

# Historical responses to disability in new zealand social work essay



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## **Abstract**

The norms and new findings in the past had led to a social movement leading to policies and laws which promoted discrimination and negative attitudes of society towards the people with disability. These created terminologies that defined, labelled and classified them, which had shaped the attitudes of the society, and created stereotypes for each label. These had resulted in barriers for them to accessing health services and society. In time began the improvement in science, redemption of education, and changes in social norms. The human justice system and righteousness started to prevail from end of World War II and towards the 21st century. Services were developed and funds were raised to help those who needed. Strategies were implemented to compensate the social injustice of the past, to reduce the inequalities and inequities to make it a society that highly values lives and continually enhances full participation for the whole population of New Zealand.

## **2. 1 & 2. 3**

### **Policies and Strategies and Services**

In 1840s Eugenics social movement prevailed in New Zealand and most part of the world. This was because of the rise of interests in the science of Darwinian genetics and hereditary in addition to the decreasing birth rate and white population's fear of losing racial supremacy and purity. Hence in 19th century, disabled people were not welcome in New Zealand and Immigration Acts, such as The Imbecile Passengers' Act 1882 and The Immigration Restriction Act 1899, were implemented to minimise the entry

of the people with disability, and " the undesirables" (other races than white) into the country. The costs for supporting the people with disability were expected to be met by the families with some help from charitable organisations. From 1880, the School for the Deaf was opened near Christchurch and in 1901 the School Attendance Act was passed to ensure parents sent their deaf and blind children to school, which effectively sent them away to residential schools. This was a form of discrimination and segregation in the form of institutionalisation. People with disabilities were institutionalised along with mental illness patients; men and women also were also segregated to prevent their reproduction of " the afflicted." In the early 20th century, The Mental Defectives Act 1911 was passed to differentiated people who are imbeciles, mentally ill, epileptics, idiots and the feeble minded. The Education Act 1914 forced to have the people with disability children reported for continuous monitoring and regulation for institutionalisation, which shows the cruelty of the past society in New Zealand. The Committee of Inquiry into Mental Defectives and Sexual Offenders 1924 connected intellectual impairment with potential sexual offending, which meant the build-up of frowning faces and stares upon the people with disability. More classification and labelling occurred in the early 20th century due to increasing medical knowledge, which started the social movement from eugenics to medical model which resulted in public notion of curing the disability. In 1920's and onwards, more funding and charity were developed. For example, 1938 Social Welfare Act was developed to provide some disability support and pensions. After World War II, the eugenics movement was largely abandoned and were replaced by medical model. The Disabled Servicemen's League was established for medical rehabilitation in <https://assignbuster.com/historical-responses-to-disability-in-new-zealand-social-work-essay/>

1954, and the Disabled Person's Employment Promotion Act 1960 promoted sheltered employment opportunities for disabled people and encouraged the participation of disabled people in work. The establishment of the Accident Compensation Commission (ACC) from 1974 Accident Compensation Act made a huge impact in New Zealand. This brought in the no fault compensation scheme for those disabled due to accident. The 1975 Disabled Persons Community Welfare (DPCW) Act provided a statutory right to support and some of the benefits of ACC to those whose impairments were not caused by accident. These included respite care, home help, attendant care, aids and appliances and vocational training.

**In the late 20th Century, during 1980's the movement of deinstitutionalisation prevailed in New Zealand. In 1990's, the government aimed at reducing the limitation and social barriers experience by disabled people. The Code of Rights 1996 granted a number of rights to all consumers of health and disability services in New Zealand, and places corresponding obligations on providers of those services. These changes have led to a paradigm shift in New Zealand entering 21st Century.**

The New Zealand Disability Strategy 2001 was developed by the government. It provides a clear vision for a society where people with impairments can say that they live in a society that highly values their lives and continually enhances their full participation. As of the establishment of this act, the New Zealand society aimed at reducing social and physical barriers that made the disabled people labelled as a sick person needing treatment. The regulation, monitoring, and implementation of this act were facilitated by the Office for Disability Issues in 2002. In 2006, the New <https://assignbuster.com/historical-responses-to-disability-in-new-zealand-social-work-essay/>

Zealand Sign Language became the third official language in New Zealand to remove barriers. However, the social discrimination and inequities, in discrete forms if not open, still remains in today's society.

### **Disability Support Services operational policy (2012-2015) - Operational Policy for the Exceptional Circumstances when a Community Residential Support Service Provider requests the Exit of a Service User.**

**The purpose of this policy is to specify the procedures to be followed by Disability Support Services (DSS) personnel when a Community Residential Support Service Provider seeks to exit a service user (Person) from their residential home and when an impasse has been reached between the service provider and the Ministry of Health. These circumstances are regarded as exceptional and require DSS managers to promptly initiate and manage appropriate processes to fulfil DSS obligations to both the Person and the service provider.**

### **Disability Services, Funding and Access**

The development of services and policies for the disabled people shows the change of social movement from the medical model to the social model. In early 19th century, the families of the people with disabilities were expected to pay for the medical or service bills. Government provided little services for people with disabilities. The lack of a voluntary services and accumulating social need signified that government had to increase provision of services by late 19th century, which happened mostly through subsidising non-profit organisations providing charity and in establishing and funding Hospital Boards, but without specific provision for people with disabilities which was a

barrier for them. From the early 20th century began the government support just for the disabled people. The Education Amendment Act 1907 allowed epileptic children to get compulsory education. This service and other provisions up to the end of the 1960s were based on the medical model of disability. These other service provisions include: The support for income for the disabled people. The Invalids Pension 1936 acknowledged the Government's responsibility to support people who cannot work due to illness or disability. The Social Welfare Act 1938 was developed to provide some disability support and pensions for medical needs, following The Invalids Pension. Psychiatric and psychopaedic institutions were established which were funded by government. The institutions were typically located in isolated rural areas and operated self-sufficiently, away from other residential or commercial activity. The World War I soldiers were entitled to receive medical rehabilitation. Developed through the Disabled Servicemen's League, it was established after the WWII and the services were available to the soldiers after 1954. In the 1950s and 1960s the idea of large institutions was challenged. Day care centres, occupation groups and residential homes were set up by the IHC. It chased a more rights-based approach in seeking appropriate educational facilities for the children. During the 1980s continued the deinstitutionalisation and support from government for community services. The Education Act in 1987 enabled the mainstreaming of children with disabilities into a "normal" school environment, reinforcing the orientation to community support for disabled people. During 1980s and 1990s, there were vocational services developed to help with employment for the disabled people. In 1992 the Government proposed that all services for the disabled people should be united from a number of government

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agencies into one, which was to improve accessibility and efficiency.

Disability Support Services (DSS) administers the Intellectual Disability Act 2003, plans and funds disability support services. Many of the services DSS funds can be accessed through a Needs Assessment and Service Coordination (NASC) service. NASC's job is to help identify the needs of the people with disabilities and to outline available support services. They also allocate support services funded by Ministry and help with accessing other support services. District health boards (DHBs) funds the provision of health services. Disability support services and some health services are funded and purchased nationally by the Ministry of Health. The services described can be also accessed through other organisations like IHC(1949), Idea Services, Health, Disability Commissioner, the Association of the Friends of the Blind (1889), the forerunner of the Royal NZ Foundation of the Blind (1890), and CCS (1935).

## **2. 2 Terminology**

People with disability in the history were defined, labelled and classified by others. They had their human rights infringed and were discriminated by such terminologies. Some of the terminologies people used to refer to the people with disabilities and may include the followings. Cripple: meaning a person with a physical or mobility impairment. Downy: Refers to someone with Down syndrome. Imbecile: persons with an IQ between 25 and 50 Idiot was the formal term for persons with an IQ of 0-25. It is also no longer used. Midget: dwarf. Mongol: people with Down syndrome, which also exerts racism on Mongolian. Moron: persons with an IQ between 50 and 75. Retard: (slow) someone with a learning disability, mental retardation, a significantly

low IQ, or some other learning or developmental disability; Wheelchair-bound: someone who uses a wheelchair Angel: used to show pity and sympathy, which is considered wrong now for acknowledging their disadvantage. These terminologies now have changed into more general terms such as " people with disability" or " people with physical disability." The use of adjective with specific article, such as " the disabled," or " the blind" or " the deaf" has changed into using " a person with" or " impaired." For example, " Hearing impaired," " Visually Impaired," and " A person who are deaf" are used.

## **Attitudes**

After 19th century, a negative stigma towards people with impairments was common. They were deemed to be weaker and less valuable members of society. A moral distinction had emerged between people who deserved support - those impaired by accident or illness - and people born with impairment. However these attitudes changed due to disease epidemics like tuberculosis and polio, and injuries from World War I. This was because " the normal" people became " different." Their impairment had not been caused by a physical or moral weakness inherent in a person's genetics. During 20th century, the medical model governed the notion of the society, saying disability is an inherent problem in individuals, where there was something wrong with the person, but could be cured or at least contained. This was termed " medicalisation of disabled people." This approach focuses on the impairment of disabled people rather than their wellbeing hence disregarded the individual and their ordinary life needs. s of Social Model of Disability, people's beliefs in disability being an individual problem changed into being



society problem. The needs for institutions were changed into needs for community. People started to appreciate the strengths and uniqueness of the people with disability rather than focus on what they cannot do. The society walked a path from isolating and segregating, to pitying and charity, finally arriving at respect and equality. However, the whole country is not changed. There are still a lot of people with different perceptions and attitudes, which create stereotypes and barriers for the people with disabilities.

## **Barriers and Stereotypes**

It seems inevitable that people with impairments may face many lifelong barriers to their full participation in New Zealand society. Attitudes of the society would be the major barrier that operates at all levels of daily life in the general population. Attitudes and ignorance make their presence felt as stigma, prejudice and discrimination. Stigma, prejudice and discrimination affect our behaviours. Sometimes the combination of attitudes and behaviours can seem to create almost insurmountable barriers, for example, whole systems or organisations can become a barrier much in the way that institutionalised racism operates. The most obvious barriers for disabled people include those that are physical like not having ramps for wheelchair access i. e. only stairs; expensive hearing aids, etc. Poor literacy is a problem for many and acts as a communication barrier. For disabled children, the finance would be a barrier to their needs and demands. Because the support and care puts financial pressure on the family and Whanau, the stereotypes for the people with disabilities is that they will be poor, and therefore have difficulties in social settings, because if they were able to afford to eliminate

such difficulties, then they would not be disabled but be impaired. Another stereotype is that disabled people are much less likely to have educational qualifications than non-disabled people. This is because they have not been "allowed" for education in the past, and not well supported throughout. The barriers to their education include not only financial but also classmate's attitudes, non-disability-friendly tutorials, geographical, access into buildings, etc. Disabled people are much less likely to be employed. In terms of attitude, some people believe that employers should not have to provide proper jobs or pay minimum wages to the disabled people. This kind of attitude also works as a barrier. Hence people are likely to assume that people with disability are probably unemployed. On top of that, disabled people are likely to have lower incomes and fewer financial and family resources than the general population. This economic disadvantage is compounded by the financial cost of disability. The earning potential of families with disabled children can be curtailed by their need to provide support for their children or live and work in areas where they can access family or professional support.