

# History of disability in new zealand social work essay



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## JENNIFER GONZALOTASK TWO: ANALYSING THE HISTORICAL RESPONSE TO DISABILITY AND/ OR AGING IN A LOCAL CONTEXT

### **2. 1 HISTORY OF DISABILITY IN NEW ZEALAND**

#### **1840 onwards**

Government policies aimed at containing the number of disabled people living in New Zealand and keeping financial aid to a minimum. Legislation discouraged disabled people from settling in New Zealand. The Imbecile Passengers' Act 1882, for example, required a bond from the person responsible for a ship that discharged any person 'lunatic, idiotic, deaf, dumb, blind or infirm' who might become a charge on public or charitable institutions. The Immigration Restriction Act 1899 included in its list of prohibited immigrants any idiot or insane person, as well as those suffering from contagious diseases. Support for disabled people was expected to be met by their families. Any financial support was usually small and temporary, and was given by charitable organizations, not the taxpayer. Institutions offering support for orphans, unmarried mothers and destitute older people began to be set up from the 1860s. Some disabled people ended up in these places as well. From 1854, institutions were established for people with experience of mental illness. The Lunatics Ordinance 1846 provided for the safe custody and prevention of offences by persons dangerously insane, and for the care and maintenance of persons of unsound mind. These people were initially housed in jails and later in designated institutions. The eugenics movement became popular in the 19th century. Eugenics applied the ideas of biological natural selection to people (also known as 'racial fitness'). It advocated preserving good genetic stock by weeding out weak

traits such as ill health or mental deficiencies. People with less desirable traits were to be prevented from having children – one way was for these people to be removed from society by placing them in purpose built institutions. Towards the end of the 19th century, people with intellectual disabilities began to be admitted to institutions previously reserved for people with mental illness. Men and women were strictly kept apart so they could not have children. The first school for deaf children in New Zealand opened in 1880 (now the Van Asch Deaf Education Centre in Christchurch)

## **1900 onwards**

Social beliefs in racial fitness increased, becoming reflected in the government's social policy on disabled people. This was connected to concerns at the trend of decreasing family size (until the 1930s), and the failure of a large number of conscripted men to meet the minimum health standard for the armed forces in World War I (57 per cent were rejected as unfit for service). Incidents like this fuelled a growing belief that the new country's pioneering spirit had become weak and infected by bad genetics and moral failings. Until 1916, the New Zealand Census identified people who were deaf and dumb, blind, lunatics, idiots, epileptics, paralyzed, crippled and/or deformed. Mechanisms were put in place to identify defective children. Institutional care, especially for mentally deficient people, was emphasized. The Mental Defectives Act 1911 differentiated between persons of unsound mind, persons mentally infirm, idiots, imbeciles, the feeble minded and epileptics. The Committee of Inquiry into Mental Defectives and Sexual Offenders of 1924-1925 expressed concern at ' feeble-minded' children. Action was needed to prevent ' the multiplication of these

degenerates' and infection of ' an inferior strain' in the New Zealand population. The goal was to ' increase the elements of the mental, moral, and physical strength of the nation'. Such activities led to an emphasis on classifying and screening children. Children with ' special needs' were segregated to institutions and services outside the mainstream education and health services. Some positive actions came out of this period - for example, the Plunket organisation, which provided care and support for the health of children and mothers. Growing medical knowledge and technical advances of the time increased the emphasis on medical treatment, rather than social inclusion, of disabled people. In 1924, legislation was passed allowing a pension for blind people. This legislation was well ahead of the social security reforms of the late 1930s, which introduced the invalids benefit for those permanently unable to work and the sickness benefit for those temporarily experiencing ill health. In 1929, Templeton Farm in Christchurch was opened for ' high-grade imbeciles and low-grade feeble-minded cases without psychotic complications', under the administration of the mental health system. The general population became increasingly aware of mental illness and physical impairments as experienced by soldiers returning home after the world wars. There was a need for better services, including psychiatric treatment, physiotherapy and plastic surgery. The rehabilitation of the mentally and physically impaired into society was emphasized. Medical rehabilitation for ex-servicemen began after World War I and developed further through the Disabled Servicemen's League, established after World War II. Services were available to civilians from 1954. Sheltered employment opportunities for disabled people began with the Disabled Persons Employment Promotion Act 1960. Operators of <https://assignbuster.com/history-of-disability-in-new-zealand-social-work-essay/>

sheltered workshops were exempted from applying the same employment conditions required elsewhere. This created a distinction between sheltered employment and employment on the open labor market. The orientation towards large institutions for disabled people began to be challenged during the 1950s and 1960s. IHC in particular, set up day care centers, occupational groups and residential homes. At the same time it pursued a more rights-based approach in seeking appropriate educational facilities for their children. From the 1970s, the government's approach to services for disabled people became more community and rights based. Following the 1972 Royal Commission into Psychopaedic Hospitals, government funds were increasingly channelled into building small residential facilities rather than large institutions. A principle of entitlement was established through the Accident Compensation Act 1972. People whose impairment was caused by injury through accident were now able to receive assistance on an individual entitlement basis. The need for disabled people to have access to a wide range of community-based support was increasingly being recognized. The Disabled Persons Community Welfare Act 1975 gave disabled people, who were not ACC claimants, access to services to help them stay in the community. There was also increasing recognition of the need for disabled people to have opportunities for mainstream employment. The Industrial Relations Act 1973 established the under-rate workers' permit. This enabled a person with impairment to work in the open labor market and receive a wage that matched their productivity. Activities promoting the International Year of the Disabled in 1981, and the associated Telethon, provided a focus for disabled people. Awareness was raised on disability issues that had not happened before. The formation of a pan-disability

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organization, DPA, made up of disabled people speaking and doing things for themselves, was one outcome from this activity. The move away from institutionalized accommodation for disabled people continued during the 1980s (also known as deinstitutionalization). At the same time government support for community-based services increased. This was reinforced by an amendment to the Education Act enabling the mainstreaming of disabled children into a 'normal' school environment. Through the 1990s more concerns were expressed about the limitations of the government provision for reducing social barriers experienced by disabled people. Government funding for support services for disabled people moved from the welfare agency (Department of Social Welfare) to health agencies (Regional Health Authorities)

## **2000 onwards**

In 2000/2001, the government developed the New Zealand Disability Strategy. The Strategy was based on the social model of disability, which makes a distinction between impairments (which people have) and disability (which lies in their experience of barriers to participation in society). In 2002 the Office for Disability Issues was set up. Its purpose is to provide a focus on disability across government and to lead the implementation and monitoring of the New Zealand Disability Strategy. In 2004, the New Zealand Sign Language Bill was introduced into Parliament. This Bill proposed recognizing New Zealand Sign Language as the third, official language in New Zealand. New Zealand has taken a leading role at the United Nations in the development of a convention making explicit the rights of disabled people. A review of long-term disability support services was begun in 2004. Led by

the Office for Disability Issues and working across government agencies, the review aims to improve the fragmentation and incoherence of services as experienced by disabled people.

## **DEFINE ATTITUDES**

Coming out of the 18th and 19th century, there was a negative stigma attached to people with impairments. They were thought 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. Attitudes changed with the impact of disease epidemics (such as tuberculosis and polio) and injuries from World War I. Suddenly, there were people with impairment who were otherwise young, fit and healthy. Their impairment had not been caused by a physical or moral weakness inherent in a person's genetic makeup. There are established organizations that focused on specific impairments and support for families so awareness of disabled people and the number of services available increased - such as, the Association of the Friends of the Blind in 1889, the forerunner of the Royal NZ Foundation of the Blind in 1890, CCS in 1935 and IHC in 1949. As the year is moving forward the acceptance of the people and government among disabled people is getting better. They provided lots of opportunities and support to the disabled people. There are many laws that are implemented for them to protect their rights and to live as normal as others. Nowadays there are lots of organizations that established, privately and government which provided care and support to the disabled people. There is public access that is provided for the disabled people to make their lives easier. There were also rehabilitation for them and counseling to give

support as well. There is a wider acceptance of the public for the disabled people.

## **DISTINGUISH STEREOTYPES AND EXPLAIN BARRIERS**

Before we look at how we can interact positively with people with impairments, we need to be aware of common stereotypes and see how damaging they can be. Physiological People often tend to focus on the impairment of a person or the limitations caused by it as opposed to the varied qualities and attributes the person may have. The reference to a person's impairment is not necessary unless impairment is the topic of the discussion. Emotional and moral It is also easy to imbue people with emotional or moral qualities - whether positive or negative - based purely on an impairment they may have. Be careful not to imply that people with impairments are to be feared, pitied or ignored, or, on the other hand, that they are more courageous, special or heroic than others. A person with impairment should be allowed the same range of emotions and responses, good and bad, as any other person. Comparative The use of the word "normal" to refer to people without impairment is restrictive and offensive, and should be avoided.

### **Stereotypes to avoid**

- People with impairments are objects of pity and charity.
- People with impairments lead boring, uneventful lives.
- People with impairments are asexual.
- People with impairments do not have the same emotional needs or desires as other people.
- People with impairments are shameful or embarrassing.

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## **BARRIERS**

Attitudes have been identified, through consultation, as the major barrier that operates at all levels of daily life in the general population of disabled people. Attitudes and ignorance make their presence felt as stigma, prejudice and discrimination. In the year to June 1999, disability discrimination was the largest category of complaints to the Human Rights Commission. Stigma, prejudice and discrimination affect our behaviors. Sometimes the combination of attitudes and behaviors can seem to create almost insurmountable barriers, for example, whole systems or organizations can become a barrier much in the way that institutionalized racism operates. For disabled children, it is hard to get the best start to their life ahead. Children's needs can put big demands, including financial pressure, on their families and whānau. Disabled people are much less likely to have educational qualifications than non-disabled people. Disabled people are much less likely to be employed. For instance, the unemployment rate for people with ongoing mental illness is very high. Half of recent complaints to the Human Rights Commission in regard to disability related to employment. Older people experience difficulties when their problems are seen as an inevitable part of ageing. Faced with this attitude, they may miss the opportunity to remain able and independent through rehabilitation, correction of health problems or provision of support services.

## **2. 3 SERVICE PROVISION AND ACCESS**

During early years services and access framework are not yet establish for the people having disability. There are locks of support from people and

government. But as the year increase there are services and access that are established now working to give support and protect people with disability.

## **Ministry of Health – Health and Disability National Service, Disability Services (DS)**

Disability Services, part of the Health and Disability National Services Directorate, is responsible for the planning and funding of disability support services, administers the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and provides policy advice to the Minister of Health. The focus of the Ministry of Health's Disability Services is based on The New Zealand Disability Strategy: Making a World of Difference - Whakanui Oranga. This document aims to ensure disabled people live in a society that highly values their lives, works to improve their participation in their communities and ensures their needs are considered before decisions that affect them are made.

## **Disability Support Services**

Disability Services is responsible for planning, funding and overseeing the provision of a range of disability support services. This includes prioritization of services, issues of quality in service provision, Maori and Pacific peoples service development, managing providers of service contracts, service focused research and responding to issues regarding the need for and provision of disability support services. The provision of disability support services is based on the philosophy of the New Zealand Disability Strategy (NZDS).

## **Human Rights Commission**

The Human Rights Commission supports basic human rights as a framework for all the people of New Zealand – seeking to promote a fair and just society. The core vision of the Commission is that people understand their rights, accept their responsibilities and respect that others have rights as well. The Commission does this through education about human rights, producing information and resources, making enquiries into and reporting on human rights issues and resolving disputes that are related to discrimination.