

National situation is  
being discussed  
social work essay



**ASSIGN  
BUSTER**

During the 20th century, disability was thought to be a problem among people. This is common sense that the 'medical model', where disability was seen as being something wrong with people, which might can be cured or contained. Solutions to the problem of disability were that took the form of government and wider society helping to accommodate the problems to different people. This was often by segregating people with the problem and providing services to meet their special needs. As a result, the human needs of a lot of individuals were unmet.

## **Identify a national situation is being discussed**

### **1840 onwards**

#### **Strategies**

Institutions offering support for orphans, unmarried mothers and poor elderly people began to be set up around the 1860s. From 1855, institutions were established for people with experience of mental disease. The Lunatics Ordinance provided for the safe custody and prevention of offence by persons dangerously insane, and for the care and maintenance of persons who have an unsound mind. These kind of people were initially housed in jails and later in designated institutions. The eugenics movement became very popular in the 19th century. Eugenics applied the ideas of biological natural selection to people. It advocated preserving good genetic stock by weeding out weak traits such as ill health or mental deficiencies. People with less desirable and health 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. Until 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 separated so they could not have children.

## **Policies**

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.

## **Funding**

Support for these disabled people was expected to be met by their own families. Any financial support was normally small and temporary, and was given by charitable organizations, not the taxpayer.

## **Access frameworks**

People could not receive any support from government. They need to pay for their medication by themselves and family members.

## **Service provision**

Institutions offering support for orphans, unmarried mothers and poor older people began to be set up from the 1860s. Some disabled people ended up in these places as well.

## **1900 onwards**

### **Strategies**

Until 1916, the New Zealand Census identified people who were deaf and dumb, blind, lunatics, epileptics, paralyzed, crippled and deformed. The general population became increasingly aware of mental illness and physical impairments as experienced by soldiers returning home after the world wars. They need a better service, including psychiatric treatment, physiotherapy and plastic surgery. The rehabilitation of the mentally and physically impaired into society was emphasized. In the 1970s, the government's approach to services for disabled people became more community and rights based. The move away from institutionalized accommodation for disabled people continued during the 1980s at the same time government support for community-based services increased.

### **Policies**

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, and the failure of a large number of conscripted men to meet the minimum health standard for the armed forces in World War I. 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. 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.

## **Funding**

Following the 1972 Royal Commission into Psychopathist Hospitals, government funds were increasingly channeled to small residential facilities rather than large institutions. Government funding for support services for disabled people moved from the Department of Social Welfare to Regional Health Authorities.

## **Service provision**

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'. Sheltered employment opportunities for disabled people began with the Disabled Persons Employment Promotion Act 1960. Operators of sheltered workshops were exempted from applying the same employment conditions required elsewhere. This created a distinction between sheltered employment and employment on the open labour market. The Industrial Relations Act 1973 established the under-rate workers' permit. This enabled a person with a impairment to work in the open labour market and receive a wage that matched their productivity. Through the 1990s more concerns were expressed about the limitations of the government provision for reducing social barriers experienced by disabled people.

## **Access frameworks**

Growing medical knowledge and technical advances of the time increased the emphasis on medical treatment, rather than social inclusion, of disabled people. 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.

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. During the 1950s and 1960s, IHC in particular, set up day care centres, occupational groups and residential homes. At the same time it pursued a more rights-based approach in seeking appropriate educational facilities for their children. 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.

## **Define terminology**

The word 'disabled' is a description not a group of people. Use 'disabled people' not 'the disabled' as the collective term. People do not define a disabled person by their impairment. It causes offence to be given a medical label. For example, avoid using " mental patient, insane, mad", but use " person with a mental health condition" instead. Also " wheelchair user" is more preferable than " confined to a wheelchair, wheelchair-bound".

## **Identify attitudes**

Attitudes to disability in New Zealand have changed radically over 100 years. These shifts show changing attitudes all around other countries all over the world, in a quite similar way to other social policy changes.

## **Distinguish stereotypes and explain barriers**

There are two important models are the medical model and the social model. Nowadays there is still having argument between them. The topic of medical model is individual. The medical model defines disability in opposition to the normal body and brain, as deviating from that model of normalcy, and any problems that arise in your life are seen as arising from your deviation. Thus, these problems are to be solved by addressing that deviation — by bringing your body and brain closer to the normal model. The topic of social model is society. The social model does not seek to define disability: instead, it proposes that the problem is that society is built such that many people are prohibited from full participation in society because of their differences. Under the social model, the problem is not that difference, the problem is that society doesn't accommodate that difference. " The problem is not the person" is a common refrain from champions of the social model. The cause of exclusion is not the disability but how the rest of society treats disability. Therefore, what needs to be addressed to eliminate this exclusion is not the individual's condition. Society should be set up in a way to these person faces trouble when attempting to exercise right to participation equal to that of a person living with disability. Not the person. It's about the society.