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ABSTRACT

A study examined the pattern and organization of services for disabled persons in New Zealand. As of 1981, there were between 250,000 and 280,000 disabled persons in New Zealand. The Accident Compensation Act of 1972 provides compensation for up to 80 percent of previous earnings, medical and dental treatment costs, and rehabilitation and training assistance. However, many persons seeking compensation under the act are faced with delays and, at times, failures in the litigation process. New Zealand has a reputation for its advanced attitude toward social welfare and for a variety of rehabilitation services (considering its size). Although advocates for those in need of rehabilitation services have captured the government's attention, the high costs of providing additional services remains a significant barrier. A lack of coordination among existing government services is another problem. Neither does New Zealand have a full training course for rehabilitation professionals. One attractive feature of New Zealand's delivery system for rehabilitation services is its Disability Resource Centre. (A draft paper on rehabilitation, dishabilitation, and the remedial process and a note on a disability resource center proposal are appended). (YN)

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Monograph #43 -

Disability in New Zealand: A Study of Rehabilitation and Disability Organizations (2nd Edition)*

by L.R. Newsome

* Published originally as an Occasional Paper in Psychology by Massey University, New Zealand

MONOGRAPH #43

DISABILITY IN NEW ZEALAND:
A STUDY OF REHABILITATION AND DISABILITY ORGANIZATIONS

(SECOND EDITION)

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International Exchange of Experts
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International Exchange of Experts and Information in Rehabilitation

Foreword

In September 1987 the World Rehabilitation Fund was awarded a grant with a cooperative agreement from the National Institute of Disability and Rehabilitation Research (NIDRR) for an additional three years of the International Exchange of Experts and Information in Rehabilitation (IEEIR) which had been initiated in 1978. From 1978 until 1987 under the IEEIR grant, forty-one monographs had been published and 112 fellowships awarded to U.S. disability experts. The charge: import ideas on disability issues which will help to enhance the knowledge base in the U.S. and provide the U.S. disability community with relevant useful information coming out of the experiences of other countries; use U.S. priority topics to stimulate this exchange.

When the project began in 1978, only four countries were involved: Sweden, England, Japan and Australia. In 1979 seven additional countries were added and by 1980 the project was opened to any part of the world from which relevant useful information could be obtained. From 1980-87, twenty-three countries were visited by U.S. specialists on a variety of topics in the disability fields. Reports of these study-visits have been disseminated to interested persons through the project.

A decision was made early on that the monographs should be authored by foreign experts (rather than by the U.S. fellows who carried out study-visits). There have been a few exceptions made, usually based on a U.S. fellow's extensive experience with a country beyond the 4-6-week fellowships offered by the IEEIR; e.g., through subsequent Fullbright fellowships.

In addition to recruiting foreign authors for the IEEIR monograph series on occasion we have translated and republished documents or monographs previously published in the country of origin; e.g., Monograph #43, which we felt would provide an overview of rehabilitation in New Zealand and the resources available there, was first published in New Zealand as an "occasional paper." To give it wider distribution in the U.S. in particular, it was decided to republish it through the IEEIR project.

The 1987-1990 IEEIR project has undergone some changes. Since we are sharing the field with the World Institute on Disability (WID); i.e., WID received a similar grant from NIDRR, we are also "sharing the world." NIDRR, in our cooperative agreement, has asked the WRF to handle information exchanges with Asia, Africa, the Middle East, the Pacific Basin and the Subcontinent. Therefore, in the future you will be seeing monographs and reports from WRF coming out of these parts of the world.

We appreciate responses and suggestions from persons familiar with our project, and we invite new people from the U.S. disability community to become familiar with the IEEIR.

Diane E. Woods
Project Director

New York
June 1988

TABLE OF CONTENTS

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Preface

People with disabilities now form over 15% of the population of Australia and the percentage is growing, according to many indications, due to longevity, increase in adventitious injury, and improvement in techniques for preservation of the seriously injured. In response to the needs of people with handicapping disabilities and intolerance by our now comparatively affluent society of a quality of life of much less than most of us would accept, a large and still growing welfare system has developed to service these needs. Today, in Australia, the disability "industry" rivals universities for annual cost to the community and many government, semi-government and voluntary welfare organizations now exist to provide a wide variety of services for people with disabilities. It follows that the infrastructure of services and of organizations that supply these is most complex with many overlaps and disjunctions. There are at least several organizations which exist for the purpose only of coordinating other organizations (A count of similar organizations in US yielded a figure of over 800!). Within this complexity are deployed a growing number of professional specialists including those with psychological training and with professional qualifications as psychologists. In general the generic name now being applied to those specializing in the disability area is "rehabilitation", although some debate can be entered into as to the suitability of that term (Matkin, 1985; Newsome, -in preparation, see Appendix IV) However specific skills required by the industry include those in research, training, organizational development, programme development, programme evaluation techniques, and ergonomics besides those more traditionally associated with clinical-welfare type services.

While there exists a demand for personnel accomplished in the above areas training programmes are falling behind in meeting the supply needs. Part of the problem is the diversity of requirements. Another problem is the lack of a comprehensive systematic view of the area to allow rational evaluation of training demands. Such a view is also required to provide input into the actual training programmes as the area is now a bewildering one for the newly emerging professional (not to mention the bewilderment of consumers!). Gaining a conceptual overview of the disability services area, however, is not easy as it requires survey of many welfare service organizations, and many policies and programs which are ever changing. In Australia there is the added difficulty of dealing with a welfare structure that involves two levels of government.

The purpose of this project was to survey the pattern and organization of services for people who are disabled in New Zealand. The intention at the outset was most ambitious. It was born in part from frustration at trying to obtain a conceptual grip on what is happening in Australia in this regard. While there are many reports, surveys, and information documents available, the situation in Australia is extensive and complex; probably too extensive and complex for any one person to resolve in a comprehensible way. It seemed that one might have a better

chance of seeing a holistic picture in a smaller country. It is perhaps fortunate, for this purpose, that there is one close at hand to Australia that has a similar culture, and a similar level of socio-economic development. One, however, that remains free of complications created by having both state and federal government programmes, services, dispensations, ordinances, and provisions, although issues involved with, and of concern to people who are disabled in New Zealand are certainly not uncomplicated. The availability of leave to engage in special studies provided this author with the opportunity to attempt to put together a picture of this New Zealand system of welfare and rehabilitation. Whether or not the picture presented here is a successful portrayal of the complexities and qualities of that system remains for others to judge as it does for the drawing of implications for the Australian scene.

Apart from the personal gratification of having a feeling that one has somehow understood how things work in respect to an issue, and that some attempt has been made to piece together a picture of a welfare system, the project, if successful, has other virtues. It gives a stance from which to view the more complex issue of disability in Australia. It may also be useful in illuminating a number of issues that are yet to be successfully addressed in Australia which have been already dealt with some profit in New Zealand.

A further purpose for the exercise was the provision of a framework for didactic purpose, especially for the training of professional personnel, particularly in psychology. Rehabilitation has become a field of considerable complication in recent years and calls on the professional to supply a wide range of skills. Besides the more traditional skills of assessment and counselling the psychologists is required to have a knowledge of organizational relationships, government sponsored services, welfare provisions, and the complexities of the welfare industry structure. In spite of numerous reviews, reorganizations and restructurings of the welfare delivery system and process, the complexity increases rather than diminishes in the progress of time. In order to contribute successfully to that process the mint-condition products of our training programmes for rehabilitation psychologists must now have a working familiarity with the structure of the welfare system.

This project was undertaken as part a Special Studies Leave programme carried out within the duty as a staff member of the University of Queensland. I am grateful to the Department of Psychology at Massey University and to Professor George Shouksmith for the facilities given and help extended during my stay at Massey University, and especially to Dr. Bob Gregory of that department for his warm welcome, his encouragement, assistance, his criticism, and his sharing of many good things. Thanks to his agency I believe that I now know a lot more about rehabilitation, and about disability matters in New Zealand. My thanks go also to the members of New Zealand's Advisory Council for the Community Welfare of Disabled People, and especially its Chairman Mr J.G.S. Reid who welcomed me and allowed me the privilege of sitting in on a meeting of council, and Margaret Geddes and Adel Carpinter of the staff who kindly provided me

with much material, and the Disabled Persons Assembly (New Zealand) Inc (DPA) who also did likewise on several occasions. Also tolerant of my presence were the New Zealand Rehabilitation Association executive committee, the Palmerston North Regional Committee of DPA, and the Federation of Volunteer Welfare Organizations who kindly invited me to attend a seminar held by them. Other organization I must mention include the Rehabilitation League unit at Napier, the Independent Living Centre (ILC) at Auckland, Manawatu Enterprises, the Ryder Cheshire Foundation, the New Zealand Society for Intellectually Handicapped (NZSIC) the New Zealand Crippled Children Society (NZCCS) and the New Zealand Disabilities Resource Centre(NZDRC), all of Palmerston North. I wish to especially mention the directors of the last two organizations. These are Paul Curry, who seems to be ubiquitous in disability affairs in New Zealand and who's "scams", as he puts it, for raising money, although far from being illicit in means, beats anything I have ever come across, and Dr Terry Cunniffe who's drive and enthusiasm makes understandable the standard and position of eminence achieved by the DRC in the world of Rehabilitation.

1. Introduction

The International Year of the Disabled Person resulted in a wide variety of activities being undertaken in many countries around the world, particularly in New Zealand and in Australia. Many of those still have impact today some five years later. One of the effects that flowed from IYDP was that it signaled to many people, including those who had become long accustomed to the social devaluation of being disabled, that people with disabilities were and are important. Even after this remove in time there is at least one committee set up under the IYDP banner in New Zealand that is still operating. IYDP had particular potency in both Australia and New Zealand in that it pulled into focus many of the issues that surround the circumstance of being disabled in the 20th century world. In the 1970s disabled people themselves were only just becoming aware that many of the irksome and often painful events and conditions they had experienced and were experiencing in their lives were common experiences of many others. They began to realize that by concerted action many things could be done to improve matters. On the other side, the exposure of the issues of disability by IYDP to the non-disabled was, to many, such a revelation that some of these people subsequently became involved in disability action.

Involvement of non-disabled persons in providing various forms of assistance for people who are disabled is of course not new by any means. The history of service provision for disabled persons goes back to the early part of the last century for New Zealand. However it is only recently that welfare provisions and facilities offering services have mushroomed, particularly so in the last decade. The combined involvement of Government, Semi-government, volunteer or charitable welfare organizations, and self-help organizations in New Zealand and in Australia now constitute a major industry which consumes a substantial proportion of government budgets. One organization in New Zealand alone obtains a substantial proportion of its annual operating costs, now in excess of $NZ40 million, direct from government subsidy. As the number of organizations, the extent of services collectively provided, the number of specific government programmes, and the identified needs of welfare consumers increase, so does the complexity. Incoordination also increases unless checked. From the governmental point of view there are many problems of policy generation, programme planning and system administration to be faced, particularly for very large programmes (Howards, Brehm, & Naghi, 1980). What was once a fairly simple matter, description of a national programme for people with disabilities is most difficult. Planning and control is even more difficult. Clearly there are many unwanted overlaps of service and there are gaps. Anomalies of service abound everywhere and many have been documented (For example, see Chee & Henderson, 1985). While the situation in New Zealand is complex, that in Australia is assuredly even more so. The perhaps optimistic expectancies of this present study are that the attempted overview of the New Zealand disability scene will lead to some insights that may be profitable if and when applied in Australia.

While the milieu in which welfare organizations now must operate has become complex, life for the professional too has become far less simple. Whereas at one time the psychologist in an organization could safely stay on one side of a testing/counselling desk, full professional involvement in habilitation and rehabilitation matters now demands extensive skills in programme planning, system organization, resource management, organizational development, and interpersonal team relationships. The same now applies to other disciplines. For most services and organizations this is the time of change, often revolutionary, as the old paradigms, patterns of service, and philosophy underpinned the basis of service are now constantly being challenged and overturned.

It seems also that most professionals involved in welfare service must now become involved in politics. This is politics with a small p. Most organizations are currently going through processes of organizational change and such change invariably challenges power relationships within an organization. As professionals usually have not just a minor place in the power relationships, and in any case, are often involved in the organization and implementation of change, they will be politically involved. The professional, thus, can no longer afford to concentrate just on what were the traditional techniques and tools of trade but must become armed with a wider variety of knowledge and skills. A further unsettling factor, at least as far as the more conservative professional is concerned, is the growing insistence that any discussion of the rehabilitation process and any decision making in respect of this process should include the client. The advent of the self-advocacy movement, thus, has added a new, and to some, a somewhat frightening element into the situation. The client, through self-advocacy organizations, is now demanding to be part of the power game.

All of the above adds up to make a complex picture indeed. Hitherto, no attempt appears to have been made to draw the picture for New Zealand, nor for Australia. This present report hopefully constitutes a start.

1.1 Definitions, distinctions and limits

"At least 10% of all the population of any country suffers from some form of mental or physical disability..."(Hammerman & Maikowski, 1981) Whereas terms like disability and handicap have been variously and interchangeably used from time to time a standardization of meaning of those two words offered by the World Health Organization (1974) has now been adopted by most writers. The WHO definition introduces a third term which has an explanatory function.

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

Disability - "Any restriction or lack (resulting from an

impairment) of ability to perform an activity in the manner or within the range considered normal for a human being."

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

The scope of this study is restricted, in the main, to matters that concern people with physical disabilities. There is, however some mention of services which are concerned primarily with people who have intellectual disabilities because often the boundary blurs between categories, especially when the same individual may be described by both categories. While a significant proportion of any population will have some form of sensory disability services that provide for this group tend very much in Australia and New Zealand to form separate entities organizationally. Their history is much older than other disability categories and there are many distinctly different issues involved in the consideration of sensory disability matters. In this study the author opted to concentrate on those matters which affect adults with significant physical disabilities. For this reason the issue of education of children with disabilities will be touched on only lightly.

1.2 Method of approach

The approach is basically experiential with a certain amount of participant observation. This author was invited to participate in several training programs run by Massey University for staff from the Department of Labour and in the teaching of several courses within the Department of Psychology programme, one at an undergraduate level and one at the graduate level. All of these activities gave opportunity for listening to, meeting with, and in many cases, becoming closely acquainted with many persons concerned with disability matters and engaged in rehabilitation. Opportunity was also taken to 'sit in' on a number of meetings of various councils and other bodies concerned with disability matters. Visits were also made to various institutions (See Appendix I for details). The discussion below results from an attempt to integrate these many experiences with the available relevant literature on social welfare matters in New Zealand.

1.3 Organization

This report is organized so as to move from the general to the particular. The first section below is intended to set the general context in which disability issues may be understood. As most of the issues that affect disabled people involve the state and its governmental departments and the state supplies the largest component of welfare, either in direct services or in

funding, this involvement and the issues generated will be dealt with first. From there the report will move to semi-governmental bodies and from there to volunteer welfare agencies. Obviously a report of this size can only deal with a few of the large number of corporate agencies that now figure in the New Zealand Disability scene. The next section will deal with disability advocacy.

2. Situation and attitudes

2.1 The New Zealand Situation

New Zealand appears, at first blush at least, a rural version of Australia. This is not surprising as the ethnic and cultural origins of both countries are very similar and their historical development were parallel, especially in the setting up of political, governmental and legislative structures. It is a beautiful country at the other end of what has become, tc local perceptions, a violent, disaster-ridden world. Citizens are fortunate to have a socio-economic climate that provides a social welfare system that is unmatched by any other country. The population is small, being comparable in size with the medium sized Australian states, and is self-sufficient for most of the basic materials required to maintain a comfortable standard of living for all of its citizens. It is politically stable with few social or economic problems which could not be ultimately solved by the application of energy and imagination (Cleveland, 1979). In general its politics are very much grounded in the basic acceptance that it is appropriate and proper for the state to use its resources for the benefit of the greatest number of people. This ideal has been expressed succinctly as "a fair go for a decent bloke" (Muldoon, 1974). All major parties stick closely to the liberal tradition which is basically enlightened humanitarianism, and successive governments, albeit of different banners, have taken part in the progressive addition to the social welfare package.

This collectivism shown by New Zealand arises historically from the needs of a pioneering country, isolated as it was from traditionally developed civilization, for the creation of a comprehensive infrastructure of services and enterprises to support its new nationhood. It was only the state's ability to borrow, as a pioneering neonate-nation, on its promising prospects that enabled the requisite infrastructure to be established. This necessity for the state to be supportive everywhere, combined with the blend of socialist, liberal and utopian ideals brought to the colony by its optimistic and enterprising founding population created the expectancy sustained by New Zealanders that it is ever the state responsibility to provide this basic platform for what they have become accustomed, 'the good life'. While still attempting to play nursemaid to independent capitalistic self-development and individual self-reliance, the government of New Zealand has retained its role in looking after the collective interests of the populace, providing, perhaps, the closest to the ideal of a welfare state according to contemporary political definitions. New Zealand, thus, in such terms, has produced an impressive track record of social legislation. It was one of the first countries to introduce in 1898 the old age pension, although with restrictive specifications Its introduction of an Invalid Pension in 1938 was likewise without precedent. It has been dubbed a land of optimism, a land of the Utopias.

Notwithstanding New Zealand's special brand of political and

social welfare development, it has most certainly not remained independent of outside influences, especially from those originating in Australia. There has also been a certain amount of legislative borrowings back and forth across the Tasman. Indeed, many of its political leaders were Australian born and six cabinet ministers of its first Labour Government in 1935 were Australians. In a way New Zealand has been regarded as a test-bed for legislative ideas as it has generally been a progressive nation, particularly in the sphere of social legislation. In the 1890s Lord Asquith described it as "a laboratory in which political and social experiments are everyday made for the information and instruction of the older countries of the world" (Sinclair, 1984). The Accident Compensation Scheme which grew out of the Report of the Royal Commission of Inquiry (1967) conducted by the Honourable Mr Justice Woodhouse, is but one example which is much admired by Australia, and which was indeed followed by its own inquiry to be conducted by Woodhouse himself assisted by Mr Justice C.D.L. Mears (The Woodhouse-Mears Report, 1974). For New Zealand, implementation of social welfare changes is a somewhat simplified operation as compared with in Australia, both because of the numbers game and the absence of the extra layer of government that intervenes in Australia between the intention of a federal programme and a state recipient. Smaller has its virtues in that it is easier to bring all of the major players together. In New Zealand it is easy to identify those who have a major stake in an issue and to conjecture as to what their agendas might be. In contrast, in Australia distances between major population centres, differences in local politics, conditions and structural arrangements often mean that discussions of issues at a national level are invariably confounded with local agendas, personal interests, and state political considerations that are unfamiliar to many if not most discussants.

2.2 Number of disabled in New Zealand

Jack, et al (1981) estimated that there are between 250,000 and 280,000 persons in New Zealand with at least one disability ranging from mild to very severe impairment. Equivocation about the exact number arises from the different ways in which it may be estimated in extrapolating from various survey results and the way in which component categories are combined for purpose of estimation. In general however, the percentage figures for component categories as well as the overall total as a percentages of the total New Zealand population do not appear to be remarkably different from those for Australia.

Social welfare provisions for persons with a disability are also not markedly different from those in Australia, but for one major category of exception; those who fall under the provisions of the Accident Compensation Commission.

2.3 Income of disabled people and its source

According to figures given by Jack et al (1981) 78% of people within the age range of 15 to 64 years classified as being

sabled in New Zealand had a gross weekly income of less than $300 and nearly 38% had an income of less than $NZ120. The inciple sources of that income were wages (44%) and National perannuation (13.8%). 16.6% had no income.

. Welfare benefits and provisions

.1 Principle of state responsibility

The principle of state responsibility for individual welfare was set by the 1972 Royal Commission on Social Welfare. This principle appears to govern much of New Zealand's attitude towards provision of social welfare. Key points are:

(i) The community is responsible - "for giving dependent people a standard of living consistent with human dignity and approaching that enjoyed by the majority, irrespective of cause of dependency." (Royal Commission on Social Welfare, 1972).

(ii) Must be comprehensive coverage of need, irrespective of cause.

(iii) Benefits must be based on need and scaled according to need.

(iv) Benefits are as of right to all.

In agreement with the Royal Commission statements the Accident Compensation Commission Act of 1972 asserted principles which included:

(i) Comprehensive entitlement

(ii) Completely free rehabilitation.

(iii) Real compensation

As yet no parallel set of statements exist for Australia!

3.2 Accident Compensation and the Accident Compensation Act, 1972

The commencement of the operations of the Accident Compensation Commission in 1974 has created an elite among the disabled of those who have acquired adventitious disabilities since then (Chee & Henderson, 1982). The Accident Compensation Act was the result of action taken, and pressure exerted by a group of individuals within the parliamentary, legal and judicial system who were dissatisfied with the method used to obtain compensation for victims of accidents. The Woodhouse Report of 1967 summed this up as being unfair in that it provided "entirely inconsistent awards for precisely similar categories." Palmer(1979), in addition, identified seven other major defects of the common law system. These are:

. Some victims miss out because of failure of the litigation process.

. The litigation process is expensive in relation to the amount of money eventually received by the victim.

. The delay in litigation.

. The difficulties in attribution of fault.

. That there is no relationship between fault and economic responsibility.

. Litigative action has no effect on reducing accidents and offers no inducement for safer behaviours.

. Traumatic impact of litigative process has negative effects for the victim.

Under the Act benefits and services provided at the direction of the Accident Compensation Corporation, as it has now become, (ACC) include:

. Compensation related to previous earnings (Up to 80%).

. Medical and dental treatment costs.

. Rehabilitation and training assistance.

. Lump sum payments for permanent physical disability, for pain, disfigurement and decrement of quality of life.

. Compensation for spouse or dependents for loss of support.

While compelled by the Act to provide the designated benefits and services the ACC, in order to contain costs, has considerable incentive to ensure quick and appropriate rehabilitation where possible. It is the role of the Rehabilitation Liaison Officer Service to facilitate matters to this end. Presently there are about 60 of these officers spread throughout the country. Although some efforts have been made recently to introduce in-service training and newer officers will be recruited from graduates of the Massey University Rehabilitation Studies programme who have had some training in rehabilitation, most officers remain largely untrained in rehabilitation.

In general the New Zealand Accident Compensation scheme has received much praise and has been described as "visionary." But it has engendered some problems such as that alluded to in the opening paragraphs of this section. Rea (1982) highlighted this problem in entitling her paper on this and other matters "Accident Compensation: A Cuckoo in the Sparrow's Nest of Social Welfare". As she summarizes the problem "As it (the cukoo -sic) has begun to grow and show its colours, its fellow-travellers have started to look dowdy, under-nourished and beleagured." In short, those who have had the misfortune to be accidentally

disabled post April 1974 are not over-much financially disadvantaged at least, while often those acquiring their disability before that date remain in penury.

Other analyses and summaries of the scheme have been provided by Palmer (1979), Kronick, Vosburgh, & Vosburgh (1981), Bolt & Heggie (1982), and by Mitchell, (1983).

3.3 Non-accident Social Welfare Benefits.

In contrast with practice in Australia where the precise nature of assistance given is left to the discretion of the relevant minister, the welfare assistance and other provisions given by the New Zealand government are specifically defined in the Disabled Persons Community Welfare Act of 1975. This act also specifies the existence and function of the Advisory Council for the Community Welfare of Disabled Persons. Several amendments to the act enable provision of suspensory loans for the purchase of motor vehicles and grants for home modifications.

The direct financial entitlements of a qualifying disabled person (excluding those who are covered by the ACC) are almost directly comparable with those of Australia in exchange adjusted values. The basic Social Security Benefit is the Invalids Benefit received by approximately 20,000 persons. There is also a disability allowance to assist with the cost of accommodation.

A range of minor concessions such as telephone rental, television fees, local bodies rates and travel are also available through the Department of Social Security.

For those engaged in vocational training and placement processes a rehabilitation allowance is available. A further allowance of the same order is available for travel to and from a place of employment. This is not means tested. Financial assistance can also be given towards the fitting of special controls in a vehicle to be driven by a disabled person and for the person and their attendant to visit a driver assessment centre. Travel for other assessment purposes can also be financed.

Some provision is available from Social Welfare for respite care for up to four weeks in any one year. In 1984 the provision was $NZ2,134,00 in respect to 9713 applications.

3.4 Government finance and the voluntary welfare agencies

New Zealand tends to be more like an Australian state in that there are usually a small number of large organizations within any one state that are almost all pervasive for that state. For New Zealand this appears to be most convenient as territorial boundaries and distributive criteria for financing are relatively clear and uncomplicated. Major participants in the New Zealand Social Welfare funding distribution are the New Zealand Society for the Intellectually Handicapped, the Rehabilitation League New

Zealand (Inc), and the New Zealand# Crippled Children Society.

These three organizations between them received just over 60% of that expended by the Department of Social Welfare under its Rehabilitation Programme in 1984 from a total allocation of $NZ26,463,000. There were 52 other organizations which received grants of over $NZ10,00 in 1984. The total expenditure by the Department of Social Welfare for rehabilitation and welfare of disabled people in 1984 was $NZ35.876,000.

In marked contrast with Australia the New Zealand disability welfare scene is the relatively low profile or absence of religious organizations as providers. Why this should be so is unknown and no informants could be found who could offer an explanation.

3.5 Service statistics

For a country of its population size New Zealand provides and amazing variety and multiplicity of services for the disabled. Precise and up-to-date figures are hard to determine because of problems of findihg the right information sources, classification difficulties and other data issues. (For the classification reason it is also difficult and perhaps hazardous to attempt to draw comparisons with other countries such as Australia.) The following figures for special educational services were derived from Bolt & Heggie (1982):

Table 1

Number of younger disabled persons served by special education facilities.

	Special Schools	Clinics or Special	Number served
Visually Handicapped Pupils	1	4	482
Hearing Handicapped pupils	2	64	760
Speech Handicapped Pupils		124	4949
Hospitalized Children	15	50	1501
Backward Children	6	344	3921
Intellectually Handicapped Children	49	29	2061
Maladjusted Children	23	34	1028
Guidance Services			8866
Correspondence School provisions for Handicapped Pupils			769
Sheltered Workshops	91		----
Adult Activity Centres	10		----
Homes for Disabled Persons provided by Voluntary Organizations			
Capacity 5	34		----
Capacity 5	129		----

3.6 Rehabilitation Policy

A criticism was leveled at New Zealand's rehabilitation policy by Pirie (1979) that there was no rehabilitation policy for the handicapped. The policy problem will be examined further in the discussion section.

According to the Chee & Henderson (1985) report produced for the DPA, "New Zealand's present Social Security system reflects the ad hoc approach of past social security legislation." (This statement could apply equally well to Australia!) Their report identified a number of anomalies arising from the fact that benefits are based on status criteria and not on needs. A chief anomaly is the discrepancy between ACC payments and those unlucky enough not to be covered by ACC provisions. (An unmarried individual under ACC provisions is at least 200% better off than under Social Welfare and may receive up to 90% of a previous average gross weekly earnings to $NZ700 per week. In comparison a recipient of basic Social Security Benefits is limited to $130.) Other anomalies arise from gender, marital status (As in Australia) and administration.

4. Government agencies and the structure of services

On the next page is presented a diagram of the New Zealand welfare service system developed by Janet E. Gregory, PhD. and Pat Cunniffe M.A. as drawn by Alan Timms of the NZDRC.

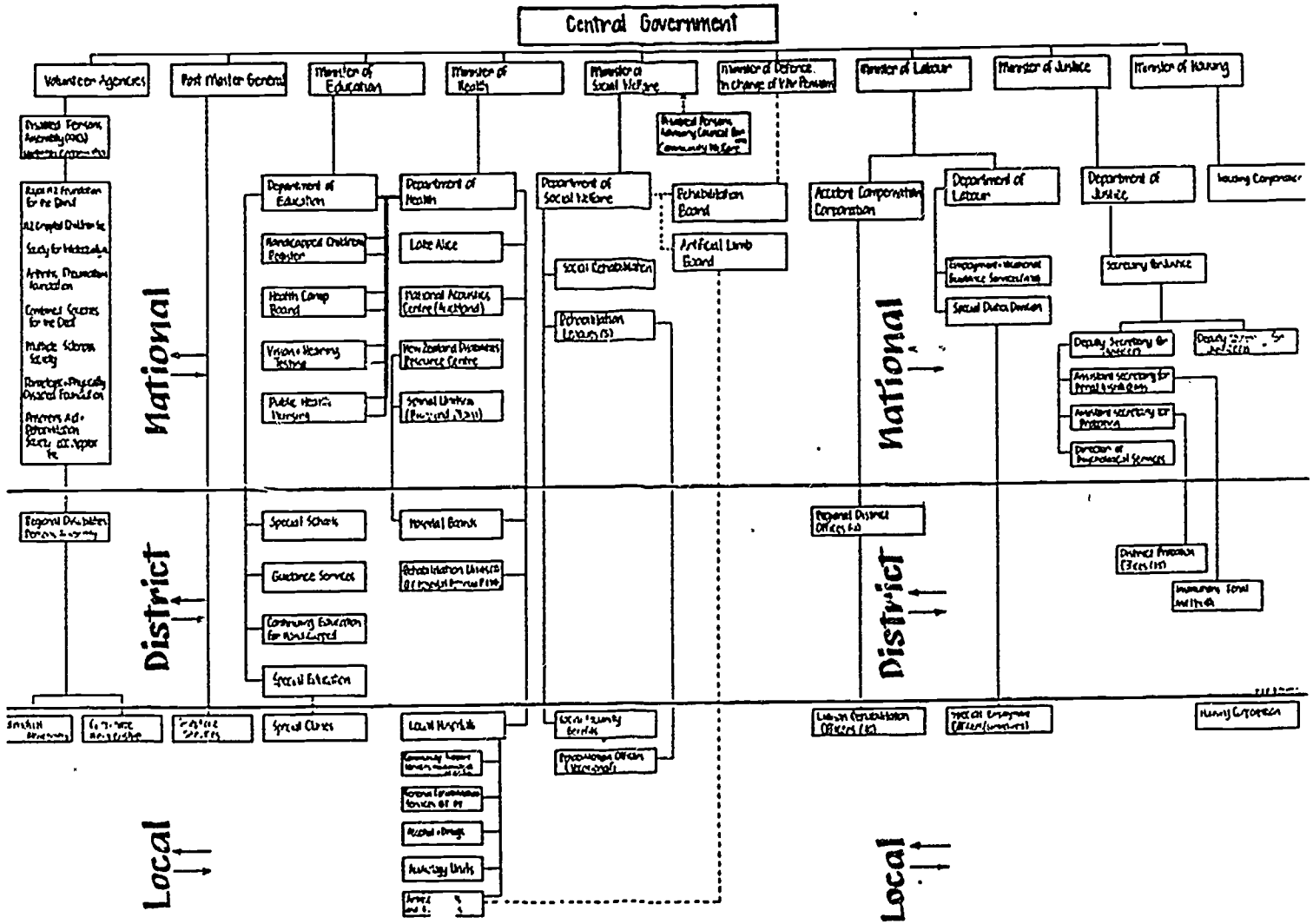

Fig. 1

4.1 Advisory Council for the Community Welfare of Disabled Persons

The ACCWDP was established in 1976 under the specific provisions of the New Zealand Disabled Persons Community Welfare Act of 1976 and makes recommendations to the Minister of Social Welfare. Although it is a smaller board than the Disability Advisory Council of Australia, with a different constitution it appears to cover much the same range of tasks and issues. The council, in addition to its chairman has five "official" government members and six "private" members. Further details on the council and its activities are given in Appendix II.

4.2 Artificial Limb Board

This was set up during World War II to service the needs of injured servicemen. Its services have since been extended to the general population and its function appears to be very similar to the Australian service provided by the Department of Veteran's Affairs.

4.3 Hospital Boards

The Department of Health in a 1975 report to Parliament was able to claim that hospital boards within New Zealand provided the majority of rehabilitation services in the health field (Bolt & Heggie, 1982). Hospital boards in New Zealand are autonomous authorities but are dependent on Government finance. Problems exist in that there is considerable variation in the type and nature of rehabilitation provided between hospital areas reflecting difference in policy, staffing, general approach, and integration with services provided by other agencies. Actual provisions range from the minimal (an occupational therapy service provided by the Hamilton public hospital) consistent with a generic service philosophy where reliance is placed on the community, home service, and other agencies, to the large unit at Palmerston North hospital.

4.4 The New Zealand Disability Resource Centre

The New Zealand Disability Resource Centre has now been some twelve years in formation and development and its purpose is to provide a national source of information and expertise in matters relating to equipment and environmental requirements of disabled persons. Presently the DRC is located in Palmerston North under the auspices of the Palmerston North area Hospital Board. It services needs within its scope for disabled people of New Zealand, and, on occasions, disabled people in adjacent countries such as Australia. Currently its range of services includes the provision of individualized form-fitting seating by the use of a unique vacuum forming process, wheelchair accessories, and various control devices for adapting motor vehicles for disabled

drivers. It also provides production-ready designs for a range of devices including model wheelchairs for children which includes electrically propelled and riser versions. Some of its designs are now internationally franchised for commercial production. The NZDRC prides itself on the excellence of its design solutions and the standard of its service. The centre employees a full industrial design team complemented by an extensive and well equipped and well staffed engineering workshop. Modifications are carried out on equipment, work places and such for individual client needs as required.

The NZDRC also serves as an abilities assessment centre for disabled drivers. Adaptations are also made for a variety of client needs. The NZDRC does product testing on commercially available aids and device components, and administers a number of ancillary services including Mobility Inc. (A Maxi-taxi service for disabled people in the Palmerston North area) and the Disability Information Centre.) Each year some expansion of service is undertaken as further resources become available.

The unit is independently located in an industrial building on the outskirts of Palmerston North and has the aspect of an industrial corporation. It is administered as an industrial services organization and presents a standard of appearance congruent with the good face forward business world. The agency sees itself as playing a major role in the establishment of a rehabilitation engineering industry in New Zealand. A number of its standard products are marketed under the registered trade name of Sedo and licenses to New Zealand and overseas organizations have been issued to allow manufacture of such items. In terms of industrial development the NZDRC has a proven and impressive track record.

4.4 Rehabilitation League NZ (Inc)

The Rehabilitation League NZ (Inc) provides the nearest equivalent in New Zealand to the Commonwealth Rehabilitation Centres in Australia. It is an incorporated society funded by government and its brief is to carry out various programmes of vocational assessment, training, counselling and placement of persons having difficulty in finding employment as a result of recent illness or sustained disability. The Rehabilitation League operates five rehabilitation centres in New Zealand, all of these except one (in Napier) being in principle cities. In addition to the centres the Rehabilitation League has Rehabilitation Officers located in most of the main hospitals.(The exceptions arise from the existence of rehabilitation units attached to a hospital) Rehabilitation League also operates two subsidiary work adjustment units, in Auckland and in Christchurch. Originally established in 1930 to offer some alleviation to the problem of remaining physically disabled World War One veterans its functions were expanded, and eventually shifted, to the civilian sector of the disabled population in the 1950s. The centres are in general somewhat smaller than counterparts in Australia. The Rehabilitation League is controlled by a Board of Management that is made up of representatives from non-governmental sectors as well as from

cognate government departments. Its character is thus non-civil service.

A Progeni New Zealand's "POLY II" educational computer system has recently been installed to provide an unique automatic assessment and remedial education process for individual clients. The VALPAR work sample test battery is also used extensively for assessment of manual dexterity and cognitive ability for small assembly tasks.

Although the Rehabilitation League has not been without some criticism as noted by Stuart (1985) their results for 1984 as reported in the Rehabilitation League Annual Report and Balance Sheet for the year of 1985 is impressive as they report a full employment placement of just over 20% of all referred (346/1691). A further 64 persons were placed in sheltered employment in the same year.

5. Large volunteer welfare organizations

5.1 New Zealand Society for the Intellectually Handicapped

This Society is by far the largest welfare organization for disabled people in New Zealand with an annual budget flow of around $NZ50 million. It operates a large number of centres and facilities. Its Palmerston North facilities includes several sheltered workshops, a training unit, a hostel, a number of houses and a flat. At Palmerston North, workshop production was mainly packaging contract work and the production of stuffed toys. The Marlett Adaptive Function Index was used for assessment but a large variability in scores was claimed to have been found and there was some questioning of the meaningfulness of some item scores. At the Cook Street Training Centre the term "phase" was used as a categorization label for trainee level. Phase I trainees were on a token-economy schedule where rewards were given for on-task performances. The programme takes trainees up to Phase III. One group home was visited (shared with ex-psychopedic patients a on one-for--one basis, a historic deal by IHC in order to get funding).

The industrial workshop at Aokautere is located about eight kilometers from town and adjacent to a 16 place residential unit. Both are facilities of NZSIH but only some of the residents work at the sheltered workshop. The majority of the trainees travel to the workshop on a bus provided by special arrangement with the local transport authority. At present around 55 trainees attend but the number is to be increased in the near future.

The workshop's central activity is heavy-duty rough woodwork: industrial pallets, crates, survey pegs and so on. A variety of horticulture and agriculture actives are also carried out. Propagation and growing of nut-bearing trees for sale seemed to be a particularly promising line. It seemed to this observer that the range of activities was perhaps too diverse to be profitably efficient. While each line of activity helps to give variety for trainees and may bring in small profits, long run economic viability usually can only be had by production of large

volumes of a small range of compatible lines. A principle problem that seems apparent, and one that befalls most sheltered workshops, is that the system gets caught between the demands of training programs and those of production and it may be that effective placement of trainees into open employment may be inhibited by poor social and independent living skills.

5.2 Crippled Childrens Society

The New Zealand Crippled Children Society was founded in 1935 and now has 27 branches and a large number of sub-branches. This is an outstanding spread for a service of its kind with a major branch for every 125,000 population. As an organization each branch runs with a high degree of autonomy. For an example of its services and activities the following description will be confined to one particular area branch, that of the Manawatu district.

The Manawatu Branch of NZCCS, with its four sub-branches provides services for some 500 people in the district. It operates from an administrative centre in Palmerston North in which an activity center is also found. This centre is small and relatively new. Its activities programme offers the traditional craftwork, and some minor contract work. The centre also performs functions of a secretariate for the local DPA branch (Manawatu Branch). Of interest was a Videotex terminal providing a link between major disability organizations including the social welfare department as well as general disability information. The office also coordinates Total Mobility for the area. One important function is that provided by three field officers who attend the home-bound disabled in the Manawatu. These officers arrange and coordinate various activities and services as well as organize parent support and parent support groups. About 30% of its operating revenue comes from government subsidies, the rest coming from a combination of subscriptions, donations, bequests, trust funds, an annual appeal (30%), and other sundry sources.

The branch has also recently completed a respite care home with the support of government subsidy, contributions from local business houses, and by a community "buy a brick" campaign.

6. Some smaller agencies

6.1 Manawatu Enterprises (Inc) Workshop, Palmerston North

Typical of many sheltered workshop to be found in Australia as well as in NZ, Manawatu Enterprises is housed in a large, rented, industrial building. Industrial laws in NZ specify the number of personnel that can work in a given sized area and the present accommodation limits the trainees plus staff to its present 36. The present facility carries out various contract tasks such as industrial sewing. At the time of the author's visit it had a large contract to supply Girl-Guide uniforms. Other contracts

include winding of electrical insulation tapes, and the winding and termination of toroids. The workshop has a comprehensive collection of woodworking machinery but lack of space appeared to be interfering with efficient production. Trainees are received from a large number of sources but the "organization of last resort" syndrome was clearly apparent and this was acknowledged by the staff with some resignation. Most of the problems typical for most sheltered workshops were present here, e.g., impoverished funding and consequently poor quality environment, poor space, poor amenities, poor office facilities and support. Due to pressure to maintain production and fragmented and unpredictable contract flow output was disorganized. One thing the organization was high on was enthusiasm. It was well recognized that the whole rationale of operation and the organization# needs to be thought through.

6.2 Ryder-Cheshire Homes

The Ryder-Cheshire Foundation is a small organization which, at present, has one residential complex in operation. This is located in a high status area of Palmerston North and provides accommodation for about twenty people. It is designed for moderately physically disabled people who are medically stable and where at least some attendant care is required. The complex is comprised of a number of bungalow-type living units interconnected with covered ways. The architecture is contemporary and appropriate and allows each unit to have maximum privacy and independence while retaining communication and facilitation of attendant care staff. A central kitchen unit and a recreation hall is included in the complex. The setting was congruent with the middle-class residential environment and would probably not be noticed as a specialized accommodation facility but for a "Disabled People Crossing" sign on approaching along the street. It is notable that the unit for the manager is not readily distinguishable from any other part of the complex. Residents spoken to by the author appeared pleased with the arrangements but an ex-resident met elsewhere was more critical of "the intrusion on independence." In general this unit was an impressive example of avant-garde facilities for disabled people, one that reinforces New Zealand's reputation for humanitarianism and progressiveness in social welfare. Unfortunately, while there are many independent housing systems for intellectually disabled people there appears to be a dearth of good facilities for people in the category of the present residents of this complex.

7. Professional alliances

7.1 Rehabilitation Association

The New Zealand Rehabilitation Association is an alliance of a number of individuals and organizations, principally from the medical and primary rehabilitation field, for the purpose of considering and undertaking coordinated actions to benefit

rehabilitation processes. The organization appears to have adopted a low profile.

8. Advocacy in New Zealand

As part of the growing concern for human rights in many parts of the world people who believe that they have been disadvantaged and prevented from enjoying the fruits of civilization have become more vocal and assertive as to their needs. This perhaps reflects the spread of the idea of human equality that pervades the idealism of much of the twentieth century literature. Equality is a central concept of democratic ideology. It is an old ideal, but its force has been growing to spread, at least in the so-called 'democratic' states, successively from rights of political and religious liberty, freedom from class and racial prejudice, votes for women, and now to the rights of minor disadvantaged groups and individuals such as people with disabilities to have their needs met. In England and its dominions this demand has been met by the liberal-democratic principle of the provision of that hopeful condition called "equality of opportunity." This is a vague prescription that all, in principle, have the same chance to achieve their just share in whatever there is to be shared made with the perhaps smug knowledge that in a capitalistic society most rewards will be shared by those who have the position, ability, and merit from personal achievement.

According to Cleveland (1979) "The genesis of the welfare state lies in a very simple proposition. The happiness of one is the happiness of all." It seems more probable that the welfare state such as is found in New Zealand arises from the tension between this liberal-democratic principle which admits that welfare provisions must be made for all needy citizens provided rein is kept to ensure that these are minimal, and the pressure from those who see it as their right to receive the ever extending range of benefits that can be had from the state. Notwithstanding socialist rhetoric, the welfare state in New Zealand has advanced steadily, somewhat independently of its brand of government at any period, except, perhaps, for the burst of legislative activity in the late 30s associated with the installation of the first labour government. This period, however, coincides with a rise in the economic circumstances of the country and the foundation of a number of welfare organizations. In regard to welfare for the disabled the Zeitgiest was on the move in many countries including Australia. New Zealand is not independent of social developments elsewhere.

The sixties on saw the rapid growth of the welfare organization, charitable, or government, or semi-government, spurred on by the growing handouts from the welfare budget, which in turn, was spurred on by the increasing demands an increasing political muscle of what was now becoming the "welfare industry." Initially, all this was good stuff for the disabled and their kin who, in remembrance of the previous dearth of assistance, were only too grateful for services received As in Australia, the service organizations main recipients tended to be children and

adolescents for many of the older people with disabilities remained under the carpet where they had been swept by society years before.

The seventies saw the emergence of a new breed of disabled person. These were the growing population of people who, through vocational, leisure, or transportation missadventure, had become disabled. For the most part, earlier disabled welfare organization were for the congenitally disabled or those suffering the effects of disease in early childhood. Whereas disabled children, and their parents, tended to remain meek and compliant to the direction of the organization, the new wave of disabled person were inclined to be much less so. These were people who had experience of being able bodied and independent and who did not take kindly to being treated as captives of the care process and as pawns in the growing power game of the rehabilitation and welfare service industry. These were the people who were motivated to form their own organizations where, in theory, the power was now in their own hands. Initially the organizations formed tended to be centered around activities not then formally catered for by the existing organizations, social clubs, sport and the like which were no threat to the traditional organizations. The initiative shown by these adventitiously disabled people, who only wanted to get on with the reestablishment of their own lives in the acquired circumstances of being disabled, formed the basis for the disabled self-advocacy movement.

A second component of the self-advocacy movement was formed from former clients of disabled childrens welfare organization who were now adults. For them self-assertiveness was somewhat a new thing and thus assumed with some trepidation as a consequence of submissive cringes acquired from long institutionalization. From yet another direction came those who, although being disabled from birth or early life, had to managed survive and perhaps flourish independently of substantial institutional involvement. While each person joins the self-advocacy movement with their own list of agendas which are usually fairly obvious the motives for involvement of the last mentioned group remain less so, especially for those who have managed to overcome most of life's hassles their own way. These people, besides forming their own organizations, became active by endeavouring to get involved in the affairs of the older organizations. While there was some welcome from the disability organization hegemony, it was more patronizing than accepting. A common experience was that opinions were politely listened to then ignored. While it was acceptable for people with disabilities to be seen at meetings, their advice was not particularly so, especially if it contradicted the wisdom of professional experience!

8.1 Disabled Persons Assembly New Zealand (Inc)

A particular instance of this patronizing devaluation was apparently experienced by a number of disabled people at the 1980 conference of Rehabilitation International where the dissatisfaction was signalled by a walkout. A conference for

disabled people only was organized by those involved in the walkout and this was held in Singapore in 1981. This conference coincided with the International Year of the Disabled Person and it was at this conference Disabled People's International was formed. DPI is now represented in many countries. Whereas in other countries such as Australia national branches of DPI were formed as separate and new entities in New Zealand Disabled Persons Assembly (New Zealand) Inc., the local arm of DPI, was formed from a merger between Rehabilitation International New Zealand and the New Zealand Council for the Disabled and held its first National Assembly in 1983. Rehabilitation International New Zealand was formed in 1980 as a standing committee of the Rehabilitation League (N.Z.) Inc from organizations both statutory and voluntary which worked with disabled people. RINZ was thus largely made up of persons who worked for disabled people rather than of persons who were disabled themselves. The major function of RINZ was to maintain international links, in particular, with Rehabilitation International, a world umbrella organization representing the rehabilitation industry. RINZ was also charged with planning and managing the 1981 IYDP activities in New Zealand.

DPA now has around two thousand individual members and 400 corporate members (although many of the latter are local units of the same corporation, e.g. NZSIH or CCS). DPA has a strong integrative function and enjoys a major position in disability affairs. DPA operates largely by interest made from investment of capital obtained from the 81 telethon and from government grants of around $80,000 p.a. DPA was given the telethon funds expressly to implement and administer certain programmes (Teletext & Total Mobility) but meanwhile makes use of interest. Funds obtained from investments and grants are not sufficient to fully# support operations, however, and drawdown on the invested principle is depleting this principle.

8.2 Example of a DPA Regional Committee and its activities

The Palmerston North branch of Disabled Persons Assembly is one of the most active in NZ. It has many active and well informed members. PNDPA is aggressive and appears to produce good results. It is involved with administration of Total Mobility in the Manawatu district and provides local updating of Teletext and Videotex disability information services. Typical of the open philosophy that appears to now characterize many New Zealand organizations all meetings are open. Any interested person may attend a meeting of the local executive and may contribute, with the permission of the chair.

Recent activities included a seminar and car rally for disabled drivers (Organized in conjunction with the NZDRC) and the organization of "wheelchair around town" day for Department of Labour vocational and rehabilitation officers taking part in a training programme to sensitize these officers in the problems of being disabled.

8.3 Total Mobility

Total Mobility is a project instituted by DPA to increase mobility options for all disabled people in most urban areas of New Zealand. From monies raised from a Telethon in 1981 and from a variety of other sources maxi taxi's have been placed in taxi fleets in most of the major population centres. Each maxi taxi is fitted with a hoist for a wheel chair and may seat up to seven people. To date over 60 maxi taxi vehicles are in service. Each unit is owned by taxi companies who use the unit for general hire when not required by a disabled person.

In most areas a voucher system has been introduced for disabled users whereby discounts of up to 50% may be obtained on the cost of a trip. In many areas this subsidy is provided by the local public transport authority.

The terms of the scheme are that the maxi taxi be available 24 hours a day, seven days a week for any disabled person who needs transport. In practice the availability is somewhat less than that as it depends on the availability of a driver who has been specially trained to handle lifting and transfer problems.

8.4 Fourth National Assembly of DPA

The 4th National Assembly of DPA held at Christchurch was illustrative of the style and status achieved by this organization. Speakers included the Minister for Social Welfare, the opposition shadow minister, and several other politicians. The two-day meeting was attended by several hundred people representing both disabled people's organizations and the disability industry and government services. Matters of concern were income maintenance, additional costs of disability, attendant care, accommodation, disabled advocacy, coordination of services, and prevention. Thirtyfive resolutions were considered by the meeting and most were passed. Other matters dealt with included reports from portfolio holders.

9. Discussion

One may be asked "what's doing for disabled people in New Zealand?" The answer, in short, is " A lot!." Yet it remains that there is still much that needs to be done. New Zealand has a reputation for its advanced attitude towards social welfare and, for a country the size of a medium sized Australian state the number a variety of services, volunteer agencies and specialist service bodies is impressive. However this comes at the cost of multiplicity, complexity and some confusion. Notwithstanding all this, summing up over the five month experience of viewing, listening, and discussing this author had the feeling that New Zealand is close to getting everything together as far as welfare and rehabilitation for people with disabilities is concerned. At least, much closer than is Australia.

In reality getting everything together may prove difficult there are still many problems and many grey areas to be resolved. At the national level rehabilitation policy, and more generally, social policy, is still lacking for the disabled in spite of the intervening years since this claim was made by Pirie (1977). More recently it was stated that "no recent record of any clear and comprehensive philosophy, overall policy or principles specifically covering the development of rehabilitation in New Zealand" has been found by the writers and that "the total structure of rehabilitation effort has tended to grow 'like topsy'"(Bolt & Heggie, 1982). While the report goes on to note a number of ideas and concepts that have been floated by various people in recent years the authors stay shy of the daunting problem of enunciating comprehensive policy proposals. The New Zealand government is, however, attempting to tackle the problem with the recently instituted Royal Commission on Social Policy. It is seen as being a "forum for a significant re-think" as a means of solving the "jigsaw" of problems in the area of social policy (Lange, 1986).

9.1 Approach to understanding policy issues

Understanding social welfare policy in the United States has been described by Howards et al (1980) as a frightening task. The generality of this statement remains true for most of the advanced social welfare nations. The statement also remains general for welfare systems themselves for such systems reflect the misunderstandings, unidentified disagreement, and general confusion among planners who govern and manipulate the structures of those systems as to the nature of the policies they espouse to be implementing. Even more confused are those who stand outside the intrinsic structure of the social welfare system, and this includes most of the target recipients of welfare, for it is rare that outsiders are privy to discussions of policy or are told, even, what they might be.

At least part of the confusion arises from differences in fundamental ideologies, or values, that underlie welfare motives. While most of us will express some belief that human beings in dire need should be helped in some way the extent and nature of

that help, if we are to explicitly justify it, requires a statement of why we should or should not act, a statement of policy in fact. Policy is derived from a ideological position which may be coherent or otherwise. When many people attempt to make policies the collectively derived ideological basis of these policies is more likely to be incoherent than coherent. Determinations and interpretations are made thereof by individuals with their own individual ideology, and will therefore tend likewise. In the field of rehabilitation, policy is at least as incoherent as anywhere else, a fact that is attested by the confusions, discrepancies and conflicts that exist in any major national rehabilitation programme.

There are four fundamental issues to be solved by social welfare ideology. These are, why we should provide assistance, what we should provide, when we should provide it, and how it should be provided. Each chains on to the other successively. Why we should provide welfare relates to cultural, religious, or humanistic values which are difficult to access and are beyond discussion here. Pragmatic economic determinants may also figure in the base rationale. The answer we may give to why determines what matters we see as social welfare ones and adds the imperative for seeking solutions. The answer to what brings in reference to a needs hierarchy based on what we regard to be acceptable as a minimum level to be achieved by a welfare recipient.

The conditional when is set by how we attribute blame for a social welfare problem and what we see as being our rights and responsibilities in intervention. For example, alcoholism historically has been perceived by western culture as self abuse and, as a social pathology, has been treated by punitive sanctions placed on the individual. Recently, however, alcoholism has become accepted as a disease entity. The alcoholic individual is thus now seen as a victim of circumstances and as worthy of the receipt of social rehabilitative measures rather than as a person of moral turpitude to be shunned or punished. It remains for New Zealand to examine these four questions in terms of its own values, resources and aspirations.

9.2 Policy issues

One of the most fundamental issues for any social welfare oriented government today is to resolve the conflict between the desire to improve the quality of life of those who suffer distinct socio-economic disadvantages because of circumstances beyond their control and the rapidly growing costs of social welfare. This especially applies to disabled people as a class because not only is this proportion of the population on the increase but the costs of services required are growing. The growing militancy of disabled people themselves adds further to the woe of any government which might seek to ignore the problem. The usual response of governments to the pressures that go both ways is what Rein (1974) terms "disjoint incrementalism," small discrete steps in policy in the welfare direction which least offend hard liners and allow eventual accommodation to the new stance as a political norm. While these are traditional political

ways of change, it is slow and somewhat haphazard, as the phrase suggests. Disjoint incrementalism is also likely to produce change fast enough to meet the rate of change in the contemporary need situation. The Accident Compensation Scheme has made social welfare look dowdy, as Rea (1982) has pointed out, and it has created two categories amongst disabled, the haves and the have-nots. While the haves, in general, have the monetary resources to solve many of the problems created by their disability, the have-nots must rely on the complex system of handouts, dispensations and services provided by government and voluntary welfare agencies. This is not to decry this welfare as such, however it does come at considerable cost, both in dignity, frustration and confusion to the disabled person who is forced to rely on this welfare and in terms of money and people-power taken up in supporting the necessary array of organizations and services. An alternative might well be for the government to 'bite the bullet' and dispense with "disjoint incrementalism". That is, to immediately lift the have-nots to the same income and compensation level as the haves on ACC payments; to provide an equitable standard of income (although this concept has its difficulties) and some form of additional adjustment for the costs created specifically by the disability. It is beyond the scope of this report to discuss the ultimate national costs but obviously there would be many offsets with reduction in need to support the present complex web of support services. Such a policy shift, and implementation would also, of course, create considerable upset in the disability industry, a matter, this author fears, is not without political boot.

9.3 Policy generation

Disabled people, in the past have never been organized enough to be in a position to state their needs and ask that these be considered in terms of social welfare. In the past any new legislative action tended to have been due to the existence of individuals of conviction and power who saw a need and who seized the opportunity to push an appropriate measure through a parliament. This process is slow and haphazard as needs tend to have to wait for that individual to appear along with the convenient legislative opportunity. Pressure for change came indirectly through power-broke politicians or through organizations. The flavour of legislation thus tended to accord more with the beliefs and philosophy of political systems of the time, the ascendant politicians, and/or the mores, beliefs and myths about disability held by the voting public rather than on consumers needs. The growth of the voluntary welfare sector since the 50s added a new element into the picture, a powerful "welfare industry" with a voice. While legislators appear to have taken some cognizance of the welfare sector opinions on occasions, no direct voice of the disabled consumer was to be heard.

With the rise in disabled person organization like DPA, and Disabled Peoples International, Australia, the situation changed again. Governments are being pressed to deliver more than tacit services and numbers based programmes. Specific and positive consumer outcomes are being pursued. For the disabled consumer legislative advances that depend on slow response political

processes and the rare, enlightened minister to sponsor these was not good enough. What is being currently demanded are programmes that deliver the goods, and legislation which will enable such programmes. Governmental response to these demands is uncertain. Noises are being made but it remains to be seen as to what way the political system will finally accommodate to pressure from disabled advocacy.

To complicate matters further, until comparatively recently the public servant had more concern about the mechanics of legislation and its subsequent implimentation than about social issues addressed by such legislation. There are now a number of public servants in the upper levels of the civil service, particularly in Australia, who have some background in the disability area, either through training programmes or through direct experience, and a few who have considerable expertise. Whereas previously public servants tended to act in a perfunctory way when carrying out welfare operations the contemporary tends to be more involved as a specialist in the area of concern. They have more involvement, and often an extended professional interest in the matter. Not only do these individuals help determine the complex organizational infrastructure of a service and the mechanisms of programmes, but they may influence future legislative directions. As government directed programmes become larger and more organized and develop agendas congruent with the needs of that programme and its personnel, they are likely to become more resistant to attempts by consumer bodies to have a say over their heads on the development of new legislation and new government programmes.

While in NZ, DPA appears to have captured the government's ear, it will need to be cognizant of the fact of considerable sophistication on disability matters within the public service and of the many complexities and considerations that now govern welfare service implementation. While many barriers to disabled persons have been overcome by appropriate advocacy, the barrier of an empowered public service officer annoyed by what she or he sees as uninformed demands by disabled pressure groups may be ultimately much more difficult to remove.

9.4 Non-policy issues

One of the more obvious problems in NZ's welfare provision system is incoordination between different parts of the overall programme, particularly between the different parts which are administered by different departments. In some cases conflict arises because of differing departmental briefs and their allegiances to a responsible minister. For example, the NZDRC has been placed under the care of a local hospital board. The NZDRC's function of servicing client needs on a nation-wide basis, many of whom have no clinical conditions, sits uneasily with a board whose concerns are focused on servicing the medical needs of a defined local area. The verticalized structure of administration often means, typically of governmental structures, that no direct link between conjoint services can be established, or, at least, not on a formal basis. While considerable networking clearly exists between various agencies at local levels, these appear to

be sometimes tenuous and remarks about frustrations experienced were noted by this author. The recent appointment of a departmental under-secretary under the Minister of Social Welfare to facilitate inter-departmental coordination may do much to improve matters.

There is also considerable cross-purpose action among agencies and organizations in the voluntary sector. No easy solution is apparent there, although some improvement may be achieved though the actions of the Rehabilitation Association, the Federation of Voluntary Welfare Organizations, and the DPA. These three organizations do not, however, constitute a full cover of all agencies and may not be sufficient devices. There is still poor community communication of information as to systems and services available and new organizations tend to spring up on the assumption that no one else is doing anything about a particular problem. Conflict may occur between the new organization trying to stir the pot and organizations which may have been working steadily in the face of complex issues to affect the changes desired by all.

Apart from the problem of incoordination, overlap, and the difficulty of achieving informed community communication, a number of gray areas are apparent. Consumer advocacy by the intellectually handicapped seems still nascent rather than in lusty development. Psychiatric disablement still produces long faces when mentioned in physically disabled circles, and disability discussions seem very much to be concerned only with pakeha type problems. That is, special needs of disabled Maori people appear not to be known or discussed. Perhaps the hosting of the 1987 National Assembly of DPA by the Maori community of Rotorua may be the watershed required.

Issues of current concern include that of income maintenance, attendant care, accommodation, employment and access. While some income maintenance provisions are generous by Australian standards, especially for those fortunate enough to be covered by the Accident Compensation Act, an argument is being formulated for a level that is more appropriate to contemporary standards and conditions. As in Australia it will be argued that compensation should be available for the extra costs of being disabled over and above that given for expenses of living. There are problems in establishing a rational basis for setting an income standard and moral and philosophical principles for such extended welfare remain hazy.

9.5 Professional issues

As yet, no full training course for rehabilitation professionals exists in New Zealand. An extension of the Massey University courses taught by the Department of Psychology to a full professional training programme has been mooted but appears to be some way down the track. There is still much to be done in the design of adequate training programmes and sub-courses for rehabilitation professionals, both as primary and as in-service devices. There are paradigms from other countries, notably the U.S.A., but there are very distinct differences in ideas, philosophies of approach, service orientations and background

preparation of students. Other problems that will need much thought, in particular for programmes for psychologists, is that the role of the psychologists in many applications is undergoing change. Traditional vocational guidance and selection, for example, become invalid in the face of narrow client job opportunity aperture and the decline in the imperative of the work ethic. As one New Zealand rehabilitation professional would put it, it is no longer a social stigma to be not working and to be supported by ACC compensation!

For the professional the concepts of rehabilitation and habilitation are under the microscope (See paper in preparation, Appendix III.). Although it can be argued that the basic skills of a psychologist remain much the same, new approaches such as trans-disciplinary teams have made many of these old skills unuseful and demand acquisition of newer skills. The psychologist's role is tending away from face-to-face testing and towards the design and management of programmes, and the evaluation of client-centred programme outcomes. Definition of the skills required of a rehabilitation psychologist remains difficult and the content of training programmes remains contentious .

9.6 Issues for Australia

Extrapolation from one country to another for the purposes of drawing social and welfare policy conclusions has always been a hazardous business. In spite of the seeming similarity between Australia and New Zealand, and the history of borrowing of social welfare ideas both ways, there are distinct contemporary differences between the two countries that have increased the hazard. However, there are some salient examples Australia might well draw upon, one of these being, of course the Accident Compensation Scheme. The Northern Territory has already implemented a version and several states are contemplating the system. The problems of the present torts system of compensation are too well known to repeat here

One feature of the New Zealand delivery system that is attractive is the Disability Resource Centre. The absence of a similar facility in Australia prompts the question of "why not?" Several rehabilitation engineering units are now operating in Australia (One in Perth and one in Sydney), but there is as yet no programme to offer a range of services that parallels those of the NZDRC. Specifically lacking is the facility to develop aids beyond the one-up approach of the present Australian rehabilitation units which must operate on a client by client basis. Also missing locally is the facility for product testing. The need for at least one NZDRC in Australia is perhaps demonstrated by the numerous requests received by the NZDRC from Australia for its services. A more complete discussion of the issues involved is presented in Appendix IV.

The Total Mobility system is another feature in New Zealand worthy of consideration for emulation in Australia. The present patchwork of solutions and non-solutions to be seen across Australian states leaves plenty of room for the implementation of

a similar scheme on a national basis.

Disabled people need information to enable them to find the many things they need to make life equitable. It is on this assumption that many information services have been created in recent years. Implementation of such services has been assisted by recent technological advances including Teletext and Videotex. (Teletex is a system of information provided by some television stations during the blanking period in picture transmission and is displayed on the users TV receiver and Videotex is a telephone linked computer-type display provided to paying subscribers.) Both systems are used in New Zealand by special disability information services. While the videotex system does have some enthusiasts, chiefly it seems, among the disability organizations who use it as an interagency message and update system, it appears not to have taken off elsewhere. Teletext is administered valiantly by the DPA but, for various reasons the number of users remains low. The message for Australia is clear, teletext and videotex are not ways to go here, at least, not until many of the problems associated with this type of technology are solved (See Newsome, 1985).

9.7 Final Comments

Looking back through what has been written so far many omissions have been noted. Possibly some of these are grievous ones. This author takes some comfort in knowing that in this era of word processors it is easily possible to make alterations and additions to a manuscript. Thus, it is probably inevitable that further versions of this report will be forthcoming as further material comes to hand, and views on issues change. At some point though one must say 'that is it'. This present report is 'it' as a statement at about mid 1986.

In a way a description of a social welfare system can never be finished as, even with a small country not all the information is available and very few elements of the scene remain constant. Already there is a promise of change in the New Zealand scene with several governmental enquiries in progress and the Royal Commission on Social Policy about to be instituted, although, Kerse (1986) has suggested that there is a danger of "Repetitive Consultative Numbness" setting in. However, the New Zealand government has already given indications of its willingness to change thinking about roles, responsibilities, methods and processes in respect to community development and preventive programmes (Lange, 1986). More specifically the announcement of the creation of and under-secretary on disability to be responsible to the Minister for Social Welfare (Hercus,1986) do much to meet concerns about lack of co-ordination of services, particularly those provided by the government (Munro, 1986). The present writer however is somewhat sceptical of the chances of any real improvement between different departments while attempts to promote co-ordination remain at a ministerial level as departments responsible to other ministers are generally reluctant to heed suggestion from other than their own master. Progress in this direction will, however, by welcomed by many, especially disabled people seeking services.

On the post accident rehabilitation front New Zealand's innovative Accident Compensation scheme is, of course, not without problems. These however are minor compared to the pre-Accident Compensation Act situation where accident victims had recourse only through torts actions. A convincing demonstration of this is the national publicity recently given to a pre-1973 case that is still being fought through the New Zealand High Court against a barrage of legal delays. Perhaps the insurance company concerned calculates that pay-out may be avoided if the claimant dies of old age before the issue is settled!

The present Accident Compensation scheme, however, does nothing for those who fall outside its net. The problem is well recognized by government but it appears afraid to bite the bullet. A recent circulating report (unconfirmed) of a successful claim against the Accident Compensation Commission by a mother for her child with cerebral palsy made on the grounds of accident of birth may prove the watershed.

Finally, this writer found the disability scene in New Zealand exciting and alive with many good and concerned people. There is a tremendous amount of good will and a co-operative spirit among those intimately mixed up in disability affairs. A few of the deeply entrenched bitternesses and the backbiting that is prevalent in Australia was noted in New Zealand. New Zealanders take these matters very seriously. They have a lot going for an eventual satisfactory resolution of the major problems for the disabled person in the community.

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APPENDIX I

Appendix I

General outline of visits and activities with brief comments.

19th Jan.
Arrived in Palmerston North and settled in at Massey University

27th- 31st Jan.
Invited participant in extra-mural course provided by Psychology Department for Department of Labor Vocational Guidance and Employment Officers organized by Dr Bob Gregory.

10th Feb.
Visit to Crippled Childrens Society unit in Palmerston North (Executive officer - Paul Curry).

13th Feb
Visit Disability Resources Centre (Director- Dr Terry Cunniffe) in Palmerston North. The premises also house the New Zealand Disability Information Centre which is also under the directorship of Dr Cunniffe . The DIC accumulates materials related to design of aids and devices for disabled.

15th Feb.
Visit to Silverstream Hospital, Upper Hutt this is a care centre for severely disabled people (90). This center is housed in wooden huts that remain of a WWII army hospital. It is a terminal care facility and the impression remains of being an out-of-the-way warehouse for the unwanted.

15-16th Feb.
Attended by invitation the council meeting of Disabled Persons Assembly in Wellington. Able to see DPA in operation and met many of the principle people involved in disability matters in NZ.

19th Feb.
Visit to Rehabilitation Unit, Palmerston North Hospital.

20th Feb.
Attended meeting of the New Zealand Rehabilitation Association in Wellington.

21-23rd Feb.
Foundation meeting for the Ergonomics Society of New Zealand.

25th Feb.
Participated in DPA working party to formulate policy on incomes maintenance and costs of disability.

6th March.
Meeting with Stuart Ransom, Chairperson of Manawatu Branch of DPA.

26th Feb.
Visited Manawatu Enterprises Sheltered Workshop, Palmerston North.

13th March.
Visited Disabilities Resource Centre to consult with Dr T. Cunniffe Director.

24th March.
Attended by invitation the Manawatu Branch meeting of DPA.

3rd April.
Attended by invitation meeting of Advisory Council for the Community Welfare of Disabled Persons held in Wellington. Met Mr J.G.S. Reid, Chairman and most council members.

8th April.
Visit to IHC facilities in Palmerson North.

10th April.
Visit to Ryder-Chesire Home for the physically disabled, Palmerston North.

11th April,
Visit to Pukeora Home for the Disabled. Established in 1957 to cater for physically handicapped adolescents and young adults. Today it has many of the original residents at an older age. Pukeora now accommodates sixtythree adult people in a complex of interconnected buildings.

15th April.
Visit to Aokautere Sheltered Workshop,(IHC) facility.

16th April.
DPA Working party on income maintenance.

28th April.
DPA Manawatu Branch AGM. Addressed meeting as guest speaker.

30th April.
Attended meeting of Federation of Volunteer Welfare Organizations held in Wellington. Speakers included Rt Hon. David Lange, Ken Munro, Russell Kerse,Repeka Evans, Sue Driver.

11th June.
Visited Rehabilitation League facilities at Napier.

14th June.
Visit to Independent Living Centre, Auckland.

16th June.
Returned to Brisbane.

APPENDIX II

Appendix II

Advisory Council for Community Welfare of Disabled People

The council is charged to give advice to the Minister for Community Welfare on the following issues:

- the provision of services, aids, facilities, and recreational opportunities for the welfare of disabled people in the community;

- the development of services and facilities for the welfare, assessment, training, sheltered employment and day care of disabled persons;

- The training requirements of those engaged in these services and facilities;

- areas of investigation for research; and

- other assignments referred to it from time to time by the Minister.

Current activities of the ACCWDP include:

- a working party on legal rights;

- a working party on special equipment;

- a working party of the UN World Plan of Action;

- a working party on employment; and

- a working party on accommodation and related services.

Other issues have been taken up from time to time and a number of reports arising from such actions have been published.

Reports

1. 'Deafness: The Invisible Handicap', 1979

2 'Mobility Matters',

3. 'Accommodation Options for Disabled Persons'; 1982,

4. 'Focus on Vision'

A series of pamphlets on employment are currently being produced and a twice-yearly newsletter is published. The council also produces from time to time a digest listing services, benefits and facilities for disabled persons.

APPENDIX III

DRAFT PAPER -Version as of 27/10/86
REHABILITATION, DISHABILITATION AND THE REMEDIAL PROCESSES

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University of Queensland

Rehabilitation psychology is, for most part, a-theoretical, and practice oriented. Although many definitions of rehabilitation can be found (e.g., WHO,1980, Wright,1980) the term, as Matkin (1985) reminds us, is ambiguous and may be applied to inanimate objects (e.g. rehabilitation of buildings) as well as to humans. Basically, definitions of rehabilitation as it applies to humans follow the medical notion of restoration of impaired bodies to the state of wholeness and health. In the practice of medicine the target condition of health and wholeness can be defined with a fair degree of objectivity. For psychological or psycho-social rehabilitation however, the target state for the client is less secure and the goal of the rehabilitation process remains largely arbitrary and dependent on such factors as personal values held by the rehabilitation team, their perceptions of the client and on socio-economic circumstances. According to Matkin (1985) with the current burgeoning of professional titles and services using rehabilitation as a label and the broadening of that term to cover processes that are arguably not strictly restorative the term has become confused and requires redefinition.

The objective of the rehabilitative process supposedly is to restore clients to former position and circumstances. In practice however, little regard is given, usually, to the client's pre-trauma life and circumstances. For most rehabilitation programs the starting point is the presenting client and the basic focus of the process is on helping the client to establish a lifestyle more in keeping with current community expectancies for an average, independent citizen. The goal reference for the rehabilitation team, is more likely to be some generalized and tacit agreement as to what constitutes a reasonable outcome for that class of client rather than specifications for producing a rebuilt replica of the pre-trauma client. In such cases the term restoration as an operational imperative does little more than to vaguely indicate a consensus as to what rehabilitation is supposed to be about. It is also becoming increasingly difficult in many services to separate rehabilitation problems from habilitation ones as it often occurs that both elements are required by the same client. For the client requiring the latter the restorative notion is inappropriate. Further reasons why the restorative notion is inappropriate will be developed below.

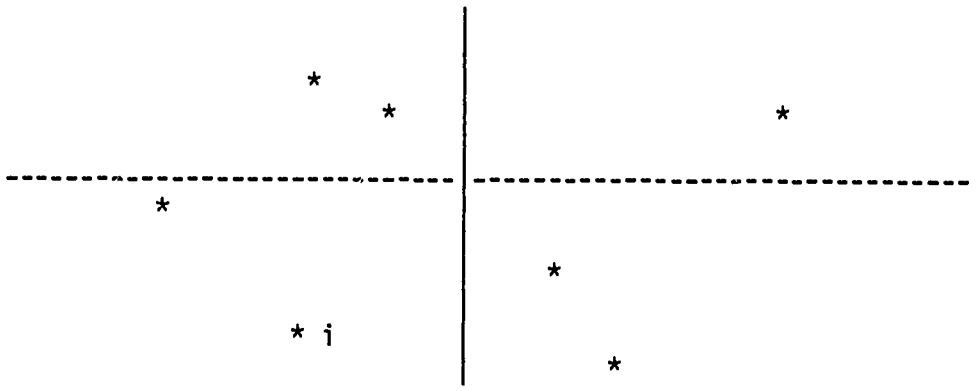
The purpose of this article is to consider the current objectives of human services that come under the rehabilitation rubric in an attempt to clarify the putative objectives of the process. The strategy taken here is to move away from the term itself to a related one which invites examination of precursory conditions and processes. It is argued here that an understanding of dishabilitation as a phenomenon in and of itself can restore clarity to the purpose of human rehabilitation. The model described here is intended as a conceptual one to help us understand what happens to a dishabilitated person and as a

suggestion about operational strategies to counteract that process.

A MODEL OF DISHABILITION AND COUNTERACTIVE STRATEGIES

For purposes of the model it is assumed that any human being can be described by reference to a multi-dimensional space with dimensions labeled according to various attributes likely to be applied to characterize individuals. Attributes can be either polar or bipolar and individuals are represented by points in this space which accords to values attributable to the individual. In general, more than one individual can have identical sets of attributes and thus may occupy the same point in the space and any number of dimensions may be used. However, some positions may be reserved for a specific individual where special conditional qualifiers exist (e.g., a monarch), or for a restricted number of individuals where there exists competition for the advantages of holding a position or competition for resources to maintain such. Typical variables may be socio-cultural status, education, wealth, acquired status and so on.

Using two dimensions only a set of individuals as may be described thus, for example:



Individual i thus is positioned in the descriptive space in relation to other individuals.

Individuals may be assigned either an actual or a virtual position. A virtual position is one assigned according to where one might expect an individual to be by reference to family background, peers and so forth in the absence of direct data about that individual. The actual position is, of course, the true position attained by that individual. This distinction will become relevant later.

In reference to orderly social structures features that might be expected include:

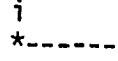
. A tendency of an individual's filial members and peers to occupy a similar spatial region.

. Movement of any individual over time according to circumstances that affect or moderate the individual's status.

. A tendency for disparity with siblings and peers to increase with time, i.e., individuals from the same family or the same clique groups will tend to move away from each other over time as they go separate ways according to the circumstances attending to each.

In this model individuals may also be assigned vectors located about their position to indicate the propensity for change of position. We may call this an 'opportunity' vector.

Thus:



will describe individual i's opportunity to change position, according to some relative measure, to position p.

Vectors can radiate in any direction and need not accord with any particular axis. An envelope drawn around the vectors will be termed an individual's 'opportunity' space. This opportunity space can be represented thus:

In any society opportunity spaces may be proscribed by various factors. In highly structured traditional societies, for example, one could expect the opportunity space envelope for most individuals to be substantially predetermined by the circumstances of the individual's birth and inherited place within the culture, and relation to others in his/her society. Under such circumstances an individual's opportunity space envelope might be described as being 'cogwheeled', or geared in with and fitted to the envelopes of others, and where the individual, unless released by extraordinary circumstances, may only move within the bounds of the envelope. Thus, in a highly structured traditional society individuals are strongly bounded by their predefined envelope. In other societies individuals may have envelopes largely, or even wholly defined by their own capabilities and resources(for example, every American child has the opportunity to become a millionaire, so the story goes.)

Displacement

An individual may displace themselves from a given position. That is, they may move by design in response to opportunities that may present, or by whatever else may motivate them. For example, a young executive may accept a vocational promotion in

order to move further up on economic and social dimensions, or may 'drop out' in order to escape pressures generated by other dimensions. Alternatively, individuals may be adventitiously moved by events or circumstances. If a move is large some adjustment may be required by the individual in relating to significant others, and by others in relating to the migrant individual. Displacement of others may occur as a result of a large movement of one individual which may be disadvantageous for those others depending on type of social structure and the mechanisms available for the dealing with such occurences. Traditional societies, for example, may have greater difficulty in accommodating large displacements than more open, unstructured ones or manage with the problem by expelling the problem individual if this is possible.

Movement by an individual may be accompanied by a change in size of some or many of the opportunity vectors. (A promotion to a professorship moves the individual on a number of attribute vectors but significantly decreases the vector of immediate, additional promotion. The size and shape of the envelope may thus change substantially.

Disability, displacement and dishabilitation

Where adventitious displacement follows onset of a disability the displacement is almost inevitably in directions of disadvantage. For example, dimensional displacements can occur in social, economic, and sexuality status, residential quality, access, and so on. For newly disabled persons a discrepancy opens up between their actual and their previous, or virtual position. If displacement is large and is disruptive of ability to continue or carry out functions associated with virtual position such persons may be said to be dishabilitated.

A correlate of a disability engendered displacement is a constriction of opportunity vectors. A person who becomes disabled is likely to find, in contrast to their pre-disabled life, that their opportunity space has shrunk, often quite dramatically. For example, possibilities may be limited for employment, the range of available accommodation may be reduced through accessibility requirements and financial restraints, and social intercourse may be restricted by lowered status and lowered mobility. A disabled person will thus have a smaller envelope than a peer who is not disabled. The effects, as depicted by the model, of dishabilitation are twofold. These effects are:

i. a significant and disadvantageous displacement, and

ii. a constriction of opportunity space.

These effects can be portrayed diagrammatically# as in Figure 4.

From

To

Factors which will moderate both displacement and constraint of opportunity will include:

. severity and nature of disability,

. previously held socio-economic position,

. resources available and used to counter the effects of displacing forces.

Any individual who suffers displacement, whether through a disablement or not, will usually try to exercise restorative action. Such action is likely to be successful only where the individual's opportunity space overlaps the individual's previously held or virtual position. Rehabilitation steps in where self-action is unsuccessful.

Rehabilitation policies and strategies

Most rehabilitation programs have focused on the objectives of restoring the client to their virtual position in life space, in fitting the client back into their old slot, as it were; or in lieu where circumstances are intransigent, to a new position designed on the clients behalf by the rehabilitation system which gives the best tendency towards their virtual position. It is contended here that such intentions are, for most part, presumptive and manipulative, and can be intrusive. It can be, and in practice usually is presumptive in that in assumes that the intervening events between initial displacement and rehabilitation can be cancelled out, that restoration to the previous position, or nearly so is the best for the client, and that the client indeed would wish it. It is manipulative in that the strategies of rehabilitation which follow from the restoration imperative invariably dictate shaping of client attitudes and behaviours. It is invasive in that a goal-directed programme, even if generated by transactional processes, involves circumscription of certain options that may otherwise be available to the client.

An alternative approach is to focus the rehabilitation programme on the expansion of opportunities for the client. More recently, the trend has been indeed to focus in on developing the opportunities presented to the rehabilitee rather than on fitting back to or supposed restoration of lost position. However this trend tends still to be mixed and confounded with notions of restoration and of placement. This writer contends that the goal of rehabilitation is to expand the client's opportunity space only and that it is the client's prerogative to make positional

changes according to those opportunities and to the circumstances that may be presented. This position is supported by the concept of the least restrictive alternative which suggests that rehabilitation clients should be maximally free to choose the endpoint of any change process affecting them. Any attempt by the rehabilitation system to suggest that endpoint represents a pressure extra to those which are normative for the client. The least restrictive approach for a rehabilitation process is to work only on expansion of opportunities. Even mild suggestion of positional endpoints for the intervention by a rehabilitation team can create unwanted circumscription for the client.

Systemic approach - implications.

If an individual is intrinsically part of a system, then his/her position in the space frame, for many attribute variables, will covary with that of significant others and vice versa. Change in position of any one member of the system will affect the positions of all others. A particularly strong example is the displacement of social and economic position of immediate family members with severe traumatic disablement of the principle breadwinner of the family.

Traditional rehabilitative approaches centre on the implicit objective of restoration of the client individual usually do so without regard of significant others. This disregard generates several problems. First, if the client is part of a system, and significant others in the system are forced to adjust and stabilize themselves to the changes induced by the client's disability there may be resistance to rehabilitative actions designed to restore the client to former position, especially if the others have taken over space vacated by the client. Second, adjustments needed to restore the comparative health of the system which includes a disabled member may result in still further# reduction of opportunity space for that disabled member.

Application to congentally disabled

It has been argued above that rehabilitation properly can only function by expanding its clients' opportunities to move in one or more positive directions. Although rehabilitation has been a term applied to the treatment of both adventitiously and congenitally disabled people there has been some attempt to distinguish between the two client categories principally on the grounds of restorative based definitions of rehabilitation (Whitehouse, 1953, Rosen, Clark & Kivitz,1977). However an opportunities definition of the function of rehabilitation eliminates the distinction as operationally it applies with equal salience to the case of both categories. In the case of congenitally acquired disability, displacement is from a virtual position rather from an actual one with the same consequence for opportunity space as for adventitious disability.

Congenitally given displacement is the result of a defect in the birth circumstance and its consequences. A congenitally disabled person is thus displaced from the start from their virtual position, or the position they may otherwise have

occupied, and may remain so all their life. The argument as to the need for a distinction made between rehabilitation and habilitation is based on the assertion that restoration cannot apply to the congenitally disabled as they have never held a position to be restored to! However, the quibble is small as it could be argued that virtual position should be the reference point. However, even that becomes irrelevant if the modus operandi of rehabilitation is restricted to enhancement of opportunities.

Concluding comments

The rise of consumerism with people with disabilities has caused considerable rethinking as to what service is to be provided by those which come under the rubric of rehabilitation. This is probably not before time as the rehabilitation industry provides a daunting array of professional expertise for the client consumer to resist if the outcomes proposed by the rehabilitation team should happen to differ from his or her own wishes.

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Appendix IV

NOTE ON DISABILITY RESOURCE CENTRE PROPOSAL

Disability Resource Centres for Australia?

The excellence of the New Zealand example of a service that is essential if disabled people are to achieve freedom of activity and mobility in a modern society suggests strongly that Australia is lagging behind in this area. This paper examines what would be involved in setting up such a centre and how this may be done.

The New Zealand Disability Resource Centre

At the moment the NZDRC has an extensive waiting list for its individual customization services. While its main preoccupation is with servicing disabled people in New Zealand, they are now receiving many requests for services from Australia. On the Australian side of the Tasman, while some nascent rehabilitation engineering services have been established, either by categorical service organizations, or as an adjunct to a local hospital system, the more generalized industrial development nature of the NZDRC remains unaddressed in Australia. Services that are supplied still are very much in the one-off phase. In some states the situation remains fragmentary and disorganized with a heavy reliance on well meaning amateurs or inexperienced professional dabblers. Of the one or two dedicated workshops providing orthotics and simple aid devices services are in the hands of technicians rather than experienced specialist engineers. While no depreciation of the skills and services of those technicians is intended, the constraints placed upon those situations make it more appropriate that the present situations obtain. However under such constraints few quality generalizable designed solutions have emerged, or will be likely to emerge.

On the other hand in the absence of anything presently that even approximates for a resource of the NZDRC which meets needs of disabled people to the standard attained by that establishment raises the question that should disabled people in Queensland be forced to suffer anything less than what is available to disabled people in New Zealand. Given that the wealth of the state is as least as good as that of New Zealand there seems little to counter the that disabled Queenslanders should have a least the same standard in facilities.

Possibilities

Recommendations have been made variously (e.g., by the Expert Committee on Rehabilitation Engineering of the National Advisory Committee on Handicap (NACH)) that rehabilitation engineering units of top excellence be established in each major state in Australia. The model proposed by Scull (198) requires that these be set up as fully fledged autonomous units. In present day financial terms an initial outlay of at least several million dollars would be required. There would also be an annual budget that would take a substantial part of another million. The Scull strategy is a grand-slam one. In the current era of

financial squeeze it seems most unlikely to be one that would attract attention from the Queensland State Government! One large drawback to the grand-slam approach is that there would be of necessity a considerable lag between payout and real service return. It would seem over-optimistic to believe that funding could be sustained at sufficient level with little colour in the pan.

An alternative that seems more feasible is to initiate a service which concentrates on providing for a defined need. Such a service could be established under the aegis of a public organization such as a university or technical institute. According to this approach the initial outlay is small and the paydirt in terms of real services to disabled people is high and almost immediate. Given a sufficient developmental model to provide the planning guide, development proceeds by planned service expansion taking each extension as a defined chunk. A sunset agreement may be incorporated in any initial setting-up agreement to allow for developing autonomy as the organization grows. Informed opinion suggests that a hospital setting would not be maximally appropriate. More appropriate may be an industrial setting, or at least one that could easily associate with industrial organizations or provide industrial links. A university setting would not appear appropriate as it is too conducive to affiliation to academic remoteness rather than to dedicated client centered service.

L.R.N. 27/10/86

Appendix V

Monographs Available from the
World Rehabilitation Fund-IEEIR

Order from: World Rehab. Fund, Inc.
400 East 34 Street
New York, NY 10016
Attn: Diane E. Woods

M14 Childhood Disability in the Family, by Elizabeth Zucman (1983), 80pp.

M15 A National Transport System for Severely Disabled Persons - A Swedish Model - $2.00

M20 Adapting Work Sites for People with Disabilities: Ideas from Sweden, Gerd Elmfeldt, Caroline Wise, Hans Bergsten, Ake Olsson, Editors (1982), 260pp. - $5.00

M21 Rehabilitation in Australia and New Zealand: U.S. Observations, Diane Woods, Editor (1983), 189pp.

M23 Methods of Improving Verbal and Psychological Development in Children with Cerebral Palsy in the Soviet Union, Robert Silverman, Translator (1983) 96pp.

M24 Language Rehabilitation after Stroke: A Linguistic Model, by Gunther Peuser (1984), 67pp.

M25 Societal Provision for the Long-Term Needs of the Mentally and Physically Disabled in Britain and in Sweden Relative to Decision-Making in Newborn Intensive Care Units, by Rev. Ernle W.D. Young, Ph.D. (1985), 86pp.

M27 Independent Living and Disability Policy in the Netherlands: Three Models of Residential Care and Independent Living, by Gerben DeJong, Ph.D. (1984), 94pp.

M28 The Future of Work for People with Disabilities: A View from Great Britain, by Paul Cornes (1984), 80pp.

M30 Employer Initiatives in the Employment or Re-Employment of People with Disabilities: Views from Abroad, Diane Woods and Sheila Akabas, Editors (1985), 128pp.

M31 The More We Do Together: Adapting the Environment for Children with Disabilities, the Nordic Committee on Disability (1985), 85pp. - $5.00

M32 Life Transitions of Learning Disabled Adults: Perspectives from Several Countries, Kate Garnett and Paul Gerber, Editors (1985), 64pp.

M33 Bridges from School Working Life: The View from Australia, by Trevor Parmenter (1986), 76pp.

M34 Independent Living and Attendant Care in Sweden: A Consumer Perspective, by Adolf Ratzka (1986), 80pp.

M35 Evaluation and Information in the Field of Technical Aids for Disabled Persons: A European Perspective, A. Pedotti and R. Andrich, Editors (1986), 59pp.

M36 An International Perspective on Community Services and Rehabilitation for Persons with Chronic Mental Illness, Mary A. Jansen, Editor (1987), 78pp.

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