and promoted parental involvement in the education process.

Education for Autistic Children

6.39 At present, because the majority of autistic children are also mentally handicapped they receive their education in special schools for the mentally handicapped, where additional resource teachers and specialist staff, such as educational psychologists and speech therapists, are provided. These special schools also have the advantage of smaller class sizes, better teacher to pupil ratios, and individualised educational programmes. In this way, they cater for the children's special training needs in behaviour management, communication and social skills.

6.40 In the light of a recommendation by the Working Group on Services for Autistic Persons, discussed in Chapter 5, the Education Department provided 12 additional resource teachers in special schools in the 1993-94 academic year and will provide 15 more in the 1995-96 academic year.

Adult Education

6.41 Adult education courses include retrieval and general education courses for adults with a disability who missed the opportunity of a formal education earlier in life, as well as a variety of cultural, social and recreational activities. Such courses are very important as they offer disabled adults a second chance to receive an academic or non-academic education. The Education Department subvents non-governmental organizations which develop retrieval adult education courses and run adult education programmes. This subvention covers the costs of the teaching and supporting staff, basic equipment and other charges. Suitable transport is provided by non-governmental organizations to enable adults with a disability to reach the course venues which must also be fully accessible and equipped with technical aids. Students may

use the Rehabus service to attend courses and may apply to a variety of non-governmental funds to purchase technical aids.

Tertiary Education

6.42 Tertiary education is available for people with a disability who are capable of receiving it. Tertiary institutions are in general aware, at the highest level, of the higher education needs of students with a disability and are prepared to consider, where appropriate, strategies for overcoming the difficulties experienced by such students wishing to study in their institutions.

6.43 A total of 33 students with disabilities were admitted to tertiary institutions funded by the University Grants Committee (UGC) in the 1994-95 academic year. To ensure equalisation of opportunities, disabled tertiary students must have access to the various buildings and facilities in tertiary institutions.

6.44 Concern has been expressed, both about the inadequacy of technical devices to facilitate studies of students with a disability and the difficulties of access to or around the various campuses. Steps are now being taken to improve the situation. Needy students may apply for the Local Student Finance Scheme for grants/loans to purchase the technical devices required, which may continue to be used by them after graduation. All the new academic buildings in the UGC-funded tertiary institutions are accessible to students with walking difficulties. As regards the older buildings, the institutions concerned should be able to improve access to these building through minor alteration works. The problem of access generally is considered in more detail in Chapter 11.

6.45 Some students with a disability find studying at the Open Learning Institute (OLI) more suitable. As at October 1994, 45 students with a disability were studying in the Institute. The OLI has established a Committee for Students with Disabilities to review and develop institute policy towards students with disabilities. The Committee is tasked to develop and review Institute policy towards students with disabilities; to establish communication with appropriate organizations supporting the disabled, in Hong Kong and elsewhere; and to monitor the implementation of policy. The OLI has also acquired some equipment to help visually impaired students and obtained a grant from the Royal

Hong Kong Jockey Club for the purchase of additional equipment to assist students with a disability.

Education for Maladjusted Children

6.46 Most maladjustment are not permanent handicaps. The disruption to learning experienced by children with emotional or behavioural problems is generally not the result of an impairment but arises from, or may be influenced by, unsatisfactory relationships in school or at home. These difficulties can be overcome if special help is provided. However, some maladjusted children may require special intensive programmes to help them in the adjustment and as such programmes cannot be provided in ordinary schools, it will be preferable for them to remain within the area of special education. The issue of whether maladjustment should continue to be included as a category of disability will be jointly reviewed by the Education Department, Social Welfare Department and non-governmental organizations.

Overall Review of Special Education

6.47 In the context of special education, this Chapter has examined issues such as the medical, welfare and transport needs, specific to children in special schools. As for general educational issues such as age coverage and class size, they are being examined by the Board of Education.

CHAPTER 7

EMPLOYMENT AND VOCATIONAL REHABILITATION

Policy Objective

7.1 To meet the goals of full participation and equalization of opportunities in the context of employment and vocational rehabilitation, the objective is to ensure that people with a disability have an equal chance to participate in productive and gainful employment in the open market. Measures are taken to facilitate open employment for people with a disability both in the public and private sectors. Supported and sheltered employment is provided for those who cannot cope with the demands of the competitive job market.

7.2 Vocational rehabilitation is part of the continuous and co-ordinated process of rehabilitation which involves the provision of vocational services, such as vocational guidance, vocational training and selective placement. These enable people with a disability to secure, retain and advance in suitable employment and, thereby, to further their integration into society. To this end, dedicated or special training is provided to increase their knowledge and skills so that they are better equipped to apply for a job in the open market. Facilities for re-training are also provided so that people with a disability can update their skills and knowledge in line with modern technology.

7.3 These goals are achieved by -

- (a) creating an environment which provides equal employment opportunities for people with a disability in so far as their disabilities allow;
- (b) identifying their vocational training needs, matching these with the social and physical environment, and providing facilities for their training and re-training;
- (c) providing sheltered and supported employment for those who cannot enter open employment;

- (d) providing day activity centres for people with a disability who cannot benefit from vocational training or sheltered employment, with the aim of assisting them to achieve a measure of independence through training in daily living and simple work skills;
- (e) making available the expertise and resources to modify existing machinery and equipment used by people with a disability and by improving the design and production of technical aids for promoting their productivity and job prospects;
- (f) fostering amongst potential employers knowledge of the abilities and work skills of people with a disability, and by encouraging and supporting those efforts made towards promoting employment opportunities for people with a disability; and
- (g) helping people with a disability to improve their work skills and habits.

Vocational Training

7.4 The Vocational Training Council (VTC) provides vocational training programmes and support services for people with a disability who are assessed as having the ability to work in the open market. To help promote the integration of trainees with a disability into the community, the VTC renamed its Skills Centre for the Disabled to Skills Centre in May 1995. The International Labour Organization's objectives and principles for vocational training for people with a disability are adopted in the design of various vocational training programmes which enable trainees to progress at their own pace and according to their own ability. The level, standards and content of these training programmes take into account the changing needs of industry and the aspirations and abilities of people with a disability. The training and re-training programmes are made available to people with a disability who have, as a result of an industrial accident, lost their original working capability and need training to acquire new skills to compete in the open market. Independent living and social skills training will continue to be strengthened and developed to prepare disabled trainees integrate into the

community. Vocational training programmes will be regularly reviewed and revised to deal with the continuous shift of Hong Kong's economic structure from a manufacturing centre to a tertiary services provider.

7.5 The VTC will strengthen its provision of short term training to adults with a disability. In collaboration with relevant non-governmental organizations, short courses on occupational skills in the servicing, printing and commercial sectors have been developed. These courses are organized in a modular structure with flexible duration and mode of attendance to suit the specific needs of particular disability groups.

7.6 Besides providing people with a disability with vocational training, counselling and guidance, the VTC also provides vocational assessment through its Vocational Assessment Service (VAS). This service assesses the vocational strengths and abilities of people with a disability, so as to judge their potential for open employment, vocational training, supported or sheltered employment. A multi-disciplinary approach is employed in order to assess the individual's capability, interest, aptitude, attitude towards work, adaptation and social needs which may affect his training and employment. Such information allows an individual vocational training programme to be drawn up. The VAS introduced a pilot scheme in 1991 to assess sheltered workers in order to identify those with the potential to move into supported or open employment with the assistance of vocational training. This scheme will be expanded, subject to availability of funds. Through the vocational assessment process, sheltered workers who have the capacity to upgrade their productivity can be identified and offered appropriate training in skills centres.

7.7 Another support service provided by the VTC is the Technical Aids and Resource Centre. This Centre designs and produces special aids and learning resources to assist disabled trainees to pursue vocational training. It also provides technical aids to improve the productivity and job prospects of disabled workers in open employment, as well as guidance and counselling for them.

Employees Retraining Scheme

7.8 In October 1993, the Employees Retraining Board extended its activities to cover disabled employees and industrial accident victims. The Selective Placement Division of the Labour Department works closely with the Board. During 1994, 14 non-governmental organizations were appointed by the Board as training bodies. They are required to identify and approach prospective employers and to get their involvement and support in the design and conduct of the retraining programme. A total of 31 tailor-made courses were held and 469 persons have completed their retraining. The successful rate in open employment was about 75%.

Supported Employment

7.9 Supported employment was introduced in Hong Kong in 1988 to complement open and sheltered employment for people with a disability, with a view to promoting their employment prospects. It enables them to work in an integrated open setting, but with the support of assistance and advice. It gives them a higher income, better job security, and a better quality of life.

7.10 As from March 1995, the Social Welfare Department has made available funds for increasing the number of supported employment places from 30 to 360. We will continue to identify funds to expand supported employment. The four models of supported employment identified in the 1990 Rehabilitation Programme Plan which have been tried out by the Social Welfare Department and non-governmental organizations are set out below.

Supported Job Model

7.11 Individual adults with a disability are placed in ordinary jobs with support provided at the work place by trained staff from a particular establishment or from a service agency engaged in supported employment. These jobs include cleansing and unskilled work in fast food shops, laundries and institutions, as well as packing and assembling work in factories. The Social Welfare Department provides support services for those working in the non-governmental sector.

7.12 A number of non-governmental organizations have introduced or are in the process of planning the following projects -

- (a) St. James' Settlement runs a gift shop which provides supported jobs for people with a mental handicap;
- (b) the Hong Kong Association for the Mentally Handicapped is trying out a job training and employment project for its special school leavers; and
- (c) the New Life Psychiatric Rehabilitation Association runs a vegetable market stall operated by recovered mental patients.

7.13 With assistance from the Agriculture and Fisheries Department, the New Life Psychiatric Rehabilitation Association is exploring the feasibility of expanding the concept of "sheltered farms" to include suitable work on horticulture.

Enclave Model

7.14 Groups of six to eight people with a disability are placed in a regular industrial or commercial setting, where help is provided by the employer. Within this enclave, employees have the same access to work and enjoy the same salary and working conditions as other workers in the company. The Society of Homes for the Handicapped has started a project on this model, while St. James' Settlement is also trying out this model by training people with a mental handicap to work in a food kiosk at Ocean Park.

Mobile Crew Model

7.15 This model consists of teams of people with a disability under the supervision of a non-disabled supervisor. Using a van, they take up tasks such as cleaning, waxing and gardening on a contract basis. With government subvention, St. James' Settlement runs a mobile cleaning crew. The Hong Kong Association for the Mentally Handicapped will provide training to its special school leavers on cleaning and gardening work in the form of a mobile crew.

Benchmark Model

7.16 Long-term employment resembling a mini sheltered workshop is provided to groups of 15 to 20 people with a disability. Examples of this model include -

- (a) a self-help workshop where visually impaired workers engage in photo-copying, packing and sewing work run by the Association of the Blind;
- (b) a workshop on desktop publishing for disabled workers run by the Association for Engineering and Medical Volunteer Services; and
- (c) a sheltered workshop and a computer workshop run by the Federation of Handicapped Youth.

Sheltered Workshops

7.17 Sheltered employment is a way of providing a meaningful occupation for people with a disability who cannot enter into open employment. It helps them establish and develop their social and economic potential. Sheltered workshops provide a planned and controlled working environment which accommodates the limitations arising from their physical or mental condition. Sheltered work also provides opportunities for work adjustment and advancement, with, as an ultimate objective and whenever possible, transfer to the open, competitive employment. The provision of and estimated demand for sheltered workshop places are at Appendix F I. Over the next four years, Government will improve the quality of training in sheltered workshops so that people with a disability will be able to realize their potential and if possible, move on to supported or open employment.

7.18 To enable sheltered workers to move on to supported or open employment, there is a need to develop their management, work and social skills, and to provide them with vocational assessment. In this respect, the Central Psychological and Central Para-medical Support Services of the Social Welfare Department have been strengthened. Supported by non-governmental funding, agency-based allied health

staff are provided to a number of non-governmental organizations with a large number of day training centres including sheltered workshops.

7.19 The Green Paper on Rehabilitation recommended that consideration be given to making sheltered workshops more commercially oriented and less dependent on sub-contract work. It further recommended that a review of the sheltered workshop system be undertaken by the Social Welfare Department. Having considered the changing circumstances and the need to ensure a continuum of support services for people with a disability, a Working Party on Training and Employment for People with Disabilities has been set up under the chairmanship of Director of Social Welfare. The Working Party, consisting of representatives from concerned departments and experts from the private and non-governmental sectors, is tasked to identify further ways to promote employment opportunities for people with a disability. It produced an interim report in February 1995 and will produce its final report in mid-1995. We will consider its recommendations and implement those which are endorsed as soon as practicable subject to availability of resources.

Day Activity Centres

7.20 The first Day Activity Centre (DAC) was set up in 1972 in the Aberdeen Rehabilitation Centre. DACs provide training in day care, daily living and self-care skills for mentally handicapped adults who cannot benefit at the time of placement from vocational training, sheltered work or open employment. The aim is to make the service recipients more independent in their daily lives and prepare them for progression to other forms of service or care. The provision of and estimated demand for DACs are set out in Appendix F I. Details are set out in paragraph 2.32 of Chapter 2.

7.21 Since 1988, changes have been made in the training provided in DACs to enable clients to progress to other community-based services or care. It is important that the programmes and training provided allow for regular assessment to make such progression possible. A training package was drawn up in December 1992 to assist staff in DACs and hostels to design and carry out more effective training programmes. This provides a useful basis for regular assessment of our clients' progress.

Open Employment

7.22 In July 1980, the Selective Placement Division (SPD) of the Labour Department was set up to place people with visual impairment, hearing impairment, and physical handicap in open employment. Four years later, the Division extended its services to include mental handicap people and the ex-mentally ill. The objectives of the SPD are to -

- (a) promote opportunities for open employment for people with a disability;
- (b) establish contact with employers to secure job vacancies for people with a disability;
- (c) place people with a disability in jobs which best suit their residual abilities, skills, qualifications, experience and interests; and
- (d) follow-up those placed in employment to make sure that they can settle in their jobs satisfactorily.

7.23 In order to provide effective placement services for people with a disability, it is important to have a clear and well co-ordinated system of vocational assessment, vocational training and job placement whereby -

- (a) the talents, abilities and potential of people with a disability are identified early;
- (b) appropriate training and re-training are identified for them to meet the changing demands of the job market; and
- (c) the interface between the Education Department, the Social Welfare Department, Vocational Training Council, Employees Retraining Board, Labour Department and the open job market is enhanced.

7.24 The SPD operates on the principles of placing the right person in the right job, and emphasizing the working abilities of the

disabled job seekers. To achieve its policy objectives, the SPD provides the following services to its clients -

- (a) vocational assessment and guidance;
- (b) job matching and referral;
- (c) follow-up service, where the placement officer visits the client at his workplace and deals with any work-related problems; and
- (d) promotion and public education to motivate people with a disability to seek employment, and employers to offer them jobs.

7.25 To remove misconceptions regarding the working abilities of people with a disability and to promote their employability, SPD undertook the following new promotional and public education programmes in 1994-95 -

- (a) the production of television and radio programmes to promote acceptance of people with a disability at the workplace and their working abilities;
- (b) the production of a new set of guidebooks targeted at employers and co-workers, giving practical guide points on "working with disabled employees"; and
- (c) the organization of promotional activities with major employers' associations aiming to identify job opportunities that allow people with a disability to develop fully their abilities and potential.

7.26 In addition, SPD produced guidebooks and videos to enhance the interviewing skills of people with a disability and will continue to run its regular publicity and promotional programmes. These include exhibitions and seminars, visits to employers to canvass vacancies, targeted campaigns at trades and industries, publication of newsletters and pamphlets and special functions to give recognition to outstanding disabled employees and outstanding employers.

Employment in the Civil Service

7.27 As the largest employer in Hong Kong, Government fully recognizes the importance of taking a lead in the employment of people with a disability. If people with a disability are found suitable for employment, they are given preference over other candidates. People with a disability who are able to carry out only certain duties of a particular rank may be appointed even though they may not be able to perform all the duties of that rank. Moreover, additional criteria that may be used to shortlist candidates of selection interviews are not applied to candidates with a disability. This means that if they possess the basic entry qualifications, they will be given the chance to attend interviews.

7.28 Government is the largest employer of people with a disability in Hong Kong. As at 1 April 1995, there were 3 941 persons with various categories of disability working in the Civil Service. We aim to increase the number to 4 000 by March 1996.

Ways to Promote Employment of People with a Disability

7.29 The Green Paper suggested a number of ways to promote the employment of people with a disability. These included tax concessions and a quota system. We have carefully examined the practicability and implications of these suggestions and concluded that they should not be pursued further. While there was support for them, some commentators, including people with a disability, pointed out that employment of people with a disability should be promoted on the basis of their abilities. The primary goal of community acceptance could be easily defeated if they were to be given employment only because of the tax benefits accruing to the employer or because of certain statutory requirements. Moreover, the suggestions are contrary to Government's policy of maintaining a simple and low tax system and laissez faire policy on the economic front.

7.30 Government, however, is firmly committed to strengthening employment opportunities for people with a disability. This is evidenced by the summit meetings on open employment of people with a disability, chaired by the Governor over the last two years and attended by representatives of major employer associations and non-governmental organizations. A number of goals were set out at the meetings for

employer associations to achieve. They were asked, for example, to urge their member companies to adopt an enlightened policy towards the employment of people with a disability. They were also requested to set voluntary targets on the number of people with a disability they intended to employ and to publish these in their annual reports. Progress of follow-up action is being closely monitored.

Public Education

7.31 Public education is essential to promote understanding of the abilities of people with a disability. To focus attention and co-ordinate efforts on the promotion of employment opportunities, the SPD established a Promotion and Publicity Unit in July 1992. The unit plans, organizes and implements various promotional projects as elaborated in the previous paragraphs. It will spend about \$1.9 million on various promotional projects in 1995-96. Adequate financial and manpower resources are needed if it has to conduct community-wide projects to promote employability of people with a disability in Hong Kong.

Policy Statement in Annual Reports

7.32 As a follow-up to the summit meetings mentioned in para. 7.30 above, the Secretary for Education and Manpower has invited major employers, statutory organizations and utility companies to set voluntary targets on the number of people with a disability they aim to employ over the next two years. There is also a need to encourage these organizations to make a statement in their annual reports or employees' handbooks of their employment policy for people with a disability.

Self-employment

7.33 Self-employment is a very important source of employment opportunities for people with a disability. Either individually or in small groups, they may set up their own small businesses at home or outside (e.g. desk-top publishing, snack bars in public parks, mobile cleaning crew), provided that they have adequate funds to meet the setting up costs of such a business. Training in business management and management skills should be provided for them. Self-employment will

establish the self-confidence and spirit of independence of disabled persons, and social integration with the community.

7.34 The Employaid Fund funded by the Community Chest and administered by the Hong Kong Society for Rehabilitation, provides financial assistance to people with a disability in the acquisition of equipment and technical devices for setting up such small businesses. Other sources of funding for self-employment projects include the Royal Hong Kong Jockey Club and the Queen Elizabeth Foundation for the Mentally Handicapped. Government is prepared to support viable projects and provide the necessary assistance. People with a disability and non-governmental organizations have been very innovative in their approach and turned a number of new initiatives into realities. These include acupuncture and massage centres set up by people with visual impairment, a coffee shop run by people with hearing impairment, a coffee kiosk operated by people with a physical handicap and two convenience stores managed by people with various disabilities.

7.35 Self-employment can cover a great variety of profit-oriented trades under different forms, some of which will induce risk of loss. Government's role is to help concerned persons with a disability, normally as a group project, to reach a viable plan and to assist them, where necessary, to secure funding support from sources other than government funds, such as the Royal Hong Kong Jockey Club and the Queen Elizabeth Foundation for the Mentally Handicapped to realize their plans. Individual people with a disability may also approach some related rehabilitation agencies for technical aids, for example, computer aids for setting up certain types of business. They may also seek assistance from various private donations.

Adaptation of Workplaces

7.36 To enable people with a disability to work in open employment, it is sometimes necessary to adapt the workplace or the machinery used. People with a disability may also need certain additional equipment to work properly. In both cases those concerned may be unable or unwilling to meet the costs involved. The Employaid Fund provides grants for the purchase of equipment and aids and the adaptation of premises and machinery. This scheme is widely publicized.

CHAPTER 8

HOUSING AND RESIDENTIAL SERVICES

Principles and Policy Objectives

8.1 A large proportion of the population of adults with a disability can live independently. A disability in itself should not be considered a basis for placement in an institution. Our aim is to provide people with a disability with the range of housing and residential facilities which will enable them to live independently as full participating members of the community.

8.2 In planning new public housing, the access needs of people with a disability are taken fully into account in terms of access to individual buildings. As far as practicable, surrounding facilities and amenities are designed to be barrier free. The creation of such an environment will facilitate the integration and full participation of people with a disability in the community.

8.3 When people with a disability cannot live independently and cannot be cared for adequately by their family a range of appropriate residential facilities is provided for them. Apart from offering accommodation, these facilities provide the necessary training and support services to enable the residents to live as far as possible in a normal home environment. Moreover, the services help them develop independent living skills and progress from one level of accommodation to another. The aim is that eventually at least some of the residents can live independently in the community.

Existing Housing Measures

8.4 Like anyone else, people with a disability, or their family members, are free to apply for public housing provided they meet the necessary criteria. In addition, under the Compassionate Rehousing Scheme, the Housing Department allocates a number of domestic units in public housing estates, on the recommendation of the Social Welfare Department, to people with a disability. Where modification to meet their needs is required, it is carried out by the Housing Department. The

Social Welfare Department and the Housing Department work together to ensure that there is adequate flexibility in the criteria of the Compassionate Rehousing Scheme to cater for the special needs of people with a disability and to avoid unnecessary delay in allocation.

8.5 In respect of the Home Ownership Scheme, it has been suggested that priority in allocation should be given to people with a disability. The Housing Department pointed out that such a proposal was considered and rejected previously by the Home Ownership Committee of the Housing Authority, because it jeopardized the chances of other applicants and was open to potential abuse. Nevertheless, the Housing Authority gives priority to people with a disability in flat selection if they are successful in the balloting exercise.

8.6 As regards private sector housing, the main problems for people with a disability usually relate to access. This will be discussed in more detail in Chapter 11.

Residential Care

8.7 Over the past decade, there has been a move away from institutional care towards community-based living. Even when residential care is necessary, it is made as least institutionalized as possible.

8.8 If life in a residential setting is to be as close to normal as possible, there are a number of factors to be taken into consideration, such as the amount of personal choice allowed to the residents, and the balance between communal and personal facilities. Since group homes or small living units provide an environment more like a home, new residential places are provided in these facilities as far as possible. However, larger residential care homes will still have an important role to play, especially in meeting the demand for residential places. The shortage of places must be met first, with improvements in the quality of the facilities being made wherever possible.

8.9 With the introduction of the training package "Skills for Life" and consultation provided by the Central Para-medical Support Team of the Social Welfare Department, residential staff can design individual programme plans for residents. With the provision of

different types of accommodation, residents are assessed for their independence to progress from one level of accommodation to another.

8.10 In the spirit of self-help and self-determination, residents are encouraged to participate in collective decision-making as far as their competence permits on matters of their own environment within a residential care home.

Residential Facilities for Children with a Disability

8.11 In line with the goal of integration, mildly mentally handicapped children requiring residential placement are accommodated as far as possible in foster care and ordinary small group homes, hostels, and children's homes for stimulative development. Special support in the form of higher incentive payment and additional manpower are provided respectively. Parallel to this, small group homes solely for mildly mentally handicapped children are also provided.

Moderately, Severely and Profoundly Mentally Handicapped Children

8.12 Residential care for these children will continue to be provided in the form of boarding facilities attached to special schools. The demand for boarding places, except those for moderately mentally handicapped children, has been fully met. Efforts will be made to provide more boarding places to meet the demand within the next four years.

Residential Special Child Care Centres

8.13 Residential special child care centres provide residential care and training to children with a moderate or severe disability, including the physically handicapped, aged two to six, who are homeless, who have inadequate home background or who live far away from day special child care centres.

Physically Handicapped Children

8.14 In view of the plans to expand boarding facilities in special schools, residential units for school-age children in hostels for physically handicapped persons will be phased out.

Boarding Facilities

8.15 As mentioned in Chapter 6, there are also boarding facilities in special schools for visually impaired, hearing impaired, physically and mentally handicapped children. These will continue to be provided, and the facilities will be reviewed as and when necessary.

Residential Facilities for Adults with a Disability

8.16 In addition to compassionate rehousing, there are four other types of residential facilities for adults with a disability. These take into account their disability levels, care and training requirements and the standard of their self-care and daily living skills. They are -

- (a) supported housing for independent living;
- (b) supported hostels for semi-independent living;
- (c) hostels for people with a moderate disability; and
- (d) hostels for people with severe/multiple disabilities (subdivided into hostels for severely mentally handicapped and multiple handicapped persons, hostels for severely physically handicapped persons, and care and attention home for severely mentally/physically handicapped persons).

Details are at Appendix H.

8.17 The schedule of accommodation for these types of residential facilities is reviewed from time to time, taking into account the special needs of people with a disability and the norms in society. As regards relatively new services such as care and attention homes for

people with a severe disability and aged blind as well as small group homes, their schedules of accommodation are being finalized.

Residential Facilities for Former Mental Patients

8.18 Former mental patients in need of residential services are those -

- (a) who are homeless or who have little family support;
- (b) who need to learn to live independently in the community; and
- (c) who are chronic mental patients not requiring active medical treatment but who need to undergo rehabilitation outside a hospital setting.

8.19 In addition to the above-mentioned facilities, half-way houses, purpose-built half-way houses and long stay care homes will continue to be provided for former mental patients. Details of these services are at Appendix I.

8.20 There is a need to streamline and unify pre-admission assessment procedures to half-way houses, and to enhance communication at the point of referral between medical institutions and social welfare organizations.

8.21 Follow-up for former mental patients discharged from half-way houses is provided by requiring them to contact medical social workers in hospitals or clinics. However, recent research has demonstrated that much better results are achieved by providing after-care service direct from the half-way houses. The chances of relapse and the pressure on mental hospital beds are also reduced. A scheme has been introduced to provide agency-based after-care workers who can each cover several half-way houses.

Respite Service

8.22 The respite (or temporary residential) service provides short term relief to the families of people with a disability by giving them a

break from the strain involved. It is run by the Social Welfare Department as well as some non-governmental organizations with their own resources. The Department is considering the possibility of providing funding support for this service.

8.23 The Director of Education is asking special schools with boarding facilities for severely mentally handicapped/moderately mentally handicapped children to provide respite services to their own pupils. In respect of other mentally handicapped children whose schools do not provide boarding facilities, we will consider how best to deliver the respite service, subject to availability of funds.

CHAPTER 9

COMMUNITY INVOLVEMENT AND FAMILY LIFE

Principles and Policy Objective

9.1 A principal tenet of human experience is full participation in the basic units of society - the family, social groups and the community. The right to equality of opportunity for such participation is set out in the Universal Declaration of Human Rights, and should apply to people with a disability just as much as anyone else. The policy objective is -

To ensure that people with a disability have the opportunity to participate fully in the activities of the socio-cultural system of which they are an integral part.

Community support services should be provided to help people with a disability to enjoy a meaningful family life as far as possible.

9.2 As a matter of principle, therefore, we aim at integrating people with a disability and their families into ordinary community services. Where this cannot be done, then special services must be provided to make up for the inadequacies.

Measures to Integrate People with a Disability and their Family Members into Ordinary Services

9.3 Measures are taken to ensure that people with a disability can use community services and facilities in the same way as any other person. This means removing obstacles to access, and where necessary, making special arrangements to meet the needs of individuals with mental or physical disabilities. To this end, we will continue to strengthen public education and introduced the Disability Discrimination Bill into the Legislative Council in May 1995. The Bill gives people with a disability the necessary legal means to fight against discrimination as well as harassment and to fight for equal opportunities.

General Social Welfare Services

9.4 A variety of welfare services are available within the community both to disabled and able-bodied persons. These services are planned on the basis of the general population and people with a disability are catered for as one of the target groups. To take care of the special needs of people with a disability, adjustments to services planning and provision must be made. Appropriate support and training should be provided to the staff who work with people with a disability.

9.5 The existing services include family counselling, home help service, family aide service, family life education, family care and demonstration and resources centres, children and youth centres, community centres, and social centres for elderly persons. It is clear that an integrated service delivery will help overcome the difficulties created by the compartmentalizing of clients' needs and the fragmenting of service provision. How services are integrated in actual practice depends on many factors, such as the needs of the target groups in the area or district concerned, resources including facilities, trained manpower available, and the particular agencies and departments involved. It is impractical to formulate a rigid model. An integrated approach, in respect of services capable of being integrated, is adopted as appropriate.

9.6 Families in need of support or counselling may approach the family service centres of the Social Welfare Department, non-governmental organizations, or medical social service units in hospitals and clinics, for assistance. In addition, there is a Hot Line Service run by the Social Welfare Department which provides immediate counselling or advice. A similar service providing counselling and referral services for the parents of mentally handicapped persons is run by the Society of Homes for the Handicapped.

9.7 The Home Help Service is an essential community support service, with people with a disability and their families as one of its major target groups. Home help teams working throughout the territory provide general personal care; house keeping; escort service; meal service; and child care.

9.8 The Family aid service, in addition to its family casework service, provides systematic training in homemaking with the ultimate

aim of teaching our clients how to run their households better. Families with disabled or mentally ill members can also benefit from the service. Training in parental and home-making skills is given to young couples and inadequate parents, including parents with disabled children, through live demonstrations and practice sessions at the family care and demonstration and resource centre.

9.9 Parents or relatives of disabled children can find mutual support, practical assistance and advice at parent resource centres. They can also make use of the drop-in enquiry service at the family activity and resource centres attached to group work units of the Social Welfare Department, which bridge the community with family services centres.

9.10 Family life education impresses upon the public the importance of family life, and how it can be sustained. The principal target groups are adolescents, young adults about to marry, parents-to-be and parents. Other target groups are served as required. People with a disability and their families may take advantage of family life education in the same way as anyone else.

9.11 The mental health group work service, piloted by the Hong Kong Family Welfare Society in 1986, provides small therapeutic group training to individuals aged between 18 to 45 who show symptoms of mental illness, but are not under acute crisis with severe stress. Programmes such as lectures and experimental training on rational thinking, relaxation, communication and skill-drilling are organized to help clients alleviate their psychiatric symptoms and to cope better with their stress. The scheme has proven to be effective. Mental health groups have continued to be operated by concerned non-governmental organization with non-governmental funding.

Social and Recreational Activities

9.12 Recreation is essential to a balanced life and is of particular importance to people with a disability. Leisure and recreational activities facilitate the learning and acquisition of social skills and competence, and are essential components for an effective programme of social integration.

9.13 The broad policy objective is -

To provide services and facilities for social, recreational and sporting programmes and through these means, to enable people with a disability to make meaningful use of their leisure time, to develop their potential and positive personal values, to enhance family and other personal relationships and to encourage their active participation in community life.

9.14 In pursuing this objective, services, which need to take into account the nature of the various disabilities, are provided in accordance with the following broad principles -

- (a) ordinary community facilities and services encourage and facilitate the participation of people with a disability;
- (b) where people with a disability require special facilities to meet their social, recreational and sporting needs, such facilities are provided, either in substitution for, or complementary to ordinary community facilities and services; and
- (c) socialization programmes and activities encourage people with a disability to develop inter-personal relationships, while recreational and sports facilities encourage them to develop hobbies and interests which facilitate their integration into the community.

Social and Recreational Centres

9.15 At present, there are 22 social and recreational centres operated by 15 non-governmental organizations and the Social Welfare Department. Services provided by these centres include interest and social service groups, committee training and mass/special activities. They vary from centre to centre to cater for the needs of people with various disabilities and to promote community acceptance through public education by assisting the Committee on Public Education in Rehabilitation, mobilize volunteers, offer social skills training and counselling, and provide resources and support services for people with a disability to participate in social and recreational activities.

9.16 Social and recreational centres are putting more effort into attracting community interest and participation in their activities. This can be done through offering centre membership to able-bodied persons on an equal basis, and the involvement of a wider network of paid staff and volunteers. [The development and training of volunteers is discussed in Chapter 13.] With greater input from the community, it is envisaged that more people with a disability will be attracted to participate in the programmes, and more people will understand and accept the abilities and needs of people with a disability.

9.17 The long term goal, however, must be for people with a disability to join in the social and recreational activities provided for the whole community. Facilities such as children and youth centres, community centres, amusement parks, cinemas, theatres, holiday resorts, beaches and other places of recreation must be accessible to people with a disability as far as practicable, as well as meeting the safety standards.

PHAB and Gateway Movement

9.18 PHAB stands for Physically Handicapped and Able-Bodied. The Hong Kong PHAB Association promotes integration of these groups of people through a variety of means. To encourage physically handicapped persons to participate in community activities as equals to other members of society, membership of the social and recreational centres managed by the Association comprises people with and without disabilities. In addition to a mixed membership, paid staff of the centres also actively help their members to form themselves into autonomous self-programming PHAB clubs. The active members of these PHAB clubs are given leadership training, financial subsidies and professional guidance. Once established, the PHAB clubs form a regional social network and become an added driving force behind the PHAB movement.

9.19 Along similar lines, the Gateway Movement was introduced in Hong Kong in 1980 to encourage mentally handicapped persons to participate in community activities in the same way as other members of society. It provides opportunities for leisure and recreational activities for mentally handicapped persons in its Gateway Clubs. These Clubs make use of premises of rehabilitation units, special schools and other community facilities. Volunteers run the programmes which are usually

organized once or twice a week at weekends and after school or office hours. Members comprise persons with and without a mental handicap.

9.20 We will co-ordinate regional-district development by setting up one Regional Gateway Unit in each of the five regions in Hong Kong, subject to the availability of funds. Each Unit will be responsible for the development of seven to eight Gateway Clubs as a social network for persons with a mental handicap.

Sports and Cultural Activities

9.21 Sports for people with a disability are becoming increasingly important and such activities will continue to be encouraged. People with a disability also have access to cultural activities so that they may develop their creative, artistic and intellectual potential to the full.

9.22 The policy objective is as follows -

To assist people with a disability to benefit from sports, arts and cultural activities and facilities, to develop their talents, and to integrate them into the community by the provision of suitable amenities, training and programmes.

9.23 This policy objective will be met by -

- (a) providing sporting, artistic and cultural activities in an integrated setting so that people with a disability may have equal opportunities to participate;
- (b) encouraging the various services to facilitate the participation of people with a disability, and to develop their talents and interests;
- (c) providing special facilities where required and as far as practicable;
- (d) promoting adapted physical education and recreational activities in special schools, and recognizing physical

education and arts as essential elements of the special school curriculum; and

- (e) giving appropriate recognition, education, training and support to people with a disability who are talented in sports or arts and who are committed to excellence.

9.24 The Urban Council and the Regional Council regularly organize sports, recreational, cultural and entertainment programmes which cater, as far as possible, for both able-bodied and people with a disability. The aim is to ensure that, people with a disability, like all members of the community, have the opportunity to enrich their leisure time, to improve their health and/or to be given quality entertainment through participation in or attending these activities. In addition, the two Councils organize and sponsor sports and recreational programmes specially designed for groups of people with a disability. These activities will continue.

9.25 Some organizations regularly run training sessions and competitions for people with a disability in track and field events, swimming and ball games. They also take an active part in international sporting events. These activities will continue. The Sports Development Board is implementing its Strategic Plan 1991-95. One of its principal aims is to increase community awareness of disabled sports, encourage a greater level of participation in sport amongst people with a disability and attract more volunteers who make such participation possible and enjoyable. The Board also seeks to develop more local and international sports programmes for people with a disability.

9.26 The first Festival of Arts with the Disabled was held in 1986, following which the Arts with the Disabled Association Hong Kong was set up. The Association aims to promote opportunities in arts for persons with disabilities, and to integrate them in the community through such activities. The Association has organized, sponsored or participated in various festivals, performances, exhibitions and workshops, both locally and internationally, since its inception, and will continue to do so in future.

9.27 The Hong Kong Arts Development Council treats funding applications for holding arts activities for and by people with a disability

in the same manner as any others. Thus, people with a disability will have an equal chance to enjoy, partake in and have access to the arts.

9.28 The Music Office runs instrumental music training and music appreciation programmes. These programmes are open to both the able-bodied and people with a disability.

Volunteers

9.29 Volunteering is the means by which members of the community become involved in rehabilitation services. In so doing, they encourage the full acceptance of people with a disability by the community, as well as supplementing mainstream services. Persons may volunteer their services as individuals, or as members of groups. They may sit on the governing bodies of non-governmental organizations, assist in the provision of direct services, or raise funds. They can provide leisure, social and recreational activities for people with a disability, and offer them concern, care, moral support and companionship. Volunteers also contribute to professional expertise and in the pioneering of new services.

9.30 Experienced volunteers, including those who sit on the executive committees of non-governmental organizations, also play an important role by serving on government advisory committees or working parties and contributing to the formulation of policies.

9.31 Volunteers are encouraged to participate in rehabilitation services at all levels. Volunteering is or will be promoted in the following ways -

- (a) it is fostered and encouraged in schools, youth groups, and other groups and organizations, including self-help groups of people with a disability;
- (b) parents, relatives and friends of people with a disability, as well as people with a disability themselves are encouraged to become volunteers. More and more programmes are, in fact, being developed by people with a disability;

- (c) short term projects and long term programmes are made available to attract volunteers with different interests;
- (d) public education stresses greater participation for volunteers and how they may learn, enjoy and benefit from the experience;
- (e) a network plan has to be developed so that professionals will supervise and organize volunteer work, and motivate volunteers to plan their own services. There is also a need to mobilize community leaders and the community as a whole; and
- (f) the provision of "seed money" will be considered for the promotion and setting up of volunteer groups.

9.32 Volunteering will be improved through -

- (a) more systematic co-ordination and training of volunteers. Ready-made packages and modules for training can be designed by professionals so that good principles and practices can be shared and followed; and
- (b) the link between organizations which promote volunteerism through their own recognition systems, and their volunteers will be strengthened.

Community-based Rehabilitation

9.33 Community-based rehabilitation (CBR) is an innovative service which makes use of resources for rehabilitation available in the community. Knowledge about disabilities and their prevention, and of skills in rehabilitation, can be transferred to people with a disability, their families, and members of the community. There is community involvement in the planning, decision-making and evaluation of CBR programmes. CBR is seen as an addition to existing services, such as outreaching or institution-based rehabilitation. Although designed for use in developing countries, CBR is still useful in Hong Kong, in that it assists in the integration of people with a disability in the community

through the organization of volunteers, people with a disability and local project committees.

9.34 In Hong Kong, an Urban Community Based Rehabilitation Steering Committee was formed in 1986, and the first urban CBR project began in 1987. The second project commenced in 1990. These two projects have proved the worth of CBR and paved the way for the launching of a new project, described in the following paragraphs.

Community Rehabilitation Network

9.35 In mid-1993, the Hong Kong Society for Rehabilitation and other non-governmental organizations drew up a proposal for implementing a pilot project called "Community Rehabilitation Network (CRN)". With firm support from Government, the project received a grant from the Royal Hong Kong Jockey Club for the setting up of a clearing house and two CRN centres for a trial period of 18 months. These facilities came into operation in early 1994.

9.36 The CRN, being the first of its kind in the Asian Pacific region, aims to enhance the quality of life of people with a visceral disability and their families. This is achieved through the provision of social work and allied health services; the promotion of self-help and advocacy; training; and the launching of educational as well as community programmes. It works in close collaboration with the Social Welfare Department, hospitals, self-help organizations and volunteers to ensure a continuum of care for people with a visceral disability.

9.37 The Social Welfare Department, involved in the planning of the CRN from the start, will evaluate its effectiveness of the pilot project. Subject to the findings of the evaluation and the availability of resources, Government will consider subventing the clearing house and a total of five CRN centres by 1998-99.

Measures to Support People with a Disability and their Families Waiting for Services

9.38 Various services are available to support people with a disability and their family members who are waiting for placement in a residential care facility, school, sheltered workshop or day activity

centre. These include a home-based teaching service, where visiting teachers conduct home-teaching for mentally handicapped children once a week, and guide parents how to carry on with the support at home until the next visit. The children can also attend school-based programmes and activities. There are regular meetings between parents and teachers.

9.39 A home-based training programme is also provided for mentally handicapped persons awaiting placement in a day activity centre or sheltered workshop. This training - three hours a week in the clients' home, with the participation of family members - aims to minimize the adverse effect of staying idle at home and to maintain or develop the skills that the school leavers have acquired from special education so as to facilitate their future placement in employment.

9.40 The respite service offers temporary residential accommodation for people with a disability for a period of not more than two weeks. It aims to give family members a break from their duties, or to allow them to carry out urgent business.

9.41 The demand for all these services will be kept under review. As steps are taken to meet the demand for day and residential places, the need for some services, such as home-based training or teaching, may diminish. Others, such as the respite service, are clearly valuable and will be expanded subject to availability of funds.

Salaries Tax Allowance

9.42 A new salaries tax allowance of \$11,000 for a disabled dependant, defined as someone who is eligible to claim an allowance under the Government's Disability Allowance Scheme, was introduced in April 1995. About 30 000 taxpayers will benefit from this new concession, which is in addition to any allowance already being claimed by the taxpayer for the disabled family member in question. We need to encourage the care of people with a disability by their family members.

CHAPTER 10

PARTICIPATION OF PEOPLE WITH A DISABILITY AND PARENTAL INVOLVEMENT

10.1 In the past two decades, people with a disability have organized themselves into self-help organizations to express their needs, and their opinions on the policies and services affecting them. They have called for participation in both policy-making and delivery of services. The importance of this practice is accepted both locally and internationally.

Principles and Policy Objectives

10.2 People with a disability have the right to speak for themselves, and to participate actively and to the fullest extent possible in the planning and delivery of services affecting them. Every encouragement is given to promote the participation of people with a disability and the development of self-help organizations. In its formulation of rehabilitation policies, Government involves people with a disability and self-help organizations, either in existing advisory bodies or other mechanisms concerning rehabilitation services. Their appointments are made on the basis of their expertise, experiences, and individual merits. Other organizations also ensure that people with a disability can participate in their activities.

Participation by People with a Disability

10.3 At present, people with a disability participate as individuals in the Rehabilitation Development Co-ordinating Committee and its Sub-committees. They also participated in the Working Party on Rehabilitation Policies and Services, which drafted the Green Paper, and the summit meetings, chaired by the Governor, on open employment and accessibility of public transport facilities for people with a disability.

10.4 In view of the size of the disabled population, people with a disability are encouraged to express their views in as many forums as possible on areas that concern them, directly or indirectly. Where they are unable to do so, then those who care for them are given similar

opportunities. To further promote their active participation, their right of access to information will continue to be ensured.

Parental Involvement

10.5 The concept of parental involvement refers to the participation of parents in activities and decision-making for the furtherance of the welfare of their children with a disability. The same principles also apply to involvement and participation by the guardians, family members, and relatives in the interests of people with a disability. Parental involvement and parent associations are important because -

- (a) parents are untapped resources for rehabilitation services because of their lengthy and intensive daily contact with children with a disability;
- (b) parents, who understand the needs of their children, are often the best spokesmen to represent the interests of their children and, therefore, are consulted on rehabilitation matters;
- (c) parent associations are an effective resource to help parents, as they provide a means for positive mutual sharing of experience and peer support. Parents' understanding, acceptance of, and positive attitude towards their children with a disability help to facilitate community education;
- (d) parents are life-long trainers in supporting the growth and development of their children;
- (e) parental involvement improves communication between other parents and professionals; and
- (f) parent associations can play an active role in expressing the common concerns of parents.

Parent Resource Centres

10.6 Parent resource centres are organized by non-governmental organizations or groups of parents to complement their existing services.

They provide a place for parents to discuss matters of mutual interest, meet others with similar problems, and let them have access to books, magazines, educational toys or other information of value to their children with a disability which otherwise they might not have. They also offer enquiry and referral services to parents and organize recreational and educational functions for the families of children with a disability.

10.7 Professionals such as social workers, psychologists and doctors help set up parent resource centres or parent associations but thereafter act largely as advisors or consultants. Office-bearers of the organizations are usually parents themselves, and they are responsible for running their own activities. Full-time staff are employed by only one or two parent associations to help organize activities for members.

10.8 In view of their valuable contribution to improving the quality of life of parents and relatives of people with a disability, Government provided subvention to six parent resource centres in 1994-95. Five of them cater to the needs of people with a disability on a regional basis, while the sixth serves ex-mentally ill people on a territory-wide basis.

10.9 Parental involvement will continue to be promoted by the following means -

- (a) parent associations which would like to provide services are encouraged to do so. This enhances the spirit of partnership;
- (b) depending on the merits of individual cases and service demand, Government will continue to provide the necessary support including subvention to parent resource centres; and
- (c) more systematic training courses are organized for parents to improve their skills and knowledge in caring for, educating and training their children.

Self-help Organizations

10.10 Self-help organizations can be defined as groups of individuals who organize themselves in a group structure to pursue common goals of furthering their own welfare and interests. The group solidarity arises from the fact that people encountering similar problems can join together to overcome them by sharing experiences and exchanging information.

10.11 These organizations not only provide meaningful social, educational and leisure activities, but also promote a spirit of mutual help among people with a disability. Through seminars, the mass media and campaigns, they foster a positive image of and promote the rights of people with a disability. Where the nature of disability prevents people from expressing and advocating their rights, parents or relatives of these people may form organizations to represent their interests on their behalf.

Development of Self-help Organizations

10.12 The following measures are taken to develop self-help organizations -

- (a) the role of self-help organizations is formally recognized;
- (b) Government will continue to enhance the participation of self-help organizations in the policy formulation process;
- (c) depending on merits of the individual case, self-help organizations are supported in their applications for welfare premises;
- (d) in appointing people with a disability to government bodies, Government provides supportive facilities, such as braille documents and sign language interpretation; and
- (e) non-governmental organizations providing services for people with a disability are encouraged to involve people with a disability in their decision-making mechanisms.

CHAPTER 11

ACCESS AND TRANSPORT

Principles and Policy Objectives

11.1 Access and transport are priority issues of concern to people with a disability. Both are necessary for the overall objective of equalization of opportunities and full participation to be met. The United Nations World Programme of Action calls for the adoption of a policy ensuring access for people with a disability to all new public buildings and facilities, public housing and public transport systems. It also calls for the adoption of measures to facilitate their access to existing public buildings, facilities, housing and transport wherever feasible, especially by taking advantage of renovation and replacement.

11.2 Integration is not possible if barriers to mobility for people with a disability are too high. With this in mind, our policy objectives in respect of access and transport are to ensure -

- (a) the development of a barrier-free physical environment, which permits access to all buildings and facilities for all people with a disability; and
- (b) the development of a transport system which includes provisions to meet the needs of people with a disability so as to enhance their ability to move around at will in society and to facilitate their full participation and integration into the community.

Access

11.3 Since 1 August 1985, new building works in certain categories of buildings have been required to comply with the design requirements stipulated under regulation 72 of the Building (Planning) Regulations and various other related regulations of the Buildings Ordinance (Cap. 123). The regulations aim to ensure that privately-owned buildings planned for public use are accessible to people with a disability, and that suitable facilities within buildings are provided

to meet their needs. The mandatory requirements are set out in a manual entitled "Design Manual - Access for the Disabled 1984". The manual also contains recommendations on requirements to cater for the needs of less severely disabled and visually impaired persons.

11.4 As a general policy, all new government buildings are designed in accordance with the 1984 Design Manual. A two-pronged approach is taken to improve accessibility to buildings which were built before 1985. We used to include an item in the Public Works Programme to modify and alter about 50 government buildings (such as post offices, health centres and magistracies). With effect from April 1994, the funding responsibility has been taken over by the Alterations, Additions and Improvement Committee and the Urban Council, Regional Council and the Hospital Authority have been responsible for carrying out the necessary alteration works for buildings under their respective management. Access improvements are also incorporated in the on-going refurbishment programmes for government buildings.

11.5 The Housing Department is committed to providing access for people with a disability to buildings within public housing estates erected since 1981. All public amenities and areas are designed to be as barrier-free as possible. The Housing Department also carries out the necessary modifications to individual flats free of charge to meet the needs of disabled tenants.

11.6 Dropped kerbs are provided at new at-grade crossings. Old crossings are modified during road maintenance and reconstruction. Access ramps for footbridges and subways have been provided since late 1985, subject to physical practicability. Where such ramps are not practicable, then alternative means of crossing the road, such as at-grade crossings with dropped kerbs, are provided. Audible traffic signals have been installed at some 2 000 signal-controlled pedestrian crossings. Since 1 January 1994, their provision has been included in all new signal-controlled pedestrian crossings. In November 1994, a lift for people with a disability came into operation to facilitate their access to the elevated walkway in Central. Planning is underway for a second lift to be installed in its vicinity.

11.7 Newly-built facilities of the Urban Council and the Regional Council are, wherever practical, provided with purpose-built access for

people with a disability, while improvement works continue to provide access to existing facilities as far as possible. The Agriculture and Fisheries Department, which is responsible for country parks, provides special barbecue sites for people with a disability at 10 locations, and many roadside picnic sites are also accessible to wheelchair users. Furthermore, there are five visitor centres and one nature education centre accessible to persons in wheelchairs, and 25 permanent toilets for people with a disability have been established in various country parks throughout the territory. More of these facilities will be provided in country parks where practicable.

11.8 While special schools for physically handicapped and mentally handicapped children are designed in accordance with the mandatory design requirements, there is at present limited provision of access for their peers in ordinary schools. As borne out from experience, only a small number of children would require such provision. Having regard to the need for equal opportunities for these children and the equally important right of other children to normal school activities, conversion of existing schools to improve accessibility will be examined when major renovation work is undertaken, the implementation of which would depend on factors such as structural feasibility, and alternative provision of schools with adequate access in the district. Access facilities will be included in all new schools which are scheduled for completion from 1998.

11.9 The present airport facilities are fully accessible to people with a disability. The new airport at Chek Lap Kok will also be fully accessible.

11.10 Since the publication of the Design Manual in February 1985, people with a disability have expressed concern about the scarcity of barrier-free buildings and the lack of access to private domestic buildings, as this severely limits their choice of places to live and their social activities. The Green Paper suggested that consideration be given to extending the coverage of the Design Manual and regulation 72 of the Building (Planning) Regulations to private domestic buildings and the domestic parts of composite buildings.

11.11 Government introduced the Disability Discrimination Bill into the Legislative Council in May 1995. This will be discussed in

greater detail in Chapter 15. But it is relevant to note here that one of the areas covered by the Bill is access to premises.

11.12 The Design Manual is being reviewed by the Secretary for Planning, Environment and Lands and the Building Regulations will be amended in line with any Code of Practice in relation to buildings issued by the Equal Opportunities Commission to be established to police the provisions of the Disability Discrimination Bill.

Transport

11.13 At present, the transport needs of people with a disability are met in the following ways -

- (a) public transport operators are encouraged to make their vehicles accessible as far as is practicable;
- (b) special transport services are provided for those who are unable to use public transport. There are two main types : centre-based transport and the Rehabus. The former caters for people with a disability attending rehabilitation institutions such as sheltered workshops and special schools. The latter is a territory-wide transport network which enables people with mobility difficulties to travel to work and school, or participate in activities other than centre-based rehabilitation services; and
- (c) a range of concessions are provided for drivers with a disability who drive their own vehicles.

11.14 To enable people with a disability to travel independently, it is important to improve accessibility along the whole journey so that they can move unrestrictedly to, from and between different transport modes. Their needs and interests must be incorporated into public transport services as far as possible during the planning stage.

11.15 Positive steps have been taken by public transport operators in recent years to make their systems more user-friendly and more accessible to people with a disability. The following paragraphs explain how this has been achieved in different transport systems.

Railway Services

11.16 No provision of access facilities for people with a disability was made in the planning of the existing Mass Transit Railway system (MTR) due to safety considerations and the high passenger volume expected to use the system. A consultancy study was completed in 1993 which showed that the system could, in fact, cater for the needs of people with a disability without affecting its safety and effectiveness. Various areas where improvements could be made have since been identified. These include the provision of ramps and stairclimbers for wheelchair users; tactile lines and guide paths for people with visual impairment; and electronic information display boards for people with hearing impairment. Trials of these facilities are being carried out and, if proven successful, will be introduced as far as possible in all stations.

11.17 As regards the new Airport Railway, the needs of people with a disability have been taken into account at the design stage. It will be fully accessible to all.

11.18 The Kowloon Canton Railway (KCR) system is relatively accessible to people with a disability, including wheelchair users. A wide range of features such as lifts, ramps, assistance call bells, tactile lines, guidepaths, and electronic display boards are currently provided at a number of stations to assist people with various disabilities to use the KCR service. These features will be introduced in most of the stations by 1996.

11.19 The Light Rail Transit (LRT) service is fully accessible to people with a disability. It will soon put on trial the use of tactile yellow lines on the platforms to ensure that they can be felt by touch by people with visual impairment. The use of braille on ticket vending machines and a digitized announcement system on the light rail vehicles is being considered.

Bus Services

11.20 Out of the 4 500 buses in the territory, over 3 000 buses have been provided with features to meet the needs of people with a disability. The design features include large destination signs, wider entrances, lower floors covered with non-slip material, special bell

pushes and step edges with contrasting colours. These features will be provided on all new buses to be ordered. In addition, the bus companies are examining the possibility of purchasing new wheelchair-accessible double-decker buses which would be the first of their type in the world.

Ferry and Tram Services

11.21 Ferry services provided by the Hong Kong and Yaumati Ferry and Star Ferry are accessible to people with a disability, including wheelchair users. Special entrances and assistance call bells are provided at ferry piers. Grooves are made on the landing ramp to facilitate the movement of wheelchair users. The Star Ferry has also reserved spaces for people with a disability on all its vessels. Hong Kong and Yaumati Ferry will complete all the necessary work in mid-1995.

11.22 Hong Kong Tramways is improving its trams for the benefit of the people with a disability including people with visual impairment, hearing impairment and those who have minor walking difficulties. Improvements include the provision of handrails and reserved seats next to the driver.

Efforts to Improve Accessibility

11.23 The Governor has chaired three summit meetings on ways to improve the accessibility of the public transport system for people with a disability. The meetings, attended by senior government officials, public transport operators and representatives of various disability groups, have produced positive and encouraging results.

11.24 The Transport Department set up a Working Group in 1993 to follow up issues agreed at the summit meetings. It has provided a useful forum for the exchange of views between public transport operators and representatives of disability groups. The Working Group will continue to identify new initiatives and monitor implementation of the proposed programmes to improve access for people with a disability. It will also take the lead in tackling problems common to all operators, such as establishing common standards and guidelines on the provision and modification of facilities for disabled passengers.

11.25 The Green Paper examined thoroughly the pros and cons of a proposal for giving a mobility allowance to people with a disability. Taking into account the arguments in the Green Paper (set out in paras. 11.28 - 11.31) and in view of the recent improvement in public transport and Rehabus services which mean people with a disability have less difficulty in getting around, we have decided not to pursue the proposed mobility allowance further. The Disability Allowance already paid by Government includes an element designed to meet transport costs.

Publicity and Education

11.26 To ensure that special facilities for people with a disability are known by those in need and thus, better utilized, the Transport Department published "A Guide to Public Transport Services in Hong Kong for Disabled Persons" in 1993. It set out the wide range of transport facilities available to people with a disability. In addition, the KCRC published a booklet "Making Railways Accessible to All" in February 1994, providing information concerning its facilities to disabled passengers.

11.27 Few of the improvements in accessibility of public transport will have any impact unless they are accompanied by a change in public attitudes. For instance, there is no point in reserving seats for people with a disability if no one keeps these seats free for their use. Campaigns are therefore required to educate the public on the rights and needs of disabled users of public transport.

Special Transport Services

11.28 Centre-based transport carries people with a disability for the purpose of receiving education, training and vocational rehabilitation services. At present, it is provided through subvention, in part or in full, at most special child care centres, special schools, sheltered workshops, day activity centres, skills centres and residential centres. The Social Welfare Department uses hired vehicles to provide centre-based transport for some of its centres. The aim is to incorporate centre-based transport in all rehabilitation institutions as a basic element of the service.

11.29 The Rehabus service, operated by the Hong Kong Society for Rehabilitation with Government subvention, provides a territory-wide transport network which enables people with a disability to commute to school, work place or activities centres. The transport service uses specially adapted vehicles with lifting devices and provides a door-to-door service for people with a physical handicap, including wheelchair users. Two types of services are provided, namely, the scheduled service and the dial-a-ride service.

11.30 The scheduled service is a regular service carrying disabled passengers to and from work, training centres and medical appointments. The fare is comparable to a similar journey undertaken on public transport. As at January 1995, there were 41 routes operating daily from Monday to Saturday during peak hours. About 380 passengers were carried every day. Despite the continual expansion of the scheduled routes in recent years, there is a steady growth of demand for rehabus service. A total of 90 applications for scheduled routes was rejected in 1994-95 and the number of applicants on the waiting list stands at about 20. It is reported that the hidden demand is much greater. A study on the potential demand is being planned. To meet the increasing known demand and to extend the service to areas not being covered by rehabuses, the service will be expanded by eight additional scheduled routes over the next two years.

11.31 The dial-a-ride service is a specialized transport service carrying people with a disability to clinics, shops, sport and leisure activities. It operates on a pre-booked basis. With effect from December 1993, it received Government subvention. As at January 1995, nine rehabuses were deployed to provide a full day dial-a-ride service. Rehabuses on scheduled services are also deployed to operate dial-a-ride service outside their usual hours of operation. In view of the increasing demand for the service, three more rehabuses will be added to the fleet in 1995-96.

Adapted Bus Service

11.32 Another option is to introduce an adapted bus service which can be used by disabled passengers. The operation would be similar to the existing public bus services which run on fixed routes at regular

intervals. The adapted bus service would use specially designed vehicles which can carry wheelchair users.

11.33 The adapted buses, however, would inevitably be less efficient and more costly in terms of operating costs per seat. Moreover, in Hong Kong's operating environment where traffic is heavy, kerbside space limited, and passenger volumes very high during peak hours, it may be difficult for people with a disability to board/alight from these adapted buses without causing inconvenience and possibly danger to themselves and other passengers. While the adapted bus service would facilitate the integration of people with a disability into the community, there are doubts about its operational feasibility and financial implications. These are being studied in detail by the Transport Department.

Concessions for Drivers with a Disability

11.34 A driver with a disability is currently exempted from payment of the following fees and duties charged by the Government -

- (a) learners' driving licence fee in respect of a private car, motor cycle or motor tricycle;
- (b) driving test fee;
- (c) full driving licence fee;
- (d) annual vehicle licence fee in respect of -
 - (i) a private car, the cylinder capacity of the engine of which does not exceed 1 500 cc and which is owned and driven by a person with a disability. (Should the engine cylinder capacity exceed 1 500 cc, the licence fee payable will be the difference between the fee payable in respect of his vehicle and that payable on a car with an engine cylinder capacity of 1 500 cc).
 - (ii) a motor cycle or a motor tricycle of which a disabled driver is the registered owners;

- (e) first registration tax on the first \$300,000 of the taxable value of a motor vehicle for which a disabled driver is applying for first registration. No exemption will be granted if he, within the previous five years, registered a motor vehicle without payment of tax or subject to exemption;
- (f) passage tax of the Cross-Harbour Tunnel;
- (g) duty on hydrocarbon oil used by a private car, invalid carriage, motor cycle or motor tricycle owned and driven by a disabled driver, subject -
 - (i) to a limit of 200 litres per month, in the case of a private car or an invalid carriage; and
 - (ii) to a limit of 100 litres per month, in the case of a motor cycle or motor tricycle.
- (h) fee for the transfer of vehicle ownership in respect of a private car, motor cycle or motor tricycle if at the time of delivery of notice of transfer of ownership, a disabled driver is not the owner of another private car, motor cycle or motor tricycle in respect of which the transfer of ownership fee has been waived;
- (i) on-street metered parking fee for holders of Disabled Persons' Parking Permit; and
- (j) tunnel tolls for Government tunnels.

11.35 Administrative arrangements are also made for disabled learner drivers to be given early driving tests.

11.36 One or two parking spaces in each of the 14 Government multi-storey car parks are reserved for disabled drivers. A total of 22 on-street parking spaces are also reserved for the exclusive use of disabled drivers holding Disabled Persons' Parking Permit. Action is being taken to ensure that reserved parking spaces are not illegally occupied by unauthorized drivers. The need to expand the number of reserved parking spaces for disabled drivers will be reviewed.

11.37 The various legislative and administrative provisions to assist people with a disability will be kept under review. However, the provision of special transport or concessions to disabled drivers cannot replace an accessible public transport system. The ultimate goal must be for public transport operators to appreciate the special needs of people with a disability and take these into account in designing and providing their services.

CHAPTER 12

PUBLIC EDUCATION AND INFORMATION

Principles and Policy Objectives

12.1 The primary objectives of rehabilitation are to ensure the full participation of people with a disability in social life and to provide them with equal opportunities. It is impossible to achieve these without stimulating community awareness of the need to adopt a positive public attitude towards people with a disability. The way to achieve community acceptance of people with a disability is through public education. Bearing in mind the overall goals of rehabilitation, the policy objectives of public education are -

- (a) To provide a comprehensive public education and information programme which informs the community of the rights and needs of people with a disability and the contribution they can make to society. This programme aims to change people's attitudes so that the goals of full participation and equalization of opportunities may be achieved; and**
- (b) To provide information in a form which can be used and understood by people with visual, hearing or other communication limitations; such information includes the rights and responsibilities of people with a disability, and details of the services and benefits which are available to them.**

Public Education

12.2 Both government departments and non-governmental organizations plan and organize public education activities in which persons with or without disabilities can participate. Such interaction leads to a greater understanding of people with a disability, and is more effective than simply providing members of the community with printed materials.

12.3 It is important to instil into the minds of children during their formative years positive attitudes towards the vulnerable and disadvantaged in the community, including people with a disability. To this end, the Education Department has included topics concerning people with a disability in existing syllabuses for both primary and secondary schools. The Education Department will introduce a new subject "General Studies" in primary schools in 1996. The syllabus will include topics on understanding the needs of people with a disability, rehabilitation services and positive attitudes towards the needy. The Department also runs programmes such as the "Sister School Scheme", where an ordinary school establishes fellowship with a special school, and the "Pick your Friend" Scheme, which encourages able-bodied children to become friends with children with a disability. The Social Welfare Department, through its "Opportunities for Youth Scheme", also provides the means whereby young people can work together on projects for people with a disability, thus assisting the process of integration.

Committee on Public Education in Rehabilitation

12.4 The Committee on Public Education in Rehabilitation (COMPERE), set up in 1982, is chaired by the Commissioner for Rehabilitation and consists of representatives from concerned departments, the Hospital Authority and the non-governmental sector. It is responsible for formulating an overall annual programme of public education activities on rehabilitation, as well as monitoring and co-ordinating these activities.

12.5 In 1993, COMPERE took a number of steps to improve the effectiveness of its work. It reviewed its strategy on public education and determined new directions in which it should be moving. It also put in place a comprehensive system to monitor and evaluate the effectiveness of its public education activities. Since parents have a deeper understanding of the special needs of people with a disability, a representative from a parent association was appointed as a member of COMPERE.

12.6 There has been a significant boost in spending on public education. A sum of about \$34 million has been secured to strengthen public education activities between 1993-94 and 1996-97. This sum includes grants of about \$11 million made by the Royal Hong Kong

Jockey Club and the Queen Elizabeth Foundation for the Mentally Handicapped.

12.7 This funding support has enabled COMPERE to plan and initiate a number of major public education activities since 1993-94. These include the Rehabilitation Special, Mental Health Week and International Day of Disabled Persons. Feedback from participants of these events has been very favourable. It was generally considered that they succeeded in spreading the important message of integration and enhancing community acceptance of people with a disability. We will continue to plan and organize major public education activities to reach out to the community at large.

Directions for the Future

12.8 COMPERE recently commissioned the Chinese University of Hong Kong to conduct three benchmark surveys between 1994 and 1996 on public attitudes towards people with a disability. The findings of these surveys will help us evaluate more accurately the effectiveness of our public education activities and review our public education strategy.

12.9 As recommended in the Green Paper, we will upgrade COMPERE to a Sub-committee of the Rehabilitation Development Co-ordinating Committee in 1995.

12.10 There is a need to deter the mass media, as well as the entertainment industry, from projecting negative stereotypes or images of people with a disability. The Code of Practice relating to TV programme standards and the Film Censorship Ordinance already sets out clear guidelines on how TV and film portray, depict or treat disability. The "Negative projection" of people with a disability in TV programmes or movies is being closely regulated.

Access to Information

12.11 It is vital for people with a disability to have access to information materials. This does not only mean information on services available to them, or on their rights and responsibilities, but also access to TV programmes, newspapers, books and magazines. The present

Government policy is to produce braille copies of Government publications, particularly source documents e.g. the Green Paper and White Paper, which would be of interest to visually impaired persons in Hong Kong. As far as information on programmes and services for people with a disability are concerned, they are available in a form which can be used and understood by those people with visual, hearing or other communication limitations.

12.12 Local TV broadcasters have responded well on a voluntary basis to the provision of TV subtitling to their programmes. Government favours a voluntary approach in extending TV subtitling service to local TV programmes. A working group consisting of representatives from concerned branches and departments, non-governmental organizations, self-help groups and local TV broadcasters was set up in 1993 to discuss the issues involved in TV subtitling. It provides a useful forum for concerned parties to exchange views and to discuss and review progress made.

12.13 More encouragement will be given to those who produce braille newspapers or other printed materials. Such moves will facilitate the full participation of people with a disability in our community.

CHAPTER 13

MANPOWER PLANNING AND TRAINING

13.1 The improvement, development and extension of rehabilitation services are dependent upon the provision of adequate qualified staff. Manpower planning is therefore an essential element in the future development of services.

Policy Objective

13.2 The objective of manpower planning in the area of rehabilitation is to ensure that sufficient trained staff at the appropriate level are available, both now and in the future, to run rehabilitation services. The purpose of training is to equip these staff with sufficient knowledge to carry out their duties.

Supply and Demand

13.3 A major constraint in the provision of rehabilitation services in Hong Kong is the shortage of trained rehabilitation personnel. This problem has arisen from the rapid expansion of services since the 1977 White Paper on Rehabilitation, and from the community's rising expectations of better quality services. In addition, competition for manpower resources has intensified with the reduction in the population of young people and the increase in emigration of experienced rehabilitation personnel. New degree courses must compete for funding and students with other programmes. In some cases non-degree courses are being replaced by those leading to degrees, thus presenting the possibility of a shortage of non-degree staff.

13.4 Overseas recruitment for many of the frontline professions is impracticable in view of the general world shortage of trained rehabilitation personnel and the need for the recruits to have a working knowledge of Cantonese.

13.5 A number of disciplines are responsible for the provision of rehabilitation services. The following allied health disciplines are those more directly involved -

Audiologists	Physiotherapists
Clinical Psychologists	Prosthetist and Orthotists
Community Nurses	Psychiatric Nurses
Doctors	Psychiatrists
Educational Psychologists	Social Workers
Nurses	Special Child Care Workers
Occupational Therapists	Special Education Teachers
Orthoptists	Speech Therapists

In addition, other personnel such as welfare workers, personal care workers and workshop instructors also play an important role in the provision of rehabilitation services.

13.6 Details of planning ratios and the demand for some medical and allied health rehabilitation staff are shown in the 1994 Rehabilitation Programme Plan. However, not all services have an estimated demand for staff, and where a service cuts across a number of disciplines, e.g. clinical psychology, there is room for better co-ordination. The Education and Personnel Sub-Committee of RDCC, which examines and reviews the supply of and demand for suitably trained and qualified personnel for the further development of rehabilitation services, is monitoring this situation and has, for example, completed a study of the need for clinical psychologists.

13.7 The Health and Welfare Branch set up a Working Group in April 1995 to examine issues involved in the demand and supply as well as recruitment and retention of allied health staff in the welfare field. The Working Group is examining ways of addressing the current and future shortfall in the provision of clinical psychologists on the basis of the findings of the Education and Personnel Sub-committee's preliminary study. Since the problems associated with the supply and demand of such allied health staff go beyond the confines of the rehabilitation sector, it is necessary for the Branch itself to take the lead in finding solutions to the shortfalls identified.

13.8 In the course of forecasting the demand for various professionals, the actual needs of each institution in addition to general planning ratios and projected numbers of people with a disability are taken into account.

13.9 There is a clear need for the professionals to maintain closer liaison with tertiary institutions funded by the University Grants Committee (UGC) in respect of courses at undergraduate and post-graduate level, and sub-degree courses for allied health professionals. The professionals should relate to the institutions and convince them of the need to include appropriate provision of places for the training of specific rehabilitation personnel in the Academic Development Plans which the institutions submit to the UGC.

Recruitment and Retention

13.10 In view of the present problems in recruitment and retention, and in consideration of the special nature and requirements of rehabilitation personnel, further consideration will be given to the following measures -

- (a) the upgrading of training in specialized subjects at sub-degree level to provide a degree qualification (this is being done for prosthetics and orthotics with a course starting in the Hong Kong Polytechnic University in 1995). This may also attract students of a high quality to the professions both directly and from other related disciplines;
- (b) where necessary, the expansion of the number of places for the training of allied health staff;
- (c) the recognition of related experience in other work settings;
- (d) the provision of job-related allowances, where justified, to Welfare Workers and Workshop Instructors in day activity centres and certain residential facilities; and
- (e) the encouragement of tertiary institutions to foster a further understanding of the needs of people with a disability, as

well as of the value of a career in rehabilitation, among their students.

Manpower Training

13.11 The purpose of training is to equip staff carrying out specific duties with the knowledge and skills required to perform these duties or to improve their performance. Strictly speaking, training is distinguished from education which aims to provide a wider perspective of knowledge relating to theoretical frameworks and skills required of a profession in order to provide for in-service development and long-term career advancement. Many rehabilitation workers, for example, nurses or clinical psychologists, must acquire professional qualifications before they are appointed. Others, such as special child care workers, are required to take in-service training courses or to undergo an internship.

13.12 Advanced specialized training in the field of rehabilitation is important because -

- (a) it improves the provision and development of services;
- (b) it allows overseas concepts to be looked at in the local context; and
- (c) it provides opportunities for research into specific areas of local interest.

There are at present limited opportunities for pursuing advanced specialized training locally. Overseas training remains dependent on the availability of funds. Funding sources open to eligible personnel include the Social Work Training Fund, the Li Po Chun Charitable Trust Fund, and the Sir Robert Black Training Scholarship.

13.13 There is a need for in-service training to upgrade the skills and knowledge of rehabilitation staff. It is also important to provide advanced training for the more junior levels of rehabilitation workers. These issues are being examined by the Departments involved in the context of the overall manpower and training policy.

CHAPTER 14

TECHNOLOGY AND RESEARCH

Principles and Policy Objectives

14.1 Many people in the community, including people with a disability, have benefited from developments in computer and information technology over the past decade, as well as from improvements in diagnostic and other medical services, and from rehabilitation engineering. The use and availability of such technology is vital in realizing the goals of full participation and equalization of opportunities, yet it remains an unfortunate fact that many such technological devices are unavailable in Hong Kong, or have to be imported at a price beyond the reach of many people with a disability.

14.2 The aim for the future is to ensure that -

- (a)** appropriate technological advances from overseas are introduced or adapted in Hong Kong for the benefit of people with a disability;
- (b)** the public and private sectors are encouraged to work together to develop further advances, to produce new assistive technological devices; and
- (c)** such devices be made available to people with a disability in Hong Kong at a price they can afford, or be provided or subsidized when appropriate.

Rehabilitation Engineering

14.3 Rehabilitation engineering is concerned with the infusion of science and technology in the rehabilitation process. It provides functional capabilities and makes possible independence and self-management partly through the provision of assistive devices to the individuals concerned. Assistive devices cover a wide spectrum of applications, such as for -

- (a) personal care and protection;
- (b) personal mobility;
- (c) communication, information and signalling; and
- (d) adapting equipment, tools, machines, and the living or working environment.

14.4 Modern technology has improved functional capabilities through electric stimulation, hearing and speaking aids, prosthetics, orthotics and so on. The wide spectrum of assistive devices solves problems of everyday life and facilitates the full participation of the individual in the community. Rehabilitation engineering is therefore an integral part of the rehabilitation system. It can have considerable positive effects on the lives of people with a disability.

14.5 Rehabilitation devices help people with a disability keep pace with developments in society and enable them to capitalize on the advances in modern technology. The intended future direction for rehabilitation engineering is to -

- (a) optimize the utilization of rehabilitation technology which already exists and ensure that a greater awareness of this technology exists among frontline workers and users;
- (b) provide and produce more affordable equipment and devices; and
- (c) develop new technological solutions to rehabilitation problems.

14.6 In view of the importance to people with a disability of rehabilitation engineering, there is a need for co-ordination between participating agencies, as well as the provision of support services. With this in mind, the Jockey Club Rehabilitation Engineering Centre was established in 1987 under the Hong Kong Polytechnic University, and offers services complementary to those provided by other organizations in Hong Kong. A co-ordinating unit under the auspices of the Joint Council for the Physically and Mentally Disabled (Rehabilitation

Division, Hong Kong Council of Social Service) provides a focal point for service providers and users.

Application of other Technological Advancements

14.7 Apart from purpose-designed assistive devices, people with a disability also make use of ordinary office automation equipment to extend their capability. For instance, hearing impaired persons can now communicate with facsimile machines, personal computers or pagers. Problems arising from their inability to use telephones are therefore partly solved, although consideration should still be given to introducing adapted telephones, such as are available overseas.

14.8 Technology helps people with a disability reduce the degree of handicap they experience and fully develop their potential. There is a need to ensure that a greater awareness of the application of rehabilitation and information technology exists among all frontline workers, and amongst people with a disability themselves.

Support Services

14.9 Apart from rehabilitation engineering, there are support services which are outside the mainstream but are important to the daily lives of people with a disability. Some of these support services are described in the following paragraphs.

Wheelchair Repair Service

14.10 At present, the vast majority of wheelchairs used in Hong Kong are imported. As importers and retailers of these imported wheelchairs currently only provide replacement parts rather than proper repair services, wheelchair maintenance has been a major problem to wheelchair-bound persons.

14.11 Since 1986, the Spastics Association of Hong Kong has been operating a wheelchair repair service. The service operates on a fee-charging basis and is financed by its own resources and grants from other charities. Since 1989-90, the rents and rates of this service have been subsidized by the Social Welfare Department.

Information and Resource Centres

14.12 Information and resource centres are important for people with a disability, and those who care for them, in that they offer advice and assistance on a variety of topics that otherwise might be unobtainable. They also allow them or parents of disabled children to meet together for mutual support and information sharing.

14.13 The Rehabaid Centre is a resource and information centre run by the Hospital Authority and Rotary Rehabaid will join the Authority in 1995-96. The Environmental Advisory Service (EAS) under the Rehabaid Society is partially subvented by Government. Together these provide information to people with a disability, care-givers and health professionals with the prime objective to improve the quality of life of people with a disability by increasing independence in daily living activities through occupational therapy consultation and treatment, architectural consultation, publications and seminars. The Hospital Authority has also established a number of resource centres based in major hospitals to provide information on rehabilitation services and assistive devices.

14.14 In view of its useful contribution to the well-being of people with disability, additional funding support has been provided to the EAS as from 1995-96.

14.15 The Association of Engineering and Medical Volunteers Services provides community rehabilitation services and develops, modifies or repairs assistive devices for people with a disability. In addition to the design and manufacture of work-related technical devices, the Technical Aid and Resource Centre of the Vocational Training Council provides a range of resource services to disabled students and trainees in the Technical Colleges, Technical Institutes and Skills Centres of the Vocational Training Council.

14.16 For people with hearing impairment and visual impairment, the Hong Kong Society for the Deaf and the Hong Kong Society for the Blind provide technical devices and resource services in respect of daily living and educational needs.

Research

14.17 To support the planning and monitoring of an effective rehabilitation programme, the United Nations World Programme of Action Concerning Disabled Persons has advocated the need "to develop a programme of research on the causes, types and incidence of impairment and disability, the economic and social conditions of disabled persons, and the availability and efficacy of existing resources to deal with these matters".

14.18 Social studies on various needs and problems of people with a disability, surveys on the employment situation of people with a disability or leavers of special schools/training institutes, access to information, and evaluation of programme effectiveness, are conducted by academic institutions, service agencies and sometimes self-help organizations, usually on their own initiative and supported by non-governmental funding. Applied research in academic institutions is now being increasingly supported by the University Grants Committee, as evidenced by the recent establishment of an interdisciplinary centre in rehabilitation engineering which serves to link the tertiary institutions.

CHAPTER 15

LEGISLATIVE MEASURES

Principles and Policy Objectives

15.1 In line with the policy objective of the Bill of Rights, Hong Kong's rehabilitation policies and services will continue to meet both the requirements of human rights and the needs of people with a disability. People with a disability should enjoy the same basic rights as other members of the community. It is important that they are given equal opportunities to exercise these rights and to take part in the life of the community to the fullest extent possible.

15.2 In considering the need for legislative measures to promote equal opportunities, we have referred to the Declaration on the Rights of Disabled Persons, proclaimed by the United Nations General Assembly on 9 December 1975. Other relevant declarations, resolutions and conventions include -

- 1948 United Nations' Universal Declaration of Human Rights;
- 1971 United Nations' Declaration on the Rights of Mentally Retarded Persons;
- 1975 The Economic and Social Council's resolution on Prevention of Disability and Rehabilitation of Disabled Persons;
- 1983 The International Labour Organization's Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and the Vocational Rehabilitation and Employment (Disabled Persons) Recommendation (No. 168); and
- 1994 Standard Rules on the Equalization of Opportunities for Persons with Disabilities.

15.3 United Nations' studies indicate that there are three main areas where legislation is important for people with a disability -

- (a) the establishment and safeguarding of human rights;
- (b) measures to permit full participation by people with a disability; and
- (c) measures to provide for equalization of opportunities for people with a disability in social life.

Existing Legislative Provisions

15.4 In respect of legislation concerning people with a disability, three approaches are identified -

- (a) legislation to provide for general services or opportunities, for example, the Education Ordinance (Cap. 279) and the Employment Ordinance (Cap. 57);
- (b) specific legislation to provide for certain special needs, for example, the Mental Health Ordinance (Cap. 136); and
- (c) the incorporation of specific sections relating to people with a disability in legislation dealing with other areas, for example, the Road Traffic (Driving Licence) Regulations (Cap. 374) and the Building (Planning) Regulations (Cap. 123).

15.5 The following paragraphs examine the need for legislation in various areas.

Civil and Political Rights

15.6 In Hong Kong, there is no restrictive legislation on individual freedom. Some restrictions do exist in the areas of control over peaceful assembly and the formation of trade unions, but these are applicable to all. As regards participation in public affairs, sections 11 and 19 of the Electoral Provisions Ordinance (Cap. 367) respectively provide that a person will only be disqualified from being registered as

an elector or, even if registered, from voting or being nominated as a candidate if he is the subject of a decision under the Mental Health Ordinance that he is of unsound mind and incapable of managing himself and his affairs. This provision is in the public interest.

Access to Polling Stations

15.7 In theory, people with a disability enjoy the same rights to hold and express opinions, receive information, and participate in elections, either as a voter or a candidate. In setting up polling stations, Government has endeavoured to identify locations and premises which are accessible to electors with mobility difficulties. However, owing to physical constraints, some of the polling stations may not be fully accessible to this group of electors. As at January 1995, 169 gazetted polling stations, out of a total of 440, were accessible to electors with mobility difficulties.

15.8 To further facilitate voting by these people, 22 specified polling stations with special access facilities for people with physical handicap were designated for the District Board elections in September 1994. There was at least one such polling station in each district of the 18 districts in the territory. If an elector with a physical handicap wishes to vote in the specified polling station designated for his district, all that he needs to do is to apply to the Chief Electoral Officer (CEO) in writing or by phone at least five days before the polling day. The CEO will then ensure that particulars of that elector will be transferred from his original polling station to the relevant specified polling station, thus enabling him to cast his vote there instead. Similar arrangements were made for the Municipal Council elections in March 1995 and will be extended to the Legislative Council elections to be held in September 1995.

15.9 Presiding officers in all polling stations are duty-bound to assist anyone who may have difficulty in filling out a ballot paper or in casting their vote. Any elector (for example, a physically handicapped, illiterate, or partially sighted person) can ask the presiding officer of a polling station to mark the ballot paper to indicate his choice of candidate and to place the paper in the ballot box. A polling officer will serve as witness throughout the process.

15.10 Templates will be provided in all polling stations to enable visually impaired electors to mark their own ballot papers without assistance. Audio-tapes will also be used to record information contained in official introductory leaflets on candidates. Visually impaired electors may then have access to such information.

Medical and Health Care

15.11 Clinics run by Government and hospitals and out-patient units administered by the Hospital Authority provide medical services to all people in Hong Kong, including people with a disability. A wide range of treatment, care and rehabilitation programmes are available. These measures are discussed in detail in Chapters 4 and 5.

15.12 The issue of consent to medical and dental treatment is of particular importance to mentally handicapped persons, especially if they are regarded as being unable or incapable of giving such consent. A doctor has to rely on the following common law principles to treat or operate on adult patients incapable of giving consent -

- (a) the treatment or operation is done under an emergency situation to save the patient's life; or
- (b) the treatment or operation is done in the best interest of the patient only if it is carried out in order to save his life, or to ensure improvement or to prevent deterioration in his physical and mental health.

15.13 In so far as treatment by private medical practitioners is concerned, there is no legal duty upon any private doctor to examine, treat or give aid to anybody, be they with or without a disability, irrespective of whether the situation is an accident or an emergency, unless he has held himself out as having undertaken the care of the individual. In the absence of a pre-existing contract or special relationship between the parties, there is no liability for failure to act when under an obligation to do so. Once treatment has commenced, the doctor may be liable for the doing of a wrongful act, irrespective of whether or not the service is performed free of charge.

15.14 Interpreting these legal rules with respect to people with a disability means that a medical practitioner need not accept a person with a disability as a patient, but once having done so, he must avoid acts or omissions which might injure him. The implication is, therefore, that the person with a disability must receive the same standard of care as any other patient. In summary, the legal position is as follows -

- (a) except for doctors on the staff of a hospital who have to treat patients accepted by the hospital, a private doctor need not accept any person as patient;
- (b) whether a doctor is negligent or otherwise in his treatment and care of his patient will be determined by what a responsible body of medical opinion considers as medically appropriate. Rule 20.1 of the Professional Code provides that a doctor may refer the patient to another doctor whenever he believes that this may benefit the patient;
- (c) a doctor is legally obliged not to commit any acts or omissions which he can foresee will lead to the deterioration of the patient's condition. In determining whether a doctor has been negligent or not, the test is on whether the procedure undertaken by a doctor or which he failed to undertake is, in the opinion of a body of responsible and competent doctors, negligent; and
- (d) in an emergency situation, the action taken by the rescuer doctor can be justified on the principle of necessity. In the case of a minor, where the child is competent and is able to consent to medical treatment if and when he achieves a sufficient understanding and intelligence to enable him to understand the nature of what is being proposed, he can give valid consent. If such is not the case and the parents withhold consent, the hospital or doctor should apply to the court before proceeding to treat the minor including any life-saving treatment.

15.15 As regards termination of pregnancy, people with a disability have the same right to bear children as other people. Abortions carried out other than in accordance with section 47A of the Offences

Against the Person Ordinance (Cap. 212), which provides for medical termination of pregnancy, are illegal.

15.16 The issue of consent to medical and dental treatment is being examined in the current review of the Mental Health Ordinance, discussed in paras. 15.33 to 15.35 below. We propose to revise the Ordinance to introduce a new legal framework for the giving of consent to medical and dental treatment.

Education and Training

15.17 Government is fully committed to the policy of providing nine years of free and compulsory education to all children, irrespective of their degree of ability. Disabled children have the same rights as other children to receive education in accordance with the provisions of the Education Ordinance (Cap. 279). Parents have a choice as to how their child will be educated but if the child is of an age when schooling is compulsory, they also have a duty to ensure that the child receives education. If it appears to the Director of Education that a child is not attending a primary or secondary school without reasonable excuse, the Director may serve upon a parent an attendance order requiring the parent to cause the child attend school regularly.

Employment

15.18 People with a disability have the same right to work as any other member of the community. There is appropriate legislation to protect employees at work, irrespective of whether they are disabled or not.

Legal Representation and Protection

15.19 People with a disability have the same right to seek protection or assistance from the law as any other member of the community. Mentally handicapped persons are accorded positive discrimination under the Crimes Ordinance (Cap. 200) and the Mental Health Ordinance (Cap. 136) to protect them from sexual abuse. Mentally ill persons receive similar protection under the Mental Health Ordinance. There are also special rules and procedures designed to protect people with a disability involved in legal proceedings under the

Evidence Ordinance (Cap. 8), the Criminal Procedure Ordinance (Cap. 221), the Homicide Ordinance (Cap. 339), and under the Rules of the Supreme Court (Cap. 4, subsidiary legislation). Pursuant to section 4 of the Official Solicitor Ordinance (Cap. 416), the Official Solicitor is to act as guardian ad litem or next friend to any person under a disability of mental capacity in civil proceedings where so appointed by court or some other suitable person may be appointed as guardian ad litem or next friend.

15.20 There are provisions to assist a person with a disability who is unable to exercise appropriate control over his financial affairs : appointment of a receiver under Part VII of the UK Mental Health Act 1983 which is applicable in Hong Kong by virtue of the Supreme Court Ordinance (Cap. 4); and appointment of a committee under the Mental Health Ordinance (Cap. 136).

15.21 At present, the police will, at the discretion of the officer-in-charge of the case, ask the parent or guardian to be present during questioning of a person who is thought to be mentally handicapped or mentally ill. To assist officers in dealing with such cases, the police reviewed an internal instruction on "Statements Taking from Mentally Handicapped Persons" in January 1993 and disseminated it throughout the Police Force.

Guardianship

15.22 Paragraph 5 of the United Nations' Declaration on the Rights of Mentally Retarded Persons states that -

"The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests. "

The following paragraphs will examine the situation in Hong Kong.

Guardianship for Children with Mental Handicap and Mental Illness

15.23 At common law, parents are regarded as the natural guardians of their children. The non-parental guardianship of children,

including children with a mental handicap or mental illness, is governed by the Guardianship of Minors Ordinance (Cap. 13) and the Protection of Women and Juveniles Ordinance (Cap. 213). A child may come under the guardianship of persons other than their parents in the following ways -

- (a) by appointment - this means that the parent may by deed or will appoint any person to be the guardian of the minor after the parent's death;
- (b) by a court order - if neither parent has appointed a guardian and there is no other person with parental rights over the child, any person can apply to the court to be appointed guardian; and
- (c) by care proceedings - the Director of Social Welfare is empowered to make an application to the court for an order to receive a child into care.

Guardianship for Adults with Mental Handicap and Mental Illness

15.24 When a child with a mental handicap or mental illness attains the age of 18, provided that he has not come under any legislation which provides for guardianship of an adult (for example the Mental Health Ordinance), the legal powers exercised by the parent or guardian shall cease, in the same way as any other person. It has been suggested that moderately, severely, and profoundly mentally handicapped adults should remain under some kind of guardianship as they are unable to live independently. Nevertheless, it is arguable as to whether mentally handicapped and mentally ill persons should be deprived of their rights as adults, simply because they lack mental capacity.

15.25 The Mental Health Ordinance provides for the reception of mentally handicapped and mentally ill adults into guardianship. A guardianship application may be made in respect of a mentally handicapped or mentally ill person who has attained the age of 18 years. The application may be made either by a relative of the mentally handicapped or mentally ill person, a registered medical practitioner or a public officer of the Social Welfare Department. Where a guardianship application names a person other than the Director of Social Welfare as

the guardian, the Director may determine not to accept the person named as guardian and appoint himself to be the guardian.

15.26 The guardianship application must be supported by a statement by two registered medical practitioners to the effect that -

- (a) the mentally handicapped or mentally ill person is suffering from mental disorder of such a nature or degree which warrants his reception into guardianship; and
- (b) it is necessary in the interests of the welfare of the patient or the protection of other persons that the patient should be received into guardianship.

15.27 The Mental Health Ordinance confers on the guardian three specific powers over the patient, to the exclusion of any other person who might have them -

- (a) to require the patient to reside at a place specified by the guardian;
- (b) to require the patient to attend at places and times specified for the purpose of medical treatment, employment, education or training; and
- (c) to require access to the patient to be given, at any place where the patient is residing, to any doctor, approved social worker or other person so specified.

15.28 The Mental Health (Guardianship) Regulations impose duties on private guardians in the exercise of their powers under the Mental Health Ordinance (Cap. 136). The regulations require, among other things, guardians to take all reasonable steps to ensure the safety and welfare of the person received into guardianship and to arrange for the provision of adequate care for him.

15.29 Safeguards are provided by the Mental Health Ordinance whereby a person admitted into guardianship, or his relative, may make an application to the Mental Health Review Tribunal for the review of any case of a person admitted to guardianship. Guardianship shall cease

to be of any effect on the expiration of two years from its commencement, unless it is discharged earlier or renewed by a further application. This allows for the suitability of the guardian to be kept under review, and for the welfare of the person received into guardianship.

Adults with a Mental Handicap and Mental Illness not under Guardianship

15.30 Adults with a mental handicap or mental illness who are not received into guardianship in accordance with the procedures described above are left to make day-to-day decisions such as where that person will reside, where he will work and the type of educational or recreational activities he may engage in. Where they are living with their parents, or in a residential care home, it is not unusual for the parents or care-givers to make decisions on their behalf and thus assume a role of de facto guardianship. Whilst the de facto guardian has no legal rights or powers over the person for whom he is caring, the principles of common law protect him from liability, provided that he acts in the best interests and for the benefit of the mentally handicapped or mentally ill person.

15.31 Some parent associations and service providers feel that separate guardianship provisions for mentally handicapped and mentally ill persons are a necessity. They consider the scope of the existing provisions under the Mental Health Ordinance inadequate to protect mentally handicapped and mentally ill persons whose parents are too old or mentally unsound, or whose parents or care-givers have died. Although any mentally handicapped or mentally ill person in such a situation has the right to facilities and services provided by the Social Welfare Department or non-governmental organizations, including residential care, there is always a waiting time before such services become available.

15.32 It is appreciated that even de facto guardians may be wary of assisting mentally handicapped or mentally ill persons to, for example, make large financial transactions. However, as discussed above, a mentally handicapped or mentally ill person can apply for the appointment of a committee or a receiver may be appointed for the purpose of managing the person's affairs and property. Under the Rules of the Supreme Court (Cap. 4), a mentally handicapped or mentally ill

person suffering from mental disorder and who is incapable of managing and administering his affairs and property, can bring legal proceedings by a "next friend". Such rules also provide for the appointment of guardian ad litem to defend a mentally handicapped or mentally ill person in court proceedings.

Review of the Mental Health Ordinance

15.33 The Mental Health Ordinance, enacted in 1962 and last amended in 1988, provides for the reception, detention and treatment of mentally disordered persons. Over the years, there have been repeated complaints from parent associations and service providers that the Ordinance fails to provide adequate legal protection for the rights and interests of people with a mental handicap. They have asked for a separate legislation to codify existing provisions relating to people with a mental handicap.

15.34 Against this background, a working party was set up in 1988 under the chairmanship of the Commissioner for Rehabilitation to examine the need and desirability of separate legislation for people with a mental handicap. It reviewed comprehensively the entire spectrum of legal and administrative provisions for people with a mental handicap. In its Report published in April 1990, the working party concluded that there was not sufficient justification for separate legislation for people with a mental handicap. However, it put forth a number of recommendations for improving the Mental Health Ordinance to better cater for the special needs of people with a mental handicap.

15.35 When the Green Paper was published for public consultation in early 1992, non-governmental organizations and parent associations renewed their calls for separate legislation for people with mental handicap. We reaffirmed our previous position on the issue, but undertook to review the Mental Health Ordinance again to identify areas for further improvement. In July 1993, the Commissioner for Rehabilitation convened an inter-departmental review group to examine the issues involved. Having sought the views of parent associations, the review group produced some initial ideas on areas for improvement. These include the redefinition of the term "mental disorder" to distinguish clearly people with mental illness from those with mental handicap; issues relating to guardianship; additional disposal options

including a guardianship order for a defendant found unfit to plead or not guilty by reason of insanity; and consent to medical and dental treatment. Revisions to give effect to these proposals are being prepared for the Mental Health Ordinance.

People with Mental Handicap Giving Evidence in Court

15.36 In October 1993, the Chief Justice appointed a Working Party "to examine the ways and means by which mentally handicapped people giving evidence in court may be assisted in order to minimize any trauma they may suffer thereby". The Working Party, chaired by a High Court judge, published an interim report and a final report in early 1994.

15.37 The Working Party made a total of 17 recommendations which were accepted by the Chief Justice. These include the use of Cantonese in court proceedings; special procedures at the trial, for example, conducting the trial in a setting similar to a juvenile court; giving evidence by means of TV link; and the use of video recording as evidence in chief. The majority of the recommendations can be implemented administratively, while others call for legislative amendments. In some cases these inter-relate with other long-term moves taking place in the Judiciary, such as the spread of the availability of the use of Chinese in court, and may therefore take some time. However they are all being taken forward and will go a long way towards protecting the well-being of people with a mental handicap giving evidence in court.

Review of Legislation

15.38 The Green Paper recommended that "legislative changes could be proposed to bring about equalization of opportunities and full participation" and that a comprehensive review be proposed for consideration by the Law Reform Commission as a matter of priority. We took up the question of whether there was a need to introduce anti-discrimination legislation for people with a disability with the Commission in 1993. Its Chairman advised that the question of such legislation and the issues it raised were ones of policy rather than law, the Law Reform Commission was not the appropriate forum to consider the subject.

Disability Discrimination Bill

15.39 As a concrete demonstration of Government's commitment to integrating people with a disability into the community and to tackling the problems of discrimination and harassment encountered by people with a disability, we introduced the comprehensive Disability Discrimination Bill into the Legislative Council in May 1995. The Bill defines "disability" to include any physical or mental impairment which presently exists, previously existed or may exist in the future. People with HIV/AIDS have also been covered.

15.40 This Bill gives people with a disability the legal means to fight for equal opportunities, and for access to and involvement in the community, to the fullest extent possible. The Bill performs both a cautionary and educational function. It will, if enacted, enshrine in the law the standards to which we believe Hong Kong, as a civilised community, should adhere.

15.41 The Disability Discrimination Bill contains provisions to cover discrimination on the ground of disability in, for example -

- (a) work (by employers, professional and trade organizations, and employment agencies);
- (b) membership of partnerships, professional organizations, qualifying bodies and clubs;
- (c) education (by educational institutions in terms of admission and treatment of students);
- (d) access to and use of buildings, places and services;
- (e) accommodation (by landlords or agents in dealing with a person's application for commercial or residential premises); and
- (f) recreation and sport.

In addition, provisions on discrimination involving harassment or vilification on the ground of disability have been included.

15.42 The Disability Discrimination Bill does not require absolute equality in all areas whatever the cost, nor prohibit special treatment (or affirmative action) which might appear discriminatory, but which is, in fact, in the interests of people with a disability. The Bill provides for two general exemptions, “unjustifiable hardship” and “genuine occupational qualification”. In determining unjustifiable hardship, all of the relevant circumstances of a particular case will be taken into account, including, for example, the financial circumstances of the employer or business concerned, the technical feasibility and costs of providing the appropriate accommodation or services.

15.43 To enforce the Bill, the purview of the Equal Opportunities Commission, to be set up under the Sex Discrimination Bill, will be expanded. The Commission’s functions in relation to disability will be to -

- (a) work towards the elimination of discrimination against people with a disability;
- (b) promote equality of opportunity between people with a disability and people without disabilities;
- (c) work towards the elimination of harassment on account of disabilities;
- (d) in the case of any act alleged to be unlawful by virtue of the future Ordinance, encourage persons who are concerned with the matter to which the act relates to effect a settlement of the matter by conciliation;
- (e) keep under review the working of the future Ordinance and, when it is so required by the Governor or if the Commission otherwise thinks it necessary, draw up and submit to the Governor proposals for amending the Ordinance; and
- (f) perform such other functions as are imposed on it under the Ordinance or any other enactment.

15.44 The Bill seeks to strike a balance. It will be the role of the Equal Opportunities Commission to ensure that all parties in the

community take a reasonable approach in working towards the greater integration of people with a disability into our community. It will issue Codes of Practice setting out what will be expected in each area of activity to which the courts will have reference in deciding areas brought under the new legislation.

CHAPTER 16

ADMINISTRATION AND CO-ORDINATION

Policy Responsibilities

16.1 The Commissioner for Rehabilitation is responsible to the Secretary for Health and Welfare for the formulation of overall policy on rehabilitation, and for co-ordinating the planning and executive action of government departments and non-governmental organizations. Rehabilitation cuts across a wide spectrum of services. Relevant branches deal with rehabilitation services for which they have policy responsibilities. These include Transport Branch for accessibility of the public transport system and Education and Manpower Branch for open employment and special education.

16.2 Rehabilitation planning is contained in the Rehabilitation Programme Plan, which was introduced in 1977 and presents a comprehensive picture of the current and planned provision of rehabilitation services. The Plan is used as the basis for estimating the financial and manpower resources required for the development of services in the context of Government's baseline forecast. It is monitored by a joint Government/non-governmental organization review committee. At least 14 government departments and 70 non-governmental organizations provide services under the Rehabilitation Programme Plan, which is reviewed in its entirety every three years. The review involves representatives of the departments involved in rehabilitation services as well as the non-governmental sector.

Rehabilitation Development Co-ordinating Committee

16.3 The Rehabilitation Development Co-ordinating Committee (RDCC) was set up following the publication of the 1977 White Paper on Rehabilitation. It is the principal advisory body to Government on the development and implementation of rehabilitation policies and services in Hong Kong. The RDCC and its three Sub-committees on Education and Personnel, Access and Transport, and Employment are chaired by non-officials, and all members are appointed in their personal capacity.

16.4 To ensure that the interests of people with a disability are represented, the membership includes people with a disability, and representatives from other sectors of the community. This follows the principle advocated by the Charter for the 80's as approved by the Assembly of Rehabilitation International. Future appointments will continue to cater for the interests of people with a disability and will include people with a disability as far as possible.

16.5 The role of the RDCC is to advise Government on rehabilitation policy matters. It also co-ordinates and monitors the implementation of rehabilitation services. To reflect these functions and to conform with the names of other committees of a similar nature, the name of the Committee will be changed to Rehabilitation Advisory Committee (RAC) in 1995. As discussed in Chapter 12, the Committee on Public Education in Rehabilitation will be turned into a Sub-committee of the future RAC. We will also examine the structure and terms of reference of its three existing Sub-committees to see whether, in the light of the changing circumstances, any changes are required.

16.6 The mechanism for planning and co-ordination will be kept under constant review and improved as necessary, to ensure that it remains sensitive to changing needs. The division of responsibilities in respect of rehabilitation policies and services within the public and non-governmental sectors is illustrated in Appendix J.

Role of Government and Non-governmental Organizations

16.7 The more formal and identifiable providers of the services needed to implement rehabilitation programmes and policies are Government and the non-governmental organizations. Government's responsibilities focus on the overall planning, development and co-ordination of services, education, training and manpower needs, statutory services, enforcement of legislation, services with legal implications, review of relevant legislation and provision of subventions. It takes on the direct provision of other services in order to acquire the necessary expertise to exercise its advisory and monitoring functions over rehabilitation services. Government also provides prevention, identification and assessment services, with some of these being provided by non-governmental organizations as well. Medical

rehabilitation services are provided by the Hospital Authority, while the Vocational Training Council provides vocational training.

16.8 The non-governmental organizations are major providers of services in partnership with Government. Subvention to these organizations accounts for a significant portion of total government expenditure on rehabilitation services. In addition, they now play a greater role in the development of policies and in service planning. The Joint Council for the Physically and Mentally Disabled (Rehabilitation Division, Hong Kong Council of Social Service), a co-ordinating body of the majority of non-governmental organizations, works closely with Government in the planning and development of rehabilitation services and facilitating consultation and communication between Government and the subvented sector. Non-governmental organizations will continue to be encouraged and supported in the pioneering of new initiatives. Their devotion, enthusiasm and commitment have contributed a great deal to the development and expansion of many of the services available to people with a disability. The maintenance of a vigorous and progressive non-governmental sector, functioning in genuine partnership with Government in the provision of rehabilitation services, is vital to the future development of rehabilitation.

Funding and Subvention

16.9 Rehabilitation services are mainly provided by and funded through five Government departments, namely, Education, Health, Labour, Social Welfare and Transport, as well as the Rehabilitation Division of the Health and Welfare Branch of the Government Secretariat, the Hospital Authority, the Housing Authority, the Regional Council, the Urban Council and the Vocational Training Council. The total provision in the approved Estimates for 1995-96, including on-costs, central administration as well as support and capital expenditure, amounts to \$7,354.6 million, consisting of \$7,264.4 million for recurrent and \$90.2 million for non-recurrent expenditure. The total provision figure has taken into account \$1,440.4 million for payments under the Comprehensive Social Security Assistance to people with a disability and \$903.5 million for Disability Allowance. These two elements were not included in the corresponding figures in the Green Paper.

16.10 Charts 4 to 6 give details on the growth of rehabilitation expenditure in the past few years and the breakdown.

16.11 At present, a typical non-governmental organization's income may come from any or all of the following sources -

- (a) Government departments;
- (b) the Community Chest;
- (c) fees and charges;
- (d) the Royal Hong Kong Jockey Club;
- (e) the Lotteries Fund;
- (f) its own fund raising programmes; and
- (g) other sources, for example trust funds.

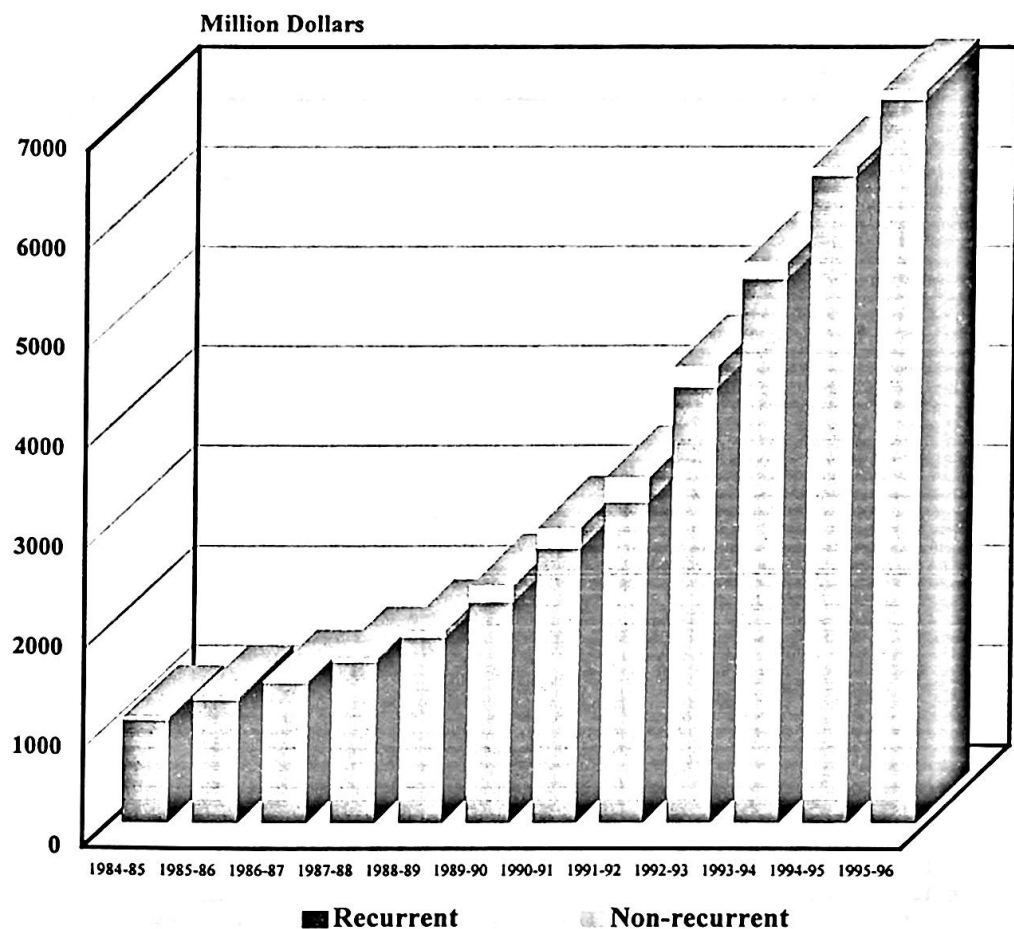
16.12 Non-governmental organizations provide the bulk of rehabilitation services. It is of crucial importance for them to adopt a more innovative, imaginative and flexible approach to the provision of services and the use of resources with a view to improving cost-effectiveness and developing sources of income, other than subvention.

16.13 Current subvention policy is founded on the following principles -

- (a) organizations receiving government subvention are accountable to the public for the use of public funds;
- (b) organizations are free to raise funds to supplement government subvention for the services they provide, and income from other sources has no "see-saw" effect on the level of subvention;
- (c) the terms and conditions of service of staff in subvented organizations should not be superior to those provided by Government to comparable grades in the Civil Service; however, within the limit of the subvention provision for

Chart 4

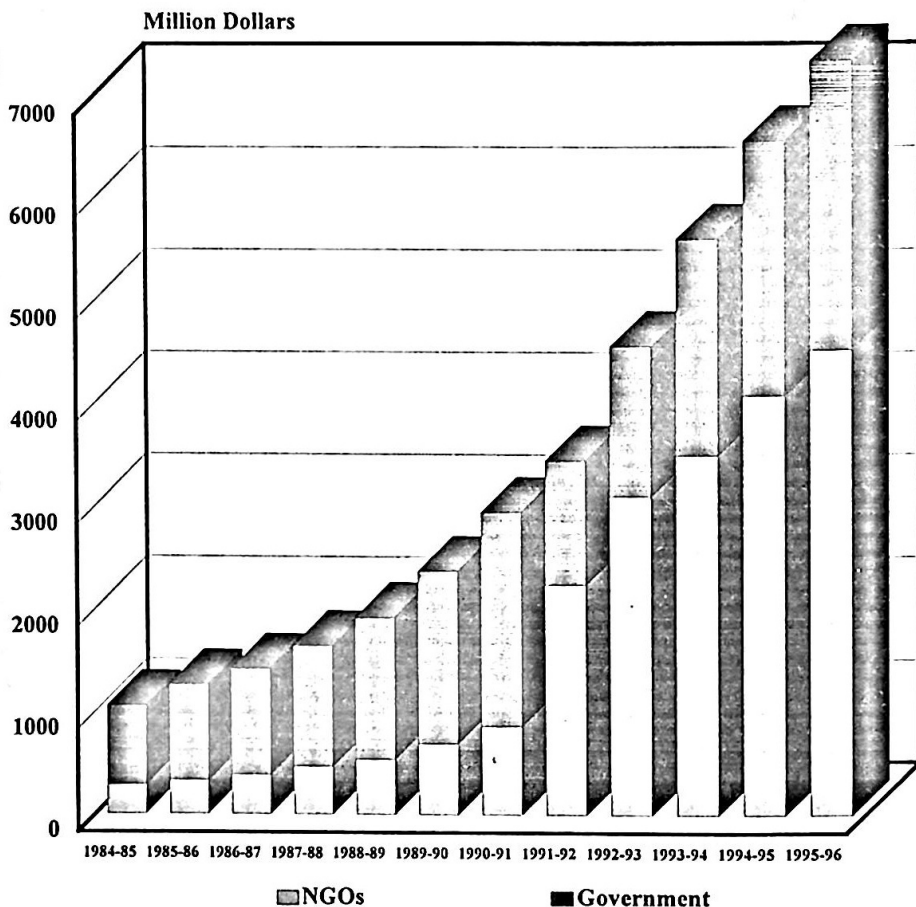
Recurrent and Non-recurrent Expenditure on Rehabilitation Services 1984-85 to 1995-96



Source : Rehabilitation Division, Health and Welfare Branch

Chart 5

Recurrent and Non-recurrent Expenditure on Rehabilitation Services by Government and NGOs 1984-85 to 1995-96



Note : On 1 December 1991, the management and operational responsibility for hospital services was transferred from the Hospital Services Department to the Hospital Authority. The full year financial impact resulted from the transfer is reflected as from the year 1991-92.

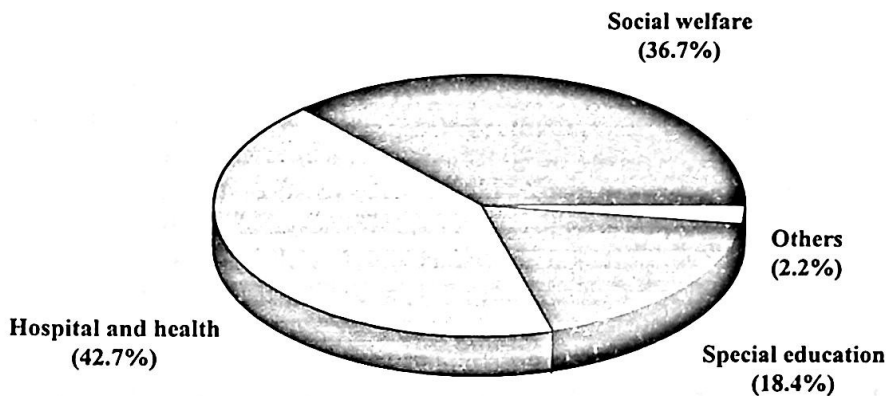
Source : Rehabilitation Division, Health and Welfare Branch

Chart 6

Functional Allocation of Recurrent Expenditure on Rehabilitation Services

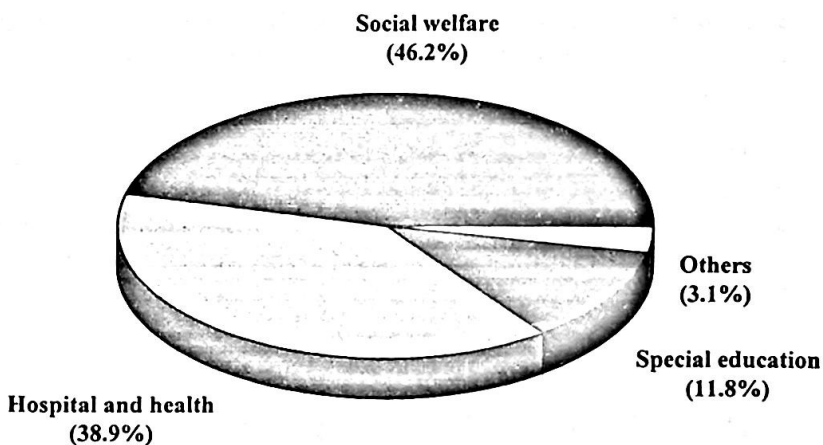
1984-85

(Total expenditure : S 1,032 Million)



1995-96

(Total expenditure : S 7,264 Million)



Source : Rehabilitation Division, Health and Welfare Branch

personal emoluments, organizations are given flexibility in the number and rank of staff which they employ;

- (d) non-governmental organizations are expected to provide the services at the standards envisaged; and
- (e) Government control will focus on the measurement of output and performance, while maintaining overall financial monitoring.

16.14 The White Paper on "Social Welfare into the 1990's and Beyond" decided that subvention would move towards a standard cost system which would offer the providers greater flexibility in the use of resources and reduce administrative costs, provided that a value for money evaluation process was developed. The same principle applies to the rehabilitation field where subvented agencies also play an important role in providing a wide range of social, medical, educational, transportation and advisory services.

16.15 The Social Welfare Department has developed a unique partnership with non-governmental organizations in providing social welfare services for the community including rehabilitation. Recognizing the need to review the subvention system which has been evolving over 30 years, the Department has commissioned a consultancy study on reviewing the social welfare subvention system. The review aims to produce a simplified and more flexible system, with greater emphasis on outputs of performance, suitable incentives/sanctions to provide a better service and better value for money.

16.16 The possibility of purchasing services from non-profit making organizations or "bought places" will be further explored. As an alternative to the current subvention system, this concept might bring about greater flexibility and innovation in the provision of rehabilitation services.

Fee-charging

16.17 The concept of fee-charging does not indicate a reduction on the part of Government's financial commitment to rehabilitation services. Likewise, it is not an attempt to recover the full costs. Fee-charging

allows clients or users to make a contribution and discourages misuse of services. At present, the levels of fees that may be charged by agencies for providing subvented services are set by Government. The income from the standard levels of fees is fully taken into account in the allocation of subvention. To enhance cost-effectiveness, organizations should be given the freedom to charge fees in excess of the standard levels and allowed to use the additional income for the improvement and expansion of their rehabilitation services.

16.18 The principle of asking those who can afford to pay for the service provided, or for service over and above the normal standard, is not unreasonable. A wider range of services should be offered so that people can have more choice depending on their ability to pay. There is a need to first identify which services should attract fees and how the system should be applied. However, since many people with a disability are unemployed, the system has to ensure that no one who is unable to contribute is either denied a service or discriminated against on this ground. It must also ensure that people with a disability will not be required to pay more than people without a disability for a similar service.

16.19 The Social Welfare Department will in collaboration with the non-governmental sector explore the possibility of providing non-profit making and self-financing services to those who are prepared to pay for quality services at reasonable rates.

CHAPTER 17

CONCLUSION

17.1 Having regard to the overall objective for rehabilitation, the strategies are -

- (a) to step up prevention, identification and assessment of disabilities with a view to preventing impairments or ensuring the maximization of abilities in the presence of impairments or disabilities;
- (b) to influence the broader environment with a view to meeting the needs of people with a disability. Measures will be incorporated into the general planning process and the administrative structure to ensure that the benefits of societal development programmes can reach people with a disability; and
- (c) to promote community acceptance of, to instil positive public attitudes towards, and to remove physical as well as social barriers against people with a disability so as to facilitate the attainment of our twin goals of equalization of opportunities and full participation for people with a disability.

17.2 Since the publication of the Green Paper in early 1992, Government has taken a big step forward both in terms of policy directions for rehabilitation and the provision of rehabilitation services. Every effort has been, and will continue to be, made to promote the integration of people with a disability into the community. To demonstrate our commitment to further improving rehabilitation services between 1995-96 and 1998-99, we have drawn up an implementation schedule, at Appendix K, for which funds have already been secured. It covers six areas, namely, social, vocational, and medical rehabilitation, special education, transport and public education, with full-year recurrent cost estimated at \$596 million at 1995-96 prices.

17.3 Certain policy decisions in this White Paper can be implemented through better co-ordination among service providers or by re-targeting existing resources, without incurring additional expenditure. As regards those improvement measures not covered by the above schedule, for example, the projected requirement for social rehabilitation services arising from the adoption of a new demand formula (described in paras. 2.36 and 2.37 above), we shall implement them as resources permit. The Secretary for Health and Welfare and the other relevant Policy Secretaries will bid for the necessary funds in Government's annual Resource Allocation Exercise.

17.4 Challenges and obstacles may continue to surface in the years ahead. With the concerted efforts of Government, non-governmental organizations, self-help organizations and the community as a whole, Hong Kong is moving steadily towards the day when the goals of full participation and equalization of opportunities are achieved. Our readiness to share Hong Kong's success with and to care for people with a disability will help us build a better tomorrow for all.

**Terms of Reference
of the Working Party on
Rehabilitation Policies and Services**

1. To formulate proposals in the form of a Green Paper on the objectives, strategies and further development of rehabilitation services for disabled persons including an assessment of the resource implications and time-frame for implementing the proposals.
2. To review the existing legislation relating specifically to disabled persons and to consider how it can strengthen the protection of their rights.
3. In undertaking the task at (1) above, to :-
 - (a) review the overall and specific objectives of rehabilitation policies;
 - (b) examine the scope of the various rehabilitation programmes for disabled persons; and
 - (c) enunciate the principles for the development of rehabilitation facilities and serviceshaving regard to past experience, international trends and realistically taking into account :-
 - (i) the likely manpower and financial constraints within the next few years, and the inevitable need to determine priorities; and
 - (ii) the need to ensure that existing or proposed new services provide the best value for money.

**Membership of the
Working Party on Rehabilitation Policies and Services**

- Chairperson*** : Mrs. Elizabeth WONG, I.S.O., J.P.
- Non-official Members** : Mr. John BUDGE, J.P.
 Mr. Peter CHAN Fuk-sing
 Miss Virginia CHAN Choi-ying
 Dr. Fanny CHEUNG Mui-ching, J.P.
 Mr. CHONG Chan-yau
 Dr. York CHOW Yat-ngok
 Mr. Nicholas CRAWFORD
 Miss Marion FANG Sum-suk, M.B.E., J.P.
 Mr. Simon LEE Kwok-yin, J.P.
 Professor Rance LEE Pui-leung
 The Hon. Eric LI Ka-cheung, J.P.
 Dr. Raymond WU Wai-yung, J.P.
 Dr. Dicken YUNG Tak-kun, J.P.
- Official Members** : Deputy Secretary (2), Health and Welfare Branch
 Commissioner for Rehabilitation, Health and Welfare Branch
 Assistant Director (Services), Education Department
 Assistant Director (Youth and Rehabilitation), Social Welfare Department
 Principal Medical Officer (Development), Hospital Services Department
 Assistant Financial Secretary A, Finance Branch
- Secretary** : Assistant Secretary (Rehabilitation), Health and Welfare Branch

* Mr. M D. Cartland, J.P., Director of Social Welfare, acted as Secretary for Health and Welfare from 7.1.1991 to 13.3.1991 and 21.8.1991 to 28.9.1991 and chaired the Working Party meetings on three occasions. He also chaired two Working Party meetings on 28.11.1991 and 4.12.1991.

Membership of the Three Sub-committees

I. Working Party on Rehabilitation Policies and Services :

**Sub-committee on Services for Persons with Mental Handicap
or Mental Illness**

Chairman : Commissioner for Rehabilitation

Members : Mr. Stephen CHAN Siu-yuen

Mr. CHANG Kwong-chi

* Mr. Nicholas CRAWFORD

Mr. KONG Siu-hong

Dr. P. S. SHUM

Miss Deborah WAN Lai-yau

Miss Nora WONG Pui-ha

* Dr. Dicken YUNG Tak-kun, J.P.

A representative of Education Department

A representative of Hospital Services Department

A representative of Social Welfare Department

Representatives of Labour Department, Transport
Department, Technical Education and Industrial
Training Department as and when necessary

Secretary : Assistant Secretary (Rehabilitation), Health and
Welfare Branch

* Denotes Working Party Members

II. Working Party on Rehabilitation Policies and Services :

Sub-committee on Services for Persons with Physically Handicap or Sensory Impairments

Chairman : Commissioner for Rehabilitation

Members : Miss BOW Sui-may

* Mr. Peter CHAN Fuk-sing

* Miss Virginia CHAN Choi-ying

Mrs. C. S. CHONG

* Mr. CHONG Chan-yau

* Dr. York CHOW Yat-ngok

* Miss Marion FANG Sum-suk, M.B.E., J.P.

Mrs. Kimberley LAM KWONG Lan-heung

* The Hon. Eric LI Ka-cheung, J.P.

Mr. K. J. Keith MARSHALL, J.P.

Dr. N. S. NG

A representative of Education Department

A representative of Hospital Services Department

A representative of Social Welfare Department

Representatives of Labour Department, Transport Department, Housing Department, Buildings and Lands Department, Technical Education and Industrial Training Department as and when necessary

Secretary : Assistant Secretary (Rehabilitation), Health and Welfare Branch

* Denotes Working Party Members

III. Working Party on Rehabilitation Policies and Services :

Sub-committee on General Services

Chairman : Commissioner for Rehabilitation

Members : * Miss Virginia CHAN Choi-ying

* Dr. York CHOW Yat-ngok

Professor John EVANS

Mr. LAI Boon-lap

Mrs. Juli LEE LAU Chu-lai

Mr. M. B. LEE, M.B.E., J.P.

* Professor Rance LEE Pui-leung

* The Hon. Eric LI Ka-cheung, J.P.

Miss Nancy TSANG Lan-see

Mr. Basil WONG Chi-wing

A representative of Education Department

A representative of Hospital Services Department

A representative of Social Welfare Department

Representatives of Attorney General's Chambers,
Labour Department, Transport Department,
Housing Department, Department of Health,
Technical Education and Industrial Training
Department as and when necessary

Secretary : Assistant Secretary (Rehabilitation), Health and
Welfare Branch

* Denotes Working Party Members

Summary of Public Submissions by Source

Source	Number of Submissions Received
Individuals	305
Group submissions*	117
Non-governmental organizations	61
District Boards	19
Tertiary institutions	10
Staff associations	10
Others	31
Total :	553

* Submissions jointly presented by two signatories or more are classified as group submissions.

Summary of Public Reaction

- (a) the basic principles and policy objectives of the Green Paper were supported;
- (b) shortfalls in social rehabilitation services should be accorded higher priority and be met within the next five years;
- (c) the Mental Health Ordinance (Cap. 136) which provides for the reception, detention and treatment of mentally disordered persons should be amended to distinguish clearly people with mental illness from people with mental handicap. Additionally, guardianship provisions in the Ordinance should be improved;
- (d) Government should provide financial assistance to parent resource centres;
- (e) Government should implement various measures including tax concessions and quota system to promote employment opportunities for people with a disability;
- (f) mobility allowance should be given to people with walking difficulty;
- (g) children with a disability should receive a longer period of special education;
- (h) Rehabus service be expanded as soon as possible;
- (i) people with chronic illnesses and people with speech impairment should be included in the categories of disability;
- (j) size of the disabled population was under-estimated; and
- (k) status of the post of Commissioner for Rehabilitation should be enhanced.

Social Rehabilitation Services

Comparison between Targets in the Green Paper on Rehabilitation
and Demand Based on New Demand Formula

	Targets in the Green Paper on Rehabilitation (See Note 1)	Additional provision between 1993-94 and 1998-99	Total provision in 1998-99 (See Note 2)	Projected demand in 1998-99 based on new demand formula	Additional provision required to meet projected demand in 1998-99 (See Note 3)
	(places)	(places)	(places)	(places)	(places)
Day Services					
(a) Day Activity Centres	1 408	1 408	3 676	3 593	NIL
(b) Sheltered Workshops	2 110	2 160*	6 495	9 690	2 788
Sub-total	3 518	3 568	10 171	13 283	2 788
Residential Services					
(c) Hostels for Moderately Mentally Handicapped Adults	501	601	1 494	2 113	558
(d) Hostels for Severely Mentally Handicapped Adults	1 558	1 758	2 503	3 335	782
(e) Hostels for Severely Physically Handicapped Adults	75	75	406	478	58
(f) Half Way Houses	380	380	1 177	2 331	707
(g) Long Stay Care Homes	370	370	570	1 204	611
(h) Homes for Aged Blind Persons	786	794	1 125	1 380	100
(i) Small Group Homes for Mildly Mentally Handicapped Children	88	88	96	NA	NA
(j) Supported Housing for Semi-independent Living	17	17	17	NA	NA
(k) Supported Hostels for Semi-independent Living	154	154	154	NA	NA
Sub-total	3 929	4 237	7 542	10 841	2 816
Total	7 447	7 805	17 713	24 124	5 604

* including supported employment

Note 1 : These targets have been revised to take account of changing needs. See para. 2.32 of the text.

Note 2 : The revised targets in the Green Paper on Rehabilitation will be achieved in full by 1997.

Note 3 : Taking into account the number of places vacated by users who will be discharged from the service in 1998-99.

Provision of and Demand for Other Rehabilitation Services

	Unit of Provision	Projected demand in 1998-99	Total provision in 1998-99	Additional provision required to meet demand in 1998-99
<u>Pre-school Service</u>				
(a) Early Education and Training Centre	No. of places	2 937	1 420	836*
(b) Integrated Child Care Centre	No. of places	1 814	1 222	67*
(c) Special Child Care Centre	No. of places	1 454	1 329	0*
<u>Special Education</u>				
(d) Integrated Kindergarten	No. of places	NA	132	NA
(e) Special School				
i. Maladjusted	No. of places	1 174	945	229
ii. Blind	No. of places	168	210	NIL
iii. Hearing Impaired	No. of places	554	740	
iv. Physically Handicapped	No. of places	603	800	
v. Mildly Mentally Handicapped	No. of places	2 522	3 040	
vi. Moderately Mentally Handicapped	No. of places	1 658	1 880	
vii. Severely Mentally Handicapped	No. of places	720	792	
(f) Hospital School	No. of places	362	499	
(g) Special Class				
i. Visually Impaired	No. of places	77	105	
ii. Hearing Impaired	No. of places	122	130	
<u>Vocational Rehabilitation</u>				
(h) Vocational Assessment Centre	No. of assessments	533	280	253
(i) Vocational Training Centre	No. of places	1 144	845	299
<u>Medical Rehabilitation</u>				
(j) Hospital Beds for Mentally Ill Patients	No. of beds	NA	5 427	NA
(k) Hospital Beds for Severely Mentally Handicapped	No. of beds	NA	825	NA

* Taking into account the number of places vacated by users who will be discharged from the service in 1998-99.

Classification Systems of Mental Handicap

Term	IQ Range	
	AAMD/DSM-IIIR (See Note 1 for description)	WHO : ICD-9/CIDH (See Note 2 for description)
Mild	50-55 to approx. 70	50 to 70
Moderate	35-40 to 50-55	35 to 49
Severe	20-25 to 35-40	20 to 34
Profound	below 20 or 25	below 20
Unspecified	—	—

AAMD : American Association on Mental Deficiency (Recently renamed American Association of Mental Retardation (AAMR))

DSM-IIIR : American Psychiatric Association's Diagnostic and Statistical Manual Revised 3rd Edition

WHO : ICD-9/CIDH : World Health Organization's International Classification of Diseases or International Classification of Impairments, Disabilities, and Handicaps

Note 1 - Description for AAMD/DSM-III-R Classification

(a) Mild Grade

Mild mental retardation is roughly equivalent to what used to be referred to as the educational category of "educable". This group constitutes the largest segment of those with the disorder - about 85%. People with this level of mental retardation typically develop social and communication skills during the pre-school years (ages 0-5), have minimal impairment in sensori-motor areas, and often are not distinguishable from normal children until a later age. By their late teens they can acquire academic skills up to approximately sixth grade level; during their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need guidance and assistance when under unusual social or economic stress. At the present time, virtually all people with mild mental retardation can live successfully in the community, independently or in supervised apartments or group homes (unless there is an associated disorder that makes this impossible).

(b) Moderate Grade

Moderate mental retardation is roughly equivalent to what used to be referred to as the educational category of "trainable". This former term should not be used since it wrongly implies that people with moderate mental retardation cannot benefit from educational programs. This group constitutes 10% of the entire population of people with mental retardation. Those with this level of mental retardation can talk or learn to communicate during the pre-school years. They may profit from vocational training and, with moderate supervision, can take care of themselves. They can profit from training in social and occupational skills, but are unlikely to progress beyond the second grade level in academic subjects. They may learn to travel independently in familiar places. During adolescence, their difficulties in recognizing social conventions may interfere

with peer relationship. In their adult years, they may be able to contribute to their own support by performing unskilled or semi-skilled work under close supervision in sheltered workshops or in the competitive job market. They need supervision and guidance when under stress. They adapt well to life in the community, but usually in supervised group homes.

(c) Severe Grade

This group constitutes 3% - 4% of people with mental retardation. During the pre-school period, they display poor motor development, they may learn to talk, and can be trained in elementary hygiene skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning sight-reading of some "survival" words, such as "men" and "women" and "stop". In their adult years, they may be able to perform simple tasks under close supervision. Most adapt well to life in the community, in group homes or with their families, unless they have an associated handicap that requires specialized nursing or other care.

(d) Profound Grade

This group constitutes approximately 1% - 2% of people with mental retardation. During the early years, these children display minimal capacity for sensori-motor functioning. A highly structured environment, with constant aid and supervision, and an individualized relationship with a care-giver are required for optimal development. Motor development and self-care and communication skills may improve if appropriate training is provided. Currently, many of these people live in the community, in group homes, intermediate care facilities, or with their families. Most attend day programmes, and some can perform simple tasks under close supervision in a sheltered workshop.

Note 2 - Description for WHO : ICD-9/ICIDH Classification

(a) Mild Grade

Individuals who can acquire practical skills and functional reading and arithmetic abilities with special education, and who can be guided towards social conformity.

(b) Moderate Grade

Individuals who can learn simple communication, elementary health and safety habits, and simple manual skills, but do not progress in functional reading or arithmetic.

(c) Severe Grade

Individuals who can profit from systematic habit training.

(d) Profound Grade

Individuals who may respond to skill training in the use of legs, hands, and jaws.

Residential Services

Mode A : Supported Housing for Independent Living

A Cluster of eight 3-person units may be provided in public housing estates for 24 disabled persons who can manage independent living under limited supervision and support to be provided by two residential staff. It is anticipated that these disabled persons would be engaged in open or sheltered employment, or would be receiving vocational training. Through readily available support and assistance, the objective of this provision is to enable the residents to have greater confidence in living in a non-institutional setting. Community support services will also be arranged by the Social Work Assistants whenever required.

Mode B : Supported Hostel for Semi-independent Living

The provision is in the form of group homes for those disabled persons who can manage semi-independent living in five 4-person units in public housing estates. The disabilities of the residents can range from moderate to severe and they might require a fair amount of assistance in some domestic tasks or community living activities. A team of six staff are provided to cater for the various needs of the residents.

Self-care hostels which have objectives similar to that of Mode A and Mode B accommodations have been set up by the Social Welfare Department and non-governmental organizations for physically handicapped persons who can manage self-care and need minimal help in daily living. It is anticipated that more such units will be planned as more physically handicapped persons are identified as capable of living in such facilities.

Mode C : Hostel for People with Moderate Disability

This is a residential provision in the form of a home for moderately disabled persons who lack self-care ability and daily living skills and are in need of an intensive training and maintenance programme. The capacity would not exceed 50 and a team of 15 staff is provided.

Mode D : Hostel for People with Severe/Multiple Disability

This is the most heavily staffed facility serving low moderately/severely mentally handicapped and severely physically handicapped persons who lack basic self-care skills and require intensive care and training. In view of the high dependency of the residents, the capacity will be kept at no more than 50 for easier and effective management. For severely mentally handicapped persons, a team of 29 staff are provided. For severely physically handicapped persons, a team of 35 staff is provided.

For those severely/multiply handicapped persons whose self-care abilities and health are in such a condition to warrant a certain amount of nursing care but not medical treatment as in an infirmary or hospital, there will be the provision of care and attention facilities. This provision can be set up either as a care and attention section in a hostel for severely mentally handicapped or severely physically handicapped persons or as a care and attention home for severely disabled persons. A care and attention home with a capacity of 50 will have a staffing of 32. Besides nursing and personal care, training and assessment will still be part of the service of the provision to make it possible for the residents to achieve further development in their skills and capability.

Residential Facilities for Former Mental Patients

(a) Half-way Houses

These are intended for former mental patients who are capable of independent living after hospital treatment but who require a transitional period of residential care for readjustment to normal life before returning home. Through group living and professional support, residents learn to maintain stability of mind and develop a sense of identity and belonging, so they may return to normal life.

(b) Purpose-built Half-way Houses

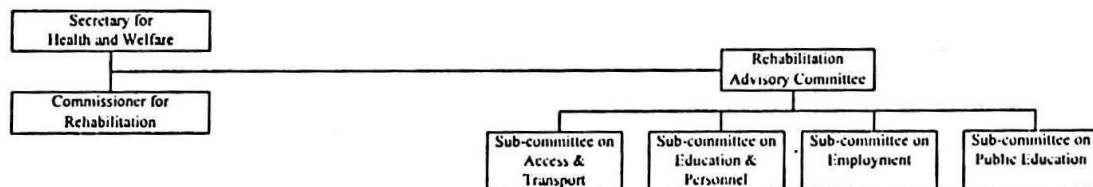
Purpose-built half-way houses are provided for both ordinary and "sub-target group" former mental patients. ("Sub-target group" as defined in the 1983 Report of the Working Group on Ex-mental Patients with a History of Criminal Violence or Assessed Disposition to Violence). Residents live in an integrated setting at the ratio of three ordinary to one sub-target group former mental patient.

(c) Long Stay Care Homes

Long stay care homes provide residential care for chronic mental patients who are in stable or controlled medical or mental condition, and who need no medical treatment other than minimal nursing care. Besides accommodation, the homes provide training programmes in social skills, domestic and nursing care to help residents achieve some degree of independence.

Division of Responsibilities on Rehabilitation Policies and Services

Formulation of Policies



Provision of Services

Buildings Dept.	Education Dept.	Dept. of Health	Rehabilitation Division, Health and Welfare Branch	Labour Dept.	Social Welfare Dept.	Transport Dept.	Other govt. depts.	Hospital Authority	Housing Authority	Vocational Training Council	Urban Council, Regional Council	* Joint Council for the Physically and Mentally Disabled	Non-governmental organizations
Building access	Special education I/KG	Health education Screening, assessment and counselling	C.R.R. Planning and co-ordination	Selective placement Industrial safety	Sheltered workshop Residential services Home-help services Community support services I.C.C.C. S.C.C.C. D.A.C.	Transport facilities	Legislation Public education Recreation Road safety	Medical treatment Medical rehabilitation services	Housing Access	Vocational training	Recreation, sports and culture	Co-ordination of NGO activities in planning, operation, public education, research and international exchange	A variety of education, medical, social and vocational services, and pilot projects

Note

C.R.R. : Central Registry for Rehabilitation

I/KG : Integrated Kindergarten

D.A.C. : Day Activity Centre

NGO : Non-governmental Organizations

I.C.C.C. : Integrated Child Care Centre

S.C.C.C. : Special Child Care Centre

* Joint Council for the Physically and Mentally Disabled (Rehabilitation Division, Hong Kong Council of Social Service)

**Major Recommendations for Which Funds Have Been Secured
for Implementation between 1995-96 and 1998-99**

Item	Unit of provision	Total provision in 1994-95	Additional provision between 1995-96 and 1998-99	Total provision by 1998-99
Social Rehabilitation				
Day Services				
(a) Day Activity Centres	No. of places	2750	926	3676
Residential Facilities				
(b) Hostels for Moderately Mentally Handicapped Adults	No. of places	993	501	1494
(c) Hostels for Severely Mentally Handicapped Adults	No. of places	1747	756	2503
(d) Hostels for Severely Physically Handicapped	No. of places	331	75	406
(e) Half-way Houses	No. of places	857	320	1177
(f) Long Stay Care Homes	No. of places	200	370	570
(g) Homes for Aged Blind Persons	No. of places	325	800	1125
(h) Small Group Homes for Mildly Mentally Handicapped Children	No. of places	56	40	96
(i) Supported Housing for Semi-independent Living	No. of places	17	0	17
(j) Supported Hostel for Semi-independent Living	No. of places	90	64	154
	Total :	4616	2926	7542
Other Services				
(k) Parent Resource Centres	No. of centres	6	0	6
(l) Autistic Children Programme in Special Child Care Centres	No. of places	66	78	144
(m) Occasional Child Care for Disabled Children	No. of places	36	4	40
(n) Integrated Child Care Centres	No. of places	910	312	1222
(o) Early Education & Training Centres	No. of places	905	450	1355
(p) Special Child Care Centres	No. of places	1047	282	1329
(q) Rehabilitation personnel for the implementation of major recommendations of the Working Group on Services for Autistic Persons	No. of posts	0	55	55
Vocational Rehabilitation				
(r) Sheltered Workshops	No. of places	5095	1400	6495
(s) Supported Employment	No. of places	360	0	360
Medical Rehabilitation				
(a) Rehabilitation Services for Chronically Ill Patients	No. of patients	3900	0	3900
(b) Additional Medical Rehabilitation Personnel	No. of posts	758	0	758
(c) Consultant-led Multi-disciplinary Teams :				
(i) Community Geriatric Team	No. of teams	4	3	7
(ii) Acute Geriatric Team	No. of teams	8	0	8
(iii) Psychogeriatric Team	No. of teams	4	1	5
(iv) Community Psychiatric Team	No. of teams	2	0	2
(v) Rehabilitation Team for Mentally/Physically Handicapped Persons	No. of teams	4	0	4
(d) Hospital Beds for Mentally-ill Patients	No. of beds	4679	748	5427
Special Education				
Resource Teachers for Autistic Children	No. of teachers	55	15	70
Transport				
(a) Scheduled Rehabus Routes	No. of routes	41	8	49
(b) Dial-A-Ride Rehabus	No. of vehicles	9	3	12
Public Education*				

*A sum of \$34 million has been earmarked for organizing public education activities on rehabilitation from 1993-94 to 1996-97.

Glossary

(for reference only)

Adaptive behaviour :

behaviour that helps the individual interact more effectively with his environment

Allied health :

have some connection with or relation to the science or practice of medicine

Autism :

a developmental disorder mainly characterized by subjective, self-centred trends of thought or behaviour

Cardiology :

the study of the heart and its function

Cardiovascular disease :

disease of the heart and the blood vessels

Cerebral palsy :

a persistent qualitative motor disorder appearing before the age of three years, due to a non-progressive damage to the brain; characterized by muscle spasm, contractures and inability to co-ordinate muscle activities

Community nursing service :

the provision of nursing services to people in their own environment, usually the home

Community psychiatry :

a discipline of psychiatry which emphasizes on psychiatric care and rehabilitation in community settings

Conduct disorder :

one group of mental illness; patients typically have conduct problems, e.g. delinquency

Congenital hypothyroidism :

deficiency of thyroid activity which is already present at birth

Depression :

a psychiatric syndrome which consists of dejected mood and many other symptoms

Diabetes mellitus :

a kind of metabolic disorder caused by insulin deficiency which results in elevated blood sugar level; common symptoms are polyuria and malaise; patients with long-standing history of diabetes mellitus may develop disabling complications affecting various organs/systems e.g. kidneys, eyes, neurological system etc.

Diphtheria :

an acute infectious disease affecting primarily the membranes of the nose, throat or larynx and characterized by the formation of a gray white membrane-like patch; very rare in Hong Kong now

Domiciliary occupational therapy service :

the provision of occupational therapy service outside hospital and clinic settings, e.g. in patients' home

Embryogenesis :

the process of embryo formation

Ever-married females :

females who were either married, widowed or divorced/separated

G6PD deficiency :

a hereditary disease caused by a deficiency of an enzyme of red blood cells making the latter liable to be damaged by certain substances, e.g. some drugs and food

Guardian ad litem :

a person appointed to defend on behalf of a mentally handicapped person in legal proceedings lodged against him

Hepatitis B :

a kind of virus commonly infecting the liver; main features of acute Hepatitis B infection include malaise, loss in appetite,

Hepatitis B carriers are more prone to develop liver cirrhosis and liver cancer from middle age onwards

Hyperkinesis :

abnormally increased motor function or activity

Learning difficulties :

educational retardation as a result of limited abilities or other conditions, requiring remedial support in learning

Locomotor :

of or pertaining to movement or the ability to move from one place to another

Maladjustment :

in psychiatric context, this refers to defective adaptation to environment which is marked by anxiety, depression and irritability

Measles :

a highly contagious viral infection involving primarily the respiratory tract and reticuloendothelial tissues; commonly presented with generalized skin rash, malaise, fever, etc.

Mumps :

a contagious viral infection occurring mainly in children and typically presenting with swellings near both ears (parotid swellings)

Neurological :

pertaining to the nervous system

Neurosurgery :

surgery of the nervous system

Oncology :

the study of tumours

Orthopaedic :

pertaining to the correction of deformities of the bones, joints and muscles

Orthoptist :

an expert in orthoptics which is a technique of eye exercises designed to correct the line of vision

Perceptual motor :

the interaction of the various channels of perception with motor activity

Peripatetic service :

visiting service, normally by a teacher or specialist to provide additional support on a part-time basis for children with special educational needs in ordinary schools

Pertussis :

whooping cough (an infectious disease characterized by peculiar paroxysms of cough, ending in a prolonged crowing or whooping respiration)

Pneumoconiosis :

permanent deposition of substantial amount of particles, usually of environmental or occupational origin, e.g. asbestos, silicon dioxide, etc. in the lungs; may result in various degrees of loss in lung function

Poliomyelitis :

an acute viral illness, occurring sporadically and in epidemics; in its severe form will result in atrophy of muscles and subsequent contraction and permanent deformity

Prosthetist and orthotist :

an expert in prosthetics (the field of knowledge relating to artificial substitutes for missing body parts used for functional and/or cosmetic reasons) and orthotics (the field of knowledge relating to apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body)

Rubella :

a mild viral infection; may result in multiple congenital anomalies if the fetus is infected; also known as German measles

Schizophrenia :

a group of psychotic illnesses characterized by misinterpretation and retreat from reality and commonly bizarre behaviour

Sensori-motor :

both sensory (pertaining to sensation) and motor (pertaining to motion or movement)

Tetanus :

an infectious disease characterized by generalized muscle spasm

Traumatology :

the branch of surgery which deals with wounds and disability from injuries

Visceral disability :

a disability resulting from disease or its treatment, its nature not being limited to locomotor functions, and the disability constitutes a disadvantage or restriction in one or more aspects of daily living activities, including work.

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