

## DISABILITY IN NEW ZEALAND: AN HISTORICAL SURVEY

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### Abstract

*This article provides an historical survey of perceptions about and provision for disability in New Zealand since the colonial period. The past shows us that what is defined as 'disabling' is subject to change, and that responses which one generation regards as progressive and enlightened can quickly be superceded by new orthodoxies.*

*In the nineteenth century disabled persons were regarded as one variant among 'the poor' and were given minimal financial assistance. By the end of the century some selected groups of young disabled persons had been recruited into institutions which we would now see as attempting 'habilitation'. Rehabilitation emerged out of the First World War, when there was a sense of having to recompense injured soldiers for their sacrifice. The emphasis for the next fifty years or so was on restoring physical functioning, and a medical approach dominated rehabilitation. In the late twentieth century multidisciplinary approaches to rehabilitation have combined with a vigorous consumer rights movement and with notions of community care to transform disability services.*

Over the last fifteen years there has been unprecedented change in disability policies in New Zealand, much of it a conscious reaction against past approaches. To an historian of social policy writing in the 1990s it is instructive how rapidly and how completely one generation's orthodoxies become superceded, denounced as unenlightened or even reprehensible by its successors. An awareness of the past underlines the fragility of today's certainties: there can be no assurance that analyses and solutions proposed in our own times (however well-intentioned and seemingly progressive) will not similarly be rejected in the future.

The aim of this article is to provide an historical survey of responses to, and perceptions of disability in New Zealand since the colonial period. Woven throughout the chronological overview are a number of general themes influencing voluntary and statutory provision for disability since the 1840s. The first is linked to expectations of health, well-being and mobility in the general population. In the past many suffered from chronic and debilitating disorders which now would be quite easily treated. Conditions which today might be defined as 'disabling' were likely to be seen as simply one of the crosses that people had to bear in a harsh existence; a matter, perhaps, for Christian fortitude. When exhaustion, suffering, pain and low life expectancy were so much part of ordinary life, disability was less distinguishable than it has since become. Today expectations of well-being are undoubtedly higher. Ideas of 'normality' centre on media-generated images of perpetual youthfulness, fitness and constantly high levels of energy. By implication, anything else is likely to be portrayed as a lesser state of existence.

A second theme is the changing state of medical knowledge and technology. This can allow the diagnosis and treatment of conditions before they become disabling, or it may improve the survival chances of those who would formally have died from a particular condition, so that they now live, but with a level of impairment. It can influence whether patients are seen as worthy of investment or written off as hopeless, increasing as well as decreasing the stigma attached to disabling conditions. The discovery of the tuberculosis bacillus in 1882 led to a new medical confidence that the disease was curable, but greater public awareness of its infectiousness caused many sufferers of the 'white plague' to become social outcasts in later years (Bryder, 1991:111). Tuberculosis also provides examples of changing fashions in treatment, with tuberculin therapy appearing in late nineteenth century and later being discredited, sanatorium treatment dominating the early twentieth century, and thoracic surgery coming into vogue during the interwar years. The medicalisation of disability provides many examples of therapies which later fell from favour - the medical story is certainly not one of unimpeded progress.

Third, demographic changes also underpin our story. Nineteenth century New Zealand was demographically a young population, characterised, at least until the 1880s, by young adults. Until the end of the century men predominated. The later twentieth century has an

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increasing proportion of elderly, who are more likely to experience degenerative conditions associated with old age. The needs of an elderly, female-dominated group may be very different from those of young male accident victims, for example.

A fourth factor to consider is the way in which sudden increases in particular disabilities have altered public sensibilities. War was an important catalyst here, as large numbers of disabled servicemen were discharged into the community. So too were outbreaks of epidemics, most notably the polio epidemics of the 1920s, 1930s and 1940s. Events which nudged young, previously fit individuals into the ranks of the disabled had the greatest impact on public consciousness.

The emergence of organised advocate groups provides a fifth historical theme in the survey. These have proliferated in recent years as disabled persons themselves began to organise and push for a consumer voice in decision making. In the past disability organisations were dominated by the charitably-inclined and, in the twentieth century, medical personnel were also prominent. Historically important were the Institute for the Blind (1890), the Crippled Children's Society (1935) and the Intellectually Handicapped Children's Parents' Society (as the IHC was first called in 1949).

Sixth, we need to be aware of overseas influences, for New Zealand's often-cited reputation as a 'social laboratory' was not especially apparent in the area of disability. Many of New Zealand's disability organisations were based on overseas models, and medical and rehabilitation personnel frequently travelled overseas to observe techniques elsewhere. As in most areas of social policy, there has been debate over the relevance of overseas initiatives to New Zealand conditions.

Finally, any historical assessment cannot ignore changes in the language used to describe disability, for these provide important clues to the mind-set of our forbears. Terms accepted by one generation have become quaint or offensive to another; categories have become more specialised; and lay terms have sometimes given way to the medical or technical. In the 1980s and 1990s the discourse surrounding disability reached unprecedented levels of

sensitivity. But past terminologies arose out of particular sets of historical circumstances, which it is more helpful to try to understand, than to condemn from the assuredness of the late-twentieth century canon.

### **Disability in Nineteenth Century New Zealand**

The settler view of New Zealand was of an ideal society characterised by pioneering vigour. Successive emigration handbooks emphasised the gains to be made by those able to work hard and long. Men were supposed to be rugged and manly, and women sturdy helpmeets and breeders of an expanding Pakeha population.

For some, reality was very different. Colonial life was not without its dangers, and infectious disease was more important as a cause of disability than is the case today. Whooping cough, measles, diphtheria, poliomyelitis and scarlet fever were among the diseases which caused death or disabling side-effects (Maclean 1964). Although rates of tuberculosis were lower than in England, Wales and most Australian states, it was the major disease causing death among Pakeha settlers (*Official Year Book* 1893:86; Dow 1995:53), an insidious and often slow killer. Many would have known an extended family member who had died from the disease or who was known to have 'weak lungs'.

Accident rates were also very high. We think of our own era as one where car accidents are a major source of death and injury, but life was considerably more dangerous in the past. The death rate from accident and violence in 1991 was 52 per 100,000 population; in 1891 it was 79 per 100,000 population (*Official Year Book* 1893:89; 1994:189). Of course, in the past accident was more likely than now to result in death from shock and blood poisoning, rather than survival with functional impairment, but either way the loss of a breadwinner's earnings often meant destitution for families. In the nineteenth century tree-felling, road blasting and other activities common in a pioneering situation caused casualties. Farmers were involved in accidents with stock, while industrial work on unregulated factory sites took its toll. Photographs of work places illustrate very clearly their dangers: freezing works and abattoirs where butchers worked on slippery floors awash with blood and intestines;

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engineering workshops with unprotected machinery and shafts and belts draped untidily throughout (Olssen 1995:126-7); Eldred-Grigg 1990:11-12). Males were more vulnerable to accident than females, but homes also had their dangers for women and children. Even without dramatic injury, a lifetime of hard physical labour left a legacy of rheumatics, bad backs and incapacitated limbs. As an initially young settler population aged in the 1880s and 1890s, there was an increasing number of elderly men, many of them unmarried and without family supports, who needed care. 'He is old and gone in the legs' was a familiar refrain in charity records (Tennant 1989:147). Many of these elderly men also suffered from ill health linked with alcoholic binges: drink caused more than its fair share of impairment, physical and psychological.

Nineteenth century provision for disability was minimal. Contemporaries perceived the basic problem as a financial one which might ultimately make disabled persons dependent upon public welfare. One of the first pieces of legislation specific to disability was intended to discourage certain groups from landing in New Zealand. The 1882 Imbecile Passengers' Act required a bond from the person responsible for a ship which discharged any person 'lunatic, idiotic, deaf, dumb, blind or infirm' who might become a charge on public or charitable institutions. The 1899 Immigration Restriction Act, mainly aimed at excluding Chinese, also included among prohibited immigrants 'any idiot or insane person', as well as those suffering from contagious diseases (*Statutes of New Zealand*, 1882, 1899). It is likely, however, that neither measure was rigorously enforced.

From a government perspective the disabled were only one group among the poor, who were supposed to be supported, in the first instance, by their families. The Destitute Persons' Ordinance of 1846 and the Destitute Persons' Act of 1877 existed to compel this support if it were not given voluntarily. Where family support was absent or inadequate, a system of public relief, akin to the English Poor Law and known as 'charitable aid', was available on minimal and rigorous terms (Tennant 1989). Voluntary welfare was provided, mostly on a short-term basis, by local benevolent societies, though only to patently 'deserving' cases. Community support was sometimes apparent in the raising of subscriptions to assist a disabled person's family, or to provide physical aids, but these were generally one-off measures for accident victims. In 1886, for example, the *Manawatu*

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*Standard* reported on a concert to be given to help send a blind man, Charles Wilson, to England 'in hopes that under the skilful treatment he will receive in an eye hospital, he may recover his eye-sight, or, failing that, be admitted to some institution for the blind, to enable him to learn a trade'. This particular effort was not entirely altruistic. It smacks of a self-interested attempt to move a local embarrassment from the district. A few months earlier Wilson had been discharged from hospital and soon after arrested for vagrancy as he had no visible means of support (*Manawatu Standard*, 24 Nov. 1885; 21 April 1886). At the time, there was simply nowhere else for him to go.

A minority of workers were covered by friendly societies or lodges which operated on an insurance principle, but their numbers and the cover provided were limited. In 1901 only 15 per cent of adult men of eligible age belonged to a friendly society, most of them craftsmen or wage-earners in regular employment. A small lodge could be ruined by the prolonged incapacity of a single member and withdrawal rates were always high (Shepherd 1976:5, 20, 44).

State-sponsored measures were more apparent by the turn of the century, but also had their limitations. The 1882 Employers' Liability Act and the 1900 Workers' Compensation for Accident Act provided some recompense for work-related injuries, but in restricted circumstances. The 1898 Old-age Pension Act was no doubt a boon to those elderly disabled who qualified under its rigorous moral, means and asset-testing and residency requirements. However, in the 1900s strict administration ensured that these individuals were a small minority of those aged 65 and over (Tennant 1989:148). Overall, it is clear that the financial support of the disabled came down largely to the family, to charitable aid, and to whatever amounts they could earn through intermittent employment or, as a last resort, busking and begging - at the risk of a vagrancy charge.

Institutional care for disability was equally limited. From the 1860s a number of 'benevolent institutions' were opened to provide care for orphans, unmarried mothers and the destitute elderly. Their number increased as the population aged over the later nineteenth century. While most of those within would today be classified as the 'frail elderly' (and most, frail or not, were expected to do some kind of work for their support, be it tending the vegetable garden or cleaning the institution), a small number of younger, disabled persons inevitably

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crept in. In 1887, for example, the Napier Refuge included in its list of inmates

Charles A., age, 36; nationality, Swedish; faith, Protestant; in the colony four months, arriving by the ship Canterbury; a sailor by profession ... is suffering from a contraction in one of his legs. Previous to his admission was an inmate of the Napier hospital. On his admission to the Refuge this man was totally destitute, and being a cripple is unable to earn a living outside the Refuge.

William B., age, 58; nationality, English; faith, Protestant. An old soldier; in the colony 38 years; formerly served in the 68th Regiment. Met with an accident whereby he lost one of his legs, and can only get about on crutches. Was admitted to the Refuge on the 1st of November 1884, and is employed as librarian and gate-keeper

(Neale 1887:1,6).

Also among the younger inmates (the term was apposite) were men described as 'partially demented', so 'addicted to drink' that they were filthy and absolutely helpless, and one 'recovering from fits of despondency' - the Napier Refuge also provided shelter for psychiatric cases.

One localised but important development in institutional care resulted from the efforts of Mother Mary Joseph Aubert, founder of the Sisters of Compassion. Aubert's activity stands out because of her strong personal identification with those termed 'incurables'. She had herself been badly injured in childhood, and had a disabled brother who died young. Aubert was later to speak out against eugenics, stating that 'If these principles were in force when I was a child, I would not have been allowed to live'. From 1899 she and her sisters began to receive chronically and terminally ill adults and then disabled children into St Joseph's Home for Incurables in Buckle Street, Wellington. In 1907 the Home of Compassion was opened in Island Bay, also catering for a wide variety of those whom disability - spina bifida, Down's syndrome, hydrocephalis, cerebral palsy, blindness and other

such conditions - had set apart from society's norm (Munro 1996: forthcoming).

However, institutional provision was most marked in the area of mental illness. This was perceived as a problem of social order in early colonial New Zealand, as indicated by the Lunatics Ordinance of 1846 which provided for the 'safe custody and the prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind' (Brunton 1987:158). The mentally ill were first placed in gaols, then, as a temporary measure, in special hospital annexes. The first lunatic asylum independent of hospitals or gaols was established at Karori in 1854, with other asylums following in Otago and Canterbury in 1863, Nelson in 1864, Auckland in 1867 and Westland in 1872. Psychiatric care from the start was a state concern, reflecting its lack of attraction for voluntary charity: until recent times the only private facility was Ashburn Hall, opened near Dunedin in 1882 (Ernst 1991:62).

'Causes of insanity' identified in asylum reports included love, sunstroke, solitude, disappointment, religious anxiety and self abuse. Childbirth and uterine disorders were particularly important on the female side, and drink, for men. It might have been the large number of alcoholics admitted (and drying out) which allowed a reasonably high 'cure' rate in the early years of the asylums' existence. By the end of the century increasing numbers of psychogeriatric and intellectually handicapped cases featured in admissions. This, coupled with the growing predominance of hereditarian beliefs, resulted in a more pessimistic scenario. The asylums were increasingly stigmatised by the association with incurability (Brunton 1987:164-5).

Generally speaking, then, nineteenth century responses to disability focused on containment or on very minimal financial aid of a safety net kind. In two areas, however, policies which might later be labelled 'habilitation' were initiated. In 1880 a school for deaf children was established by the Education Department at Sumner. At this time some blind children were being sent, with government funding, to Melbourne for their education. In 1889 the Association of the Friends of the Blind was formed in Auckland (Newbold 1995:19). Dominated by charitably-inclined sighted people, it appears to have been New Zealand's first example of a disability interest group. The Jubilee



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Institute for the Blind, which was opened in Auckland in 1890, eventually provided for the training of adults in work skills as well as the education of children (Catran & Hansen:1992). From this time on particular groups of the disabled began to be singled out as 'worthy' of state and voluntary investment, some being treated more generously than others.

Historical sources provide few personal insights into the colonial experience of disability. Charity records suggest that much depended on the degree of family support and, of course, the nature and degree of disability in a society where manual labour was still very important. Writing about her childhood in the 1900s, Sylvia Ashton-Warner has described the tensions within a family where the father was disabled by rheumatoid arthritis and the mother, was a teacher and the main breadwinner. In a peripatetic existence the family periodically faced the debt collector and became dependent on charitable aid, despite Margaret Warner's teaching qualifications. At these times 'Puppa' would often end up in the nearest old men's home, his crutches removed so that he could not abscond. When well and at home Francis Warner would feed and care for the younger children; when ill he would lie in bed, shouting in pain: 'O God, why must I endure this infirmity? O God, release me from this hell'. The Warner family was, in Sylvia's words, 'one large highly visible irregularity wrecking the social landscape' in the rural areas where 'Mumma' taught:

For one thing, our father was known to be cripple, a rank disgrace since nice fathers could not only walk but went out to work on their legs without crutches. Next, our mother was a teacher who went out to work instead, which was ranker still since nice mothers were to be found in their kitchens making cakes all day. Finally, we were not only poor but were seen to be poor, which was unacceptable ....

(Ashton-Warner 1979: 26)

For the Warners disability resulted in an inversion of conventional gender roles and a poverty out of keeping with their supposedly well-born origins (Hood 1988:14).

## The Early Twentieth Century.

Racial fitness was a dominant motif in social policy during the early twentieth century, and it had profound implications for disability. Interacting with it were the experiences of war and epidemic. The First World War, the 1918 influenza epidemic and recurrent outbreaks of poliomyelitis influenced attitudes to physical disability, providing examples of young, visibly disabled persons able to sway public sympathy. Against this was an increasingly negative attitude towards mental deficiency. The state took a more proactive stance than before, putting mechanisms in place to identify 'defect' among the young. Legislative provision increased and policy makers' opinions moved in favour of institutional care.

These years were also characterised by an expansion of white collar work and an emphasis on education and training rather than manual strength as qualifications for work. This may have provided more opportunities for young people with physical disabilities while creating difficulties for others, and most especially for those with intellectual disabilities. Within industry employers were seeking higher levels of efficiency from their workers. Workers' autonomy declined as the pace of work was decided by their bosses and, increasingly, measured against the clock. Practices such as workplace medical inspections began to weed out the elderly and infirm, who might once have been shielded by team-mates working on a contract basis (Olssen 1988:23;61).

Identification of the 'defective' and inefficient was even more general than this. From its inception, the *Census of New Zealand* had asked a question about Pakeha infirmity. By the 1900s this required householders to identify those 'unable to follow their usual occupations by reason of sickness and accident', but the *Census* also sought to enumerate those who were, in the stark language of the day, 'deaf and dumb, blind, lunatics, idiots, epileptics, paralysed, and crippled and deformed'. In 1916, the last year the question was asked, some of the categories had been collapsed, but particular attention was paid to those classified as blind and as deaf and dumb: in their case a break-down of occupations was also given. For the record, in that year 206 persons were identified as 'deaf and dumb'; 566 as 'blind'; 3741 as 'lunatics'; and 777 as 'feeble minded' (*Census* 1916). The question is more significant for the fact that it was asked,

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and for the terminology used, than for giving any accurate tally of disability. It was eventually dropped because (not surprisingly) there was 'a species of natural reluctance on the part of individuals to record such infirmities' (*Census 1921:12*).

The enumeration exercise was not an attempt to gauge need as a precursor of service provision: rather, it linked in with concerns about the quality of New Zealand's population. There had long been attempts to discern whether the medically and psychiatrically ill were home-grown or imports from overseas. However, from the late nineteenth century, concerns about racial quality and national fitness reached unprecedented heights. A decline in average family size was often presented as proof that the 'better sections of society' were failing to reproduce themselves, leaving the breeding of future generations to physical, social and moral inferiors. The revelations of Britain's 1904 Interdepartmental Committee on Physical Deterioration fuelled a more general concern that the Anglo-Saxon race was in decline (Tennant 1994:20-23). Although there had been considerable mythologising about the physical superiority of New Zealand troops in the Boer War, the larger scale of recruitment for the First World War dealt a severe blow to such beliefs. Only 34 per cent of conscripts to the armed forces between 1916 and 1918 were found to be completely fit, and 57 per cent were classified as 'C2' or 'D', and rejected for overseas service or for special training (Callon 1980:27;62).

Over the first three decades of the century a number of Royal Commissions into health and social issues expressed concern that New Zealanders were losing their pioneering vigour. The most overtly eugenist of these was the 1924-25 Committee of Inquiry into Mental Defectives and Sexual Offenders, and, as well as Plunket's Sir Truby King, it included among its number such prominent public servants as Ada Paterson, Director of School Hygiene, Frederic Truby King, founder of the Plunket Society, John Beck, soon to be first head of the Division of Child Welfare in the Education Department and the Under Secretary for Justice, C.E. Matthews. The coupling of mental deficiency with sexual offending indicates the paranoia that surrounded intellectual disability at the time. As the Committee concluded:

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In the inquiry into the problem of the feeble-minded the most saddening experience of the Committee was the sight of so many children deprived of their full share of the light of reason, often maimed and stunted in body as well as in intellect. The sight was made sadder still by the reflection that unless prompt and effective action is taken the multiplication of these degenerates will increase and the race will steadily deteriorate.

...The pioneers were for the most part an ideal stock for a new off-shoot of the Mother-country. The Great War revealed that from their loins have sprung some of the finest men the world has ever seen, not only in physical strength, but in character and spirit. It also revealed that an inferior strain had crept in and that New Zealand was already getting its share of weaklings. Surely our aim should be to prevent, as far as possible, the multiplication of the latter type, and to increase the elements of the mental, moral, and physical strength of the nation.

The language of eugenics linked disability, intellectual, and to some extent, physical, with degeneracy, inferiority and low morality. By extension, it required the grading of disorders, the identification of those who could be brought up to requisite racial standard, and the segregation of those who could not. New legislation, mechanisms for classification, and institutions for training and detention were the result. The positive side of this involved moves towards special education and measures to promote child health.

The 1901 School Attendance Act required the parents of deaf and blind children to ensure their education. This was extended in 1907 to 'defective and epileptic' children. In 1907 Otekaike Special School was established for the training of such boys; Richmond School for Girls followed nine years later. Whereas these two institutions were special schools run by the Education Department, Templeton Farm School, established in 1929, was for 'high-grade imbeciles and low-grade feeble-minded cases without psychotic complications' and was managed by the Mental Hospitals Department (Winterbourn 1944:309). All represented a marked trend towards institutional care.

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As the Education Department very firmly noted in 1919, 'the ordinary community holds no place for the feeble-minded child' (Annual Report, Department of Education, AJHR, 1919, E.4:13).

The trend towards classification was shown in the 1911 Mental Defectives Act, which distinguished between 'persons of unsound mind', 'persons mentally infirm', 'idiots', 'imbeciles', the 'feeble minded' and epileptics. At a lower level it involved agencies such as the School Medical Service, established in 1912 and extended in the 1920s (Tennant, 1991). School doctors sought to identify children with health problems (hearing and sight disorders, for example) that could be rectified before they became permanently disabling. Children were increasingly examined, assessed and labelled, and by the 1920s the school doctors were also helping to select backward children for special classes. The so-called 'testing movement' gained momentum from the late 1920s as overseas measures of intellectual competence were applied to New Zealand children (Vincent 1985:93-5; Goodyear 1987:85). Responsibility for different levels of ability was debated between education and mental health authorities, but a large number of children remained beyond any effective provision.

Although there was certainly disapproval of persons with congenital conditions and illnesses such as tuberculosis having children, physical disability commanded greater tolerance than intellectual. In the area of physical disability World War I had major consequences. Its devastating casualty rate led to a rehabilitation problem of major proportions (though the term 'rehabilitation' was not then in common use - the reintegration of servicemen into New Zealand society was termed 'repatriation'). Health services were not generally supplied free at this time, but state-funded medical treatment and state-assisted vocational training were provided to compensate soldiers for their sacrifice in military service. A Department of Soldiers' Re-establishment was set up in 1918, controlling hospitals, clinics and medical centres. Within five years it had also given vocational training to some 40,000 disabled servicemen. At the same time, cheap government credit was made available to soldiers wishing to set themselves up in business and on farms. Voluntary groups such as the Red Cross were also involved in the rehabilitation pact, often running convalescent homes.

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Despite this, the focus was still on providing pensions rather than services to disabled servicemen. These were determined by rank, and by level of disability: on a 1917 schedule the loss of two limbs commanded a 100 per cent disability pension; the loss of an index finger a 20 per cent pension. The link with income maintenance was underlined with a shift of financial responsibility for medical treatment from the Defence Department to the Pensions Department from 1922. Of 12,834 men receiving war disability pensions in 1925, 53 per cent were attributable to gunshot wounds, 17.6 per cent to respiratory conditions such as tuberculosis, and 5.4 per cent to shellshock and insanity (Boston 1993:4-5). Soldiers in the last two categories had the hardest time of it in later years. Amputees and those with gunshot wounds had visible conditions, in keeping with the image of the wounded hero. Those with 'invisible wounds' such as neuroses or fluctuating conditions such as TB carried more of a stigma, often being seen as dangerous to society or congenitally predisposed to their 'weaknesses'. More generally, there was a lack of understanding about the long-term effects of war injuries, mental and physical. When conditions did not become disabling until some years after the war, aging returned servicemen frequently found it hard to gain recompense. The advent of depression compounded their difficulties and was the last straw for many already stressed ex-soldiers. As one wrote to the RSA in 1932:

I have tried to be independent up till 2 years ago of the pension hoping that I would get better but now I seem to have lost all hope and courage. I feel I am a bore to my dear wife & children she having to do so much of the home work that a man should do and it is upsetting her nerves. I feel that if a change some way or other doesn't come soon - well I'm afraid to say. I am afraid of myself sometimes.

(Boston 1993:32).

Frustrated in getting adequate state recognition of the problem, the RSA was instrumental in the establishment of the Soldiers' Civil Re-establishment League in 1930. Patriotic and art union funds were used to finance its activities, and government grants eventually followed. (Thomson 1983:21-2).

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Despite marked deficiencies in the rehabilitation contract, war resulted in new procedures and facilities which later influenced civilian rehabilitation. Shellshock among returned soldiers did help to raise public consciousness about neuroses, and led to calls for halfway houses and outpatient psychiatric clinics (Clarke 1991:178-9). Physiotherapy training had commenced at Dunedin Hospital in 1913, but with an increased demand for masseurs and masseuses to treat wounded soldiers, this was rapidly extended and a Registration Act passed in 1920 (Angus 1984:166). A number of new medical procedures, in orthopaedics and plastic surgery, for example, were devised to treat men suffering from war injuries and were soon applied to civilians. Medical ascendancy in the treatment of disability was reinforced.

If war had important consequences for physical disability, so too did successive epidemics of poliomyelitis. Polio, endemic in many countries with high infant mortality, is often disguised in these places by other diseases. It tends to be less severe and rarely paralytic in infants. But as infant mortality dropped in Western countries, more children survived infancy without prior exposure to the virus, epidemics recurred and cases of paralysis in later childhood or adulthood became more common (Ross 1993:3-4). New Zealand experienced epidemics in 1916, 1924-5, 1936-7, 1947-49 and 1952-3 (Maclean 1964:321-3). A variety of remedies, orthodox and unorthodox, emerged in response to polio, but the medical specialty of orthopaedics was most obviously consolidated by the disease. Convalescent hospitals for returned soldiers were adapted for children recovering from polio, and the existence of young patients requiring long-term treatment gave impetus to campaigns for children's wards in public hospitals.

Alexander Gillies, a surgeon experienced in dealing with disabled soldiers and polio victims, led a campaign to change public attitudes towards 'cripples'. A member of Rotary, he was aware of that organisation's international activities to help crippled children. In 1934 each chapter of Rotary NZ undertook to set up a branch of the Crippled Children's Society in its area and in 1935 the Society was formally established (Ross 1993:43). The society was greatly assisted in its early years by a grant of £50,000 from the Nuffield Foundation. Although the Wilson Home was soon established in Auckland, it had been decided by 1940 that the Society's main



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activities would involve direct assistance to children in their own homes, rather than the management of residential homes. Welfare officers were also being appointed by this time (Carey [n.d]:20-4).

Initially some 5000 crippled children were identified, most of them disabled by tuberculosis of the joints and bones, by polio or by accident. The Society's definition of a crippled child was restricted to

a person under the age of 21 years who not being mentally deficient or not educable, has a defect which causes or tends to deformity or interference with normal functions of bones, muscles or joints, the defective condition may be congenital or acquired, but does not include defects of the vital organs.

(Carey:20)

Publicity material showed photographs of engaging children in callipers and on crutches: they were young, previously fit and healthy in most cases, usually lacking in other disabilities. Despite some initial hostility to Gillies' message (Ross 1993:42), the clients of the Crippled Children's Society were a marketable product in terms of fundraising and public support. The support of public figures and the fact that polio, in particular, crossed social boundaries, all helped to sway public sympathies.

While the voluntary sector showed signs of expansion during the interwar years, so did state financial support for disability. One of the first groups to receive a civilian disability pension was miners, but only those totally incapacitated by a condition known as miners' pneumoconiosis. The Miners' Phthisis Act was passed in 1915 (and, significantly, miners were in a strategically important occupation during the war years) (Social Security Department 1950:27).

Pensions for the blind were next introduced, in 1924. This was a means tested pension paid from the Consolidated Fund. The fact that blind persons were singled out is significant. The debate on the Pensions Amendment Bill focused overwhelmingly on changes to existing pensions, and only one or two speakers expressed, in passing, a hope the measure would be extended to other 'confirmed invalids' (NZPD, 205:422;427) The prioritising of visual impairment was largely due to agitation by Clutha Mackenzie, a returned



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serviceman blinded at Gallipoli, scion of a prominent political family and himself a former member of parliament, who since 1923 had been Director of the Auckland Institute for the Blind (Catran & Hansen 1992:46). However, it also reflected the sympathies commanded by this class of disability, which was more obvious and less contestable than many other conditions.

Depression precluded further measures, and it was not until the First Labour Government had gained power that a more general invalidity pension was introduced in 1936. It covered those permanently unable to work through accident, illness or congenital conditions. The state's focus was still on financial aid, but the principle of state support for persons unable to earn a living because of physical incapacity, regardless of age, was well and truly established.

The 1938 Social Security Act introduced a sickness benefit to cover loss of earnings arising from temporary sickness. More important for the history of disability were the Act's medical benefits which, by substantially reducing the costs of medical treatment, encouraged early attention to conditions likely to be disabling, and allowed for the free provision of drugs and appliances. The principle of the Act, that the state would tax each person according to their means, and provide for each according to their needs, had fundamental implications for the disabled.

Generally speaking, the interwar period was characterised by an expansion of income maintenance and of medical interest in disability. The latter was linked to new procedures arising out of war and the polio epidemics, and had pluses and minuses for the physically disabled. It meant that there was growing research into and optimism about many conditions, but it increased the likelihood that disabled persons would be viewed in terms of specific functional impairment - as parts of bodies that did not work, rather than as whole individuals.

Equally significant during the interwar years was the appearance of national disability organisations; advocates and service providers which still exist. To the Crippled Children's Society (now the CCS) and the Soldiers' Civil Re-establishment League (later the Rehabilitation League, now Workbridge), we can add the League for the Hard of Hearing, established in 1932 (Morris 1945:12-3), and

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various after care associations for the mentally and intellectually disabled (Goodyear 1987:85). The eugenics movement, influential among politicians and policy makers in the early years of the century, was less reputable by the 1930s. It was increasingly discredited by the excesses revealed in Nazi Germany, but probably remained an undercurrent in some quarters. And, whereas early state activism in New Zealand has been depicted as helping those best able to help themselves (Oliver 1988:4), the First Labour Government markedly extended the role of the government. Fundamental for the disabled was Labour's emphasis on comprehensive welfare coverage and on equality of opportunity for all.

### **The 1940s to the 1970s**

These decades saw the negotiation of disability policies between voluntary groups and the enhanced welfare state. Successive committees were established to examine the relationship between agencies dealing with disability, but coordination was less than ideal. We can also see the start of two vitally important developments which are only now coming to fruition: the emergence of a consumer voice, and a questioning of institutional care. Initially, however, the needs of ex-service personnel once again dominated policy.

Rehabilitation as a concept was more effectively promoted after the Second World War than the First. Disablement pensions provide the closest measure of disability among New Zealand servicemen and women during the war, and these peaked at 26,000 in 1947. It has been estimated that between 1946 and 1954 disabled servicemen and women averaged 23,000 or nearly 11 per cent of those demobilised. Most of them had less than 40 per cent disability. The use of anti-personnel mines meant that there was a higher proportion of eye and leg injuries than in the First World War, but tuberculosis continued to be a problem, especially among returned prisoners of war and ex-navy servicemen, and anxiety neurosis was the most common medical problem identified (Thomson 1983:281-3).

Services provided under the 1941 Rehabilitation Act were generally more comprehensive and efficient than those which had followed the previous war. Assistance with higher education and job training was provided, along with land settlement schemes. The close involvement of Labour Prime Minister Peter Fraser and Finance Minister Walter

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Nash ensured that such schemes meshed with Labour's broader programme of economic development, and were informed by its commitment to social justice and equality of sacrifice (Thomson 1983:37). The majority of disabled servicemen were assisted through general welfare channels rather than through one unified agency which dealt specially with ex-service personnel, as happened in many countries. In New Zealand, a policy of topping up existing structures and services was developed (Thomson 1983:285). Veterans' reintegration into the workforce was aided by labour market buoyancy over the 1940s and 1950s. This contrasted with the economic fluctuations of the 1920s and early 1930s, and it meant that the government was able to reject a policy of coercing employers to take on disabled workers.(Leadley 1948.)

A mix of new and established community groups also provided support to disabled servicemen, in some cases with government funding. The New Zealand RSA, St John Ambulance, the Red Cross, and the Blinded Servicemen's Trust Board provided services of various kinds, but the Disabled Servicemen's Rehabilitation League had a particularly close relationship with government. Although the numbers it assisted were limited and its approach to job training of an unimaginative basket-making and leatherwork kind, it later (in 1954) became the official arm of government for providing training schemes to physically disabled civilians.

Over the 1950s and 1960s there was a clearer commitment by the state to civilian rehabilitation, and a redefinition of civilian assistance that went beyond financial support. At the same time, the whole policy area was becoming much more complex and bureaucratised. In 1954 the National Government established an interdepartmental committee consisting of representatives of the departments of Health, Labour, Education, Rehabilitation and Social Security, as well as appointees from Treasury, the British Medical Association and the Auckland Hospital Board to advise Cabinet on civilian rehabilitation. Although the committee was of limited effectiveness, its establishment at least recognised the need for coordination between public sector service providers, if not with voluntary services.

Of far more significance in the post-war era was the emergence of consumer advocate groups dominated not by professionals or the charitably-inclined, but by disabled persons and their families. In

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1945 the Dominion Association of the Blind emerged, partly as a reaction against the autocracy and paternalism evident in the New Zealand Institute for the Blind. Over the 1950s the Association gained in support and political influence, challenging existing pensions regulations and the constitution of the Foundation for the Blind (Newbold 1995:88).

Another such organisation was the Intellectually Handicapped Children's Parents' Association (IHCPA), formed in 1949. Similar parents' bodies emerged in other western countries during the late 1940s and early 1950s, a reflection of concerns about the rights of the intellectually disabled and a revulsion against the excesses revealed in Nazi Germany. The writings of John Bowlby on the negative effects of maternal deprivation and institutional care on children, with or without disabilities, may also have been a factor in parental activism. The Association included those who had resisted pressures to have their children placed in institutions on the basis that this was 'best' for other family members and for the children themselves. Parents initiating the Association tended to be those whose children had a moderate disability, and who sought the right for them to be educated to their best abilities, just like other children (Riseborough 1986:40-44). The title of the Association was significant, as a move away from the more established term 'mental defective', which still carried the baggage of the eugenics movement. The emphasis on parents was also important, as a statement that the organisation was not for officials or professionals - initially those who were not parents of an intellectually handicapped child were excluded (Riseborough 1986:58). After a debate about whether to remain a support and pressure group, or to move into the provision of services, the IHCPA eventually began to provide short-stay homes, hostels for country children and, through its descendant, the Intellectually Handicapped Children's Society, training facilities for adults and young children. It provides a fascinating case study of the translation of small, female-dominated parents' group into a large, bureaucratically structured service provider receiving large amounts of money from government (Riseborough 1986; Munford 1989). Initially, however, the IHCPA struggled to promote a lay voice in disability policies, and to highlight the role of carers.

This was an important perspective, but it was one which had a struggle to be heard against professional interests. The older medical

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model of rehabilitation had too often encouraged a perception of disabled persons as dysfunctional parts of bodies. By the 1960s multidisciplinary approaches to assessment and treatment were encouraged, and the social, psychological and vocational aspects of rehabilitation stressed alongside the physical. A 1965 Report by a three person National Rehabilitation Commission stressed the need for more accurate assessments of cases by teams including not only a doctor, but also a psychiatrist, psychologist, occupational therapist, social worker, placement officer of the Labour Department and manager of the local DSRL workshop NZ National Civilian Rehabilitation Commission 1965). This was an ideal not widely attained at the time, but it did indicate that medical hegemony was being undermined.

For those with a psychiatric disability changes were also under way. Despite the emergence of the 'villa' system and better classification of patients within mental hospitals (the official term at the time), histories of individual institutions testify to the grim conditions of the post-war years (Brunton 1972; Williams 1987). All were chronically short-staffed and patients were largely kept under lock and key. One patient, first admitted to Porirua in 1958, recalled: 'My first impression was that I'd arrived at the Mad Hatter's Tea Party. I was desperately depressed and people seemed to be acting in a macabre sort of way. The staff seemed as mad as the patients.' For her, the one or two humane nurses 'shone out as being magnificent people in a really terrible situation' where staff had tremendous power, and where 'the only hope was to have someone on the outside who cared for you'. Even this woman acknowledged that Porirua, however horrific, did save her life - it is a reminder of the very difficult and ambiguous role of the mental health services then and now (Williams 1987:273-7).

Staff recollections of work in a Porirua Hospital during the 1950s are also shocking, involving fights, physical restraint of patients and conditions which employees described as 'zoolike' and 'unspeakably awful' (Williams 1987:208; 220). However, substantial changes can be dated to the late 1950s, when the new drug therapies became more widespread. Although these drugs were found to have side-effects, and often replaced physical restraint with chemical, they did help stabilise patients' behaviour and promote staff morale (Brunton 1972:28). The appalling 'severe' wards were transformed, open door policies initiated, and shorter average stays of only a month or so

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became the norm. More psychiatric patients were able to be treated outside an institutional setting until, by 1978, the average number of occupied beds in psychiatric hospitals was 2.4 per 1000 population, the lowest since 1881 (*Official Year Book* 1980:144).

By the 1970s 'deinstitutionalisation' was starting to become a catch-cry in many areas of social policy. For the disabled persons the principle of community care was enshrined in the 1975 Disabled Persons' Community Welfare Act. This important measure established an advisory committee to make recommendations to the Minister of Social Welfare on services for the disabled. More significant, it gave practical assistance to disabled persons, to persons caring for disabled persons, and to organisations providing support and counselling. Among its provisions were suspensory loans for motor vehicles and home alterations, short-term alternative care for the children of disabled persons and measures promoting disabled access to public buildings. This aspect of the legislation was especially noteworthy. For once, parts of the environment were to change to suit disabled persons: the longstanding assumption of earlier policy had been that disabled persons should 'fit in' to their surroundings or decently hide themselves away.

The 1975 Act supplemented an earlier landmark enactment, the 1972 Accident Compensation Act. Because it did away with costly and time-consuming litigation for those injured in accidents and replaced it with a no-fault system of earnings-related financial relief, the Act was regarded internationally as an extremely advanced piece of social legislation. ACC also allowed for lump-sum payments for permanent disfigurement and disability and established an Accident Compensation Commission with responsibilities for rehabilitation. However, the very generosity of its provision for persons injured in accidents created disparities with those whose disabilities stemmed from disease and congenital conditions. Marked increases in the cost of Accident Compensation over the next two decades were due, in part, to claims for short-term injury, and in 1988 the Royal Commission on Social Policy recommended a longer 'pause' period before payments were made.

By the 1970s there was a much wider range of provision for disability than had been the case thirty years earlier. From the government's perspective, the hospitals boards were at the hub of services,

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providing acute care and, increasingly, specialised rehabilitation assistance under multidisciplinary teams. Spinal cord injury units were being expanded in Auckland and Christchurch, and rehabilitation units had been developed at the Otago Civilian Rehabilitation Unit (1952), Queen Elizabeth Hospital in Rotorua (1965) and Palmerston North (1972). The Waipawa Hospital Board had opened the Pukeora Home for the Disabled in 1957, but other boards were working towards the more effective provision of home services.

The Department of Social Welfare (DSW) not only administered rehabilitation allowances, training allowances and social security benefits, but it provided subsidies to voluntary organisations and oversaw the activities of the Artificial Limb Board. The DSW, the Department of Labour and Hospital Boards all worked closely with the Rehabilitation League (as the DSRL had been renamed). Although the League still provided trade training, it was moving more towards training in work experience and habits, and in skills and processes paralleling private industry.

The Department of Education and the psychopaedic hospitals worked more in the area of habilitation than rehabilitation. The ideal at this time was to integrate children with minor disabilities into ordinary schools, but special schools and classes were still provided for those with more severe disabilities.

Voluntary organisations such as the IHC, the Royal New Zealand Foundation for the Blind and the Crippled Children's Society continued to assist specific categories of disabled people. However, they were having to take on board the fact that clients might experience dual or multiple disabilities, and that they now needed to interact with a range of other agencies and professionals. In terms of vocational rehabilitation, most of these organisations offered sheltered workshops rather than assessment and training programmes aimed at eventual work in outside industry (Rehabilitation Services in New Zealand, *AJHR* 1975, E-10:109-119).

Between 1940 and 1980 the term 'rehabilitation' lost its association with ex-service personnel and it had come to mean much more than physical methods of treatment. In 1975 it was defined as 'the process of the restoration of individuals rendered unfit from any cause be it



physical or mental, to a degree of social and economic independence, within the limits imposed by any residual restriction of function' (Rehabilitation Services in New Zealand, *AJHR* 1975, E-10:109). Infectious disease was less important as a source of death or disability but, with longer life expectancies, degenerative disorders were gaining greater prominence among those needing rehabilitation.

### **1981 to the Present**

The 1980s and early 1990s were characterised by transformations in social policy which are still being negotiated. Though many readers of this paper will have been active participants in the process, such transformations were certainly not unique to the area of disability. Two key developments stand out: the first is the emergence of a much more vocal consumer voice; the second, the expansion of community care. From 1984 these processes took place against a background of major political change, involving the withdrawal of the state from a wide range of activities. Under the fourth Labour government this was most apparent in the areas of economic and fiscal policy, with more profound changes in social policy taking effect under the 1990 National government. Relationships between the state and the voluntary and private sectors began to be radically reshaped as competitive, free market dogmas gained ascendancy.

During the 1980s many minority groups throughout the world claimed the right to control their own affairs and to participate in decisions affecting their well-being: this was equally true of disabled persons. The new assertiveness among New Zealand's disabled population by the 1980s has been attributed, in part, to the increasing numbers of people who were surviving accidents as adults. These individuals interacted rather differently with the 'rehabilitation and welfare service industry' from those who had grown up with disability and, it has been suggested, they formed an important element - but by no means the only element - in the self-advocacy movement (Newsome 1987:22). Self-advocacy often included a trenchant critique of medical models of disability, professional power and the portrayal of disabled people from a non-disabled point of view (Georgeson 1993). The 'charity' or 'pity' ethos in agencies dealing with disability was challenged, as was the concentration of power within these agencies in the hands of a few (Hunt 1988:772, 784-5).



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The 1981 International Year of Disabled Persons and its associated Telethon helped raise the profile of disability. In 1983 the Disabled Persons Assembly was formed as a 'grass-roots forum and action group' operating at local and national levels throughout New Zealand (Gregory & Curry 1989). Required in its constitution to have a majority of people with disabilities on committees, the DPA became an important support and advocacy group. At local level it was involved in such activities as the administration of mobility services and teletext information services. It monitored disabled access buildings and the performance of local service agencies. At national level the DPA fought for adequate income levels for disabled people and the removal of discrimination. It was not, however, until 1993 that the Human Rights Commission Act was amended to include disability among the grounds upon which it would be illegal to discriminate.

Another voice for disabled persons was *AID (Advancing the Interests of the Disabled) Magazine*, later to become *NZ Disabled*. First published late 1980, the magazine contained information on such topics as travel accommodation with disabled facilities, fashion for the disabled, sporting and other achievements by disabled people, and latest medical responses to particular conditions. Articles discussed marriage and sexuality among physically and developmentally disabled persons, interaction with persons who were not disabled, government policies affecting disability, and appropriate language to describe disability. Language change had, in fact, become a vital accompaniment of disabled rights, as the entrenched and stigmatising terminology of crippledness, deformity, retardation, affliction, restriction and suffering was challenged, though not eradicated (*AID Magazine* May 1985:41).

In most areas of social policy community care became an ideal in the 1980s. A new generation of field workers and policy makers was as wedded to the virtues of community care as their predecessors had been willing to staff and sanction the use of institutions. For disabled persons, community care was associated with policies of 'normalisation' and integration into mainstream life. Disabled children began to enter ordinary school classrooms, not just special classes in schools. Some institutions were closed, and others greatly reduced in size, used mainly for short-term care. However, such policies came at a time when the welfare state was contracting and many of its earlier responsibilities 'devolving' (devolution being another 1980s buzz-

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word) to voluntary and community groups. These had to compete with each other and with remaining state agencies for government funding, and with lotteries, yacht races and consumer goods for voluntary donations. While greater accountability and responsiveness to consumer demand was certainly needed in agencies, the new competitive environment sometimes worked against cooperation and consistency. Goals were likely to be defined in terms of what could be translated into the late 1980s 'managerspeak' of measurable outputs and outcomes and less quantifiable ends neglected. In some organisations tensions between paid and unpaid workers were compounded by a clash between the new managerial thrust and the older charitable ethos.

By the 1990s deficiencies in the implementation of community care and 'normalisation' were becoming apparent, with cutbacks in classroom assistance for disabled children, for example. Community care came under strongest attack in relation to former psychiatric hospital patients, though much of the alarm generated through the media was excessive. There were nonetheless valid criticisms encompassing lack of funding, preparation, support and therapies for those shifted into community care. Often, it seemed, 'the community' did not particularly 'care'. And, at a time when agencies such as the Rehabilitation League (as 'Workbridge') and the Crippled Children's Society (as 'CCS') were starting to move more into a service brokerage role, continuing high levels of unemployment made it difficult for their clients to obtain jobs or to become fully integrated into the workforce.

In 1992 a government policy document, *Support for Independence for People with Disabilities - A New Deal*, set out goals for disability support services (Shiple & Upton 1992). These were intended to reduce duplication, encourage responsiveness to clients' needs and give value for money. Significantly, the document not only stated a desire to 'improve the quality of life for people with disabilities', **but** it also 'recogni[sed] the financial realities facing the country today' (Shiple & Upton 1992:25). Services previously subsidised by the state were now to be purchased on a market-inspired contracts basis. In July 1993 the regional health authorities took responsibility for disability support services previously funded through area health boards and the Department of Health. Other services under the Department of Social Welfare were to follow: aid to families,

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attendant care, loans, information and advisory services, and aids and appliances. Not all agreed that the health sector, with its connotations of sickness and disease, was the appropriate place for the broad range of disability services. The full impact of these changes is still to be evaluated, but by 1995 there were signs that agencies were under stress. The new arrangements did not cover the whole cost of services and problems occurred where needs increased beyond the fixed amounts budgeted for in contracts (*NZ Disabled* August 1994:3; October 1995:8).

In other areas, too, financial realities were taking effect. Changes to the administration of Accident Compensation in 1992 resulted from a need to contain spiralling costs. 'Clients' of the scheme saw an end to lump sum payments, reductions in attendant care, and the tighter vetting of those on ACC payments, with attempts to transfer some to other benefits. While in many respects those on disability and sickness benefits were treated more tolerantly than other beneficiaries (and regarded as more 'deserving'), age-old suspicions of malingering still surfaced. Within financially stretched organisations staff also felt pressures to deliver a more professional service while paying the price of reduced working conditions and job security. On the positive side, the total range of services for disabled persons was considerably greater than even ten years earlier, there was more attempt at consultation with consumer groups, and service providers were accountable to a degree which would have been unthinkable in the past.

In the nineteenth century disabled persons were just one variant within the amorphous mass of the poor, and were given the minimal financial, and sometimes medical, assistance available to the totally destitute. By the end of the century, some selected groups of young disabled persons had been recruited into institutions which we would now see as attempting 'habilitation'. Rehabilitation emerged out of the First World War, when there was a sense of having to recompense injured soldiers for their sacrifice. The emphasis for the next fifty years or so was on restoring physical functioning. Disability in the late twentieth century is seen as having psychological, social and economic, as well as physical, dimensions, with a variety of agencies and helpers 'empowering' 'clients' to achieve their maximum potential. We should not, however, think that this is the end of the story. The past shows us that what is defined as 'disabling' is subject

to change and that responses which one generation regards as enlightened and valid are likely to be modified or disowned by another. What seems least likely to change is the claim by disabled persons for recognition and for a voice in decisions affecting them.

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