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Living a Useful Life
Physically Disabled Children in New Zealand: 1935-1980s

A dissertation submitted in partial fulfilment of the requirements for the
Degree of Master of Social Sciences at the University of Waikato

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ABSTRACT

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This dissertation examines the history of physically disabled children in New Zealand between 1935 and the mid 1980s. It is designed to provide an insight into a dimension of history that has been missing from mainstream histories. It examines official and popular attitudes towards disabled people and the changes to these over the period discussed here

Using a range of primary and secondary materials, this study indicates the ways the notion of 'social utility' has given way to discussions about equality with regards to the role of disabled children in New Zealand society. The dissertation introduces ideas and theories about the study of disability in a general sense and applies them in a New Zealand context. It also introduces ideas about childhood and applies these to disabled children in New Zealand. This dissertation explores events that have been pivotal in the study of disability, for example, the emergence of the Crippled Children Society (later CCS) and changes in the fields of rehabilitation and special education. Events such as the beginning of Social Security are discussed in the light of their impact upon childhood disability.

Other developments in the health sector such as the increase in orthopaedic practice have had an impact upon the lives of disabled children. This dissertation explores the relationship between the field of Orthopaedics and the Crippled Children Society which was the main agency providing for the needs of disabled children. A further area that is explored is the influence of visiting specialist Dr Earl Carlson as well as parental guides upon the treatment of disabled children. The final section looks at the changes in special education including ideas about inclusion and mainstreaming. It discusses the notion that education changed from a focus on utility to one of equality. It also explores the role of the family with regards to education.



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Introduction

'Living a useful life: physically disabled children in New Zealand 1935-1980s', examines the history of disabled children in New Zealand and argues that between 1935 and the mid 1980s there was a broad shift in the 'culture' of disability. In this context 'culture' refers to opinions and policies influencing the treatment of physically disabled children. The dissertation demonstrates that there was a discursive emphasis on the training of physically disabled children and on the notion on social utility because of the greater numbers and survival rates of disabled children due to advances in technology. In an era when citizenship was invoked by the participation in a 'healthy nation' this change in emphasis was particularly important. Children were central in this concept of a healthy nation as Margaret Tennant asserts, it was considered a 'civil duty' to rear healthy children.¹ A 1935 guide to parents stated that 'health of children is of greatest national importance'.²

The dissertation addresses ideas and understandings about disability from the 1930s until the mid 1980s in New Zealand and how these shaped childhood experience. The material I examine includes official sources, contemporary newspapers and publications, life reminiscences and selected secondary sources. By addressing these issues I expose a lacuna that appears in both the childhood and medical literature. The nature of this project allows historians to survey childhood experience through a variety of sources, each giving a unique and valuable perspective on childhood and historically specific attitudes towards disabled children.

The final aspect of my dissertation links policy shifts to personal experience. To achieve this the dissertation compares official government literature concerns to personal sources including biographies. I also take into account other sources such as parental guides, which highlight the contemporary interests of the disabled and

¹ Margaret Tennant, 'Missionaries of Health: The School Medical Service in the Interwar Period', in *A Healthy Country? : Essays in the Social History of Medicine in New Zealand* L. Bryder ed. (Wellington: Bridget Williams Books, 1991), pp.128-9.

those associated with them. Much of my information is obtained from the North Island and as a result many examples are drawn from there. Since many of the conditions pertaining to disability and education were nationwide these examples can be applied at a national level.

Margaret Tennant outlines several distinct phases in the history of disability in New Zealand.³ A number of these phases are particularly relevant to the history of children with physical disabilities, and I have used them as a model here. The first phase that has influenced the development of the history of disabled children in twentieth-century New Zealand is the nineteenth-century focus upon institutionalisation. As a result of changing attitudes and circumstances both here and abroad this phase gave way to growing 'social awareness' and later a focus upon rehabilitation.⁴ The education theme, also important in my dissertation, arises from sources such as parental guides and the Reports of the Education and Health Departments in *Appendices to the Journal of the House of Representatives*.⁵

The period immediately prior to the Second World War was characterised by growing awareness of need and social responsibility, aided in New Zealand by the election of a Labour government. This idea of growing 'social awareness' of need is identified by Margaret McClure in her book *A Civilised Community?* McClure links awareness to ideas of repugnance of the dire poverty apparent during the 'Great Depression' of the 1930s.⁶ Derek Dow illustrates the general debates surrounding health in his history of the New Zealand Health Department entitled

² Health Department, Division of School Hygiene, *Suggestions to Parents* (Wellington: Department of Health, 1935), p.1.

³ Margaret Tennant 'The History of Disability in New Zealand' *New Zealand Journal of Disability Studies* 2, (1996).

⁴ Tennant, 1996, pp.3-29.

⁵ 'Special Education for the Handicapped' *Appendices to the Journal of the House of Representatives* (Wellington: R.E.Owen, Government Printer, 1960) M.V., Kennedy and H.C.D., Somerset, *Bringing Up Crippled Children: Suggestions for parents, teachers and nurses* (Wellington: New Zealand Council for Education Research and Crippled Children Society, 1951) and the 1949 Carlson Report (Wellington: Crippled Children Society, 1949) also identify education as being important but real changes were not made until after 1960.

⁶ Margaret McClure, *A Civilised Community? A History of Social Security in New Zealand, 1898-1998* (Auckland: Auckland University Press, 1998), p.36.

Safeguarding the Public Health.⁷ This text provides a useful chronology of public health in New Zealand. When read alongside institutional histories such as those of the Crippled Children Society, Dow's work is useful in assessing the relationship between developments in public health and changes in practices and theories surrounding disability.⁸ Comparing general texts such as Dow to more specifically disability-related texts allows historians to see the relationship between public health and changes in the experience of disability.

When considering the history of disabled children in New Zealand there are few sources more valuable than the two Crippled Children Society histories (published in 1960 and 1995) and associated texts such as 1951 book *Bringing Up Crippled Children*.⁹ These, viewed together with local publications and newsletters for each region, give an indication of the contemporary concepts of disability.¹⁰ Karen Butterworth's *Mind over Muscle: Surviving Polio in New Zealand* is also helpful for discussions surrounding rehabilitation, particularly as a result of Polio. This text gives explanations about the course and effects of the Polio epidemics in twentieth century New Zealand. Personal accounts of illness are used to illustrate their impacts upon children both physical and emotional.¹¹

The international study of the history of medicine has not foregrounded disability. Roy Porter's book *The Greatest Benefit to Mankind? : A Medical History of Humanity from Antiquity to the Present* is a comprehensive history of medicine. Porter wrote explicitly *medical* grand-narrative, focusing on the practitioners and practices, medical models of health and unhealthy and medical explanations of life and death. Whilst he covers areas that touch on the history of childhood

⁷ Derek Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995).

⁸ I have referred to the New Zealand Crippled Children Society as simple 'Crippled Children Society'. For references after 1989 I have used the current name NZCCS or CCS.

⁹ M.V. Kennedy and H.D.C. Somerset *Bringing Up Crippled Children: Suggestions for parents, teachers and nurses* (Wellington: Crippled Children Society, 1951).

¹⁰ The first of these was written in 1960 by H.E. Carey to celebrate the 25th Anniversary of the Society. The Second, entitled *On the Move: A Celebration of 60 years of the New Zealand Crippled Children Society: A pictorial history* was published in 1995 and was written at a more 'popular' level. *Bringing Up Crippled Children* was published in 1951, Local publications and newsletters include *The Crippled Child*, various Crippled Children Society News Letters and the Auckland Branch 50th Anniversary publication.

¹¹ Karen Butterworth, *Mind over Muscle: Surviving Polio in New Zealand* (Palmerston North: Dunmore Press, 1994).

disability, such as Polio and developments in health in general, he does not make an explicit attempt to cover disability as a topic.¹² A more useful text for placing the study of New Zealand children with physical disabilities within an international context is the *Disability Studies Reader*.¹³ The need for disability issues to be addressed is expressed in the *Reader's* introduction, stating that disability has been too long relegated to the hospital, the clinic and the remedial classroom. Whilst in America people with disabilities make up the largest minority group in society, this is not reflected in literature dealing with minorities. Furthermore, while ethnicity, gender, and sexuality have all become accepted frameworks for critiquing mainstream society, disability has not been given the same status.¹⁴ In New Zealand the story is similar; children with disabilities are doubly infantilised and marginalized through their position as physically disabled people and young people.

Disability definitions have altered over time. New Zealand writers P.O'Brien and Ray Murray in their 1997 publication *Human Services: Towards partnership and support* offer two broad 'models' of disability.¹⁵ These theories assess the way in which disability is constructed and understood. The first model of disability calls attention to the physical and medical considerations surrounding disability. Until relatively recently this has been the predominant model applied to disability. This governed attitudes and actions towards those with disabilities by the medical profession and society at large. Adherents to this medical model describe disability in terms of impairment. Types of treatment seek to cure or at least ameliorate these impairments.¹⁶ Institutionalisation and segregation of those deemed 'incurable' by society helped to foster the 'disabled as tragic victim' mentality.¹⁷ The 1935 Crippled Children's Society definition of disability was modelled on the medical view of disability:

¹² Roy Porter, *The Greatest Benefit to Mankind? A Medical History of Humanity from Antiquity to the Present* (Hammersmith: Fontana Press, 1999), p.5.

¹³ *Disability Studies Reader*, Lennard J Davis ed. (New York: Routledge, 1997).

¹⁴ Davis, pp.1-2.

¹⁵ Patricia O'Brien and Ray Murray, *Human Services: Towards Partnership and Support* (Palmerston North: Dunmore Press, 1997).

¹⁶ O'Brien and Murray, pp.18-19.

¹⁷ Michael Oliver, *The Politics of Disablement* (London: Macmillan, 1990). This discourse described by Oliver has surrounded and influenced debate over disability studies.

A Crippled child is a person under 21 years of age, who, not being mentally deficient or not educable, has a defect which causes or tends to deformity or interference with normal functions of the bones, muscles, or joints, the defective condition may be congenital or acquired, but does not include defects of vital organs.¹⁸

This definition of disability places emphasis on the deficiencies and impairments of physical disability. For my purposes, and due to consultation of a number of texts operating under this definition my personal definition of disability is much the same as that used by the Crippled Children Society.

Society and its reaction towards disability provide a basis for an alternative model of disability. This view focuses on the social construction of disability and asserts that society and its institutions create barriers for disabled people and thus influence the disabled experience. This theory, although helpful in providing an alternative view to the medical and clinical view of disability, tends to 'forget' that there are some inescapable physical facets of disability that have a formative influence of the experience of disability.¹⁹

The language used to describe disability is inextricably linked to the models used to understand it. This language, like the models of disability themselves, has not been immune to the forces of historical change. Indicative of this is the very acronym CCS, which started life as the Crippled Children Society but was changed to New Zealand CCS in 1989 to present a more modern and positive image.²⁰ At the time of its formation in the 1930s, 'cripple' was quite obviously considered a purely descriptive and non-pejorative word. Additionally the term 'invalid' might be considered inappropriate, but it is still the term used in the

¹⁸ H.E Carey, *New Zealand Crippled Children Society History: 1935-1960*, (Wellington: New Zealand Crippled Children Society, 1961), p20; Other definitions of disability in a modern day context are given by the World Health Organisation (international definition) and more locally by the 1994 Health and Disability Act.

¹⁹ O'Brien and Murray, pp.19-20. This view is expressed by scholars such as M.J. Sullivan in his dissertation 'Paraplegic bodies: Self and Society', unpublished Phd. Thesis, University of Auckland, 1996 Sociologists Mariam Corker and Sally French also express a similar view in an English context.

²⁰ Coral Atkinson, *On the Move: A Celebration of 60 Years of the New Zealand Crippled Children Society* (Wellington: New Zealand Crippled Children Society, 1995), p.3.

name of the major disability pension, hinting at the past language of disability.²¹ The following short excerpt from *A Life Regained*, (1967) the story of Dennis McEldowney, shows use of the term invalid by disabled people to describe themselves; 'Most invalids however well they are adapted to their invalidity are still anxious to end it as soon as possible.'²² In this passage he points out that most people would rather not be 'invalids' if they had the choice. Whilst it is agreed that such terms should be avoided by contemporary society in general, there is dispute over just what to use instead. For the purposes of this dissertation I have used '(physically) disabled person' or like terms except where use of another term such as 'cripple' is appropriate due to time period considerations.²³

Definitions of childhood, like definitions of 'disability' have evolved over time. In this dissertation I have decided that childhood should end with the conclusion of secondary education. This often marks a transition between parental and, to a degree, state control and personal life choices. Historically, there has been much debate about just what constitutes childhood. Phillipe Ariés, whose text, *Centuries of Childhood*, (1962) is considered seminal in its field, asserts that childhood has developed over time. He argues that only the infants were treated substantially differently in the middle ages but with the development of formalised schooling and differing social conventions governing behaviour young people began to be seen as a group apart and were treated accordingly.²⁴ Other historians including Joseph Hawes and N. Ray Hiner have criticised his use of sources but not the essential premise that childhood is not immune to historical change in wider society.²⁵

Erik Eriksson posited a psychological explanation of childhood, expressing it in terms of developmental stages. Other historians such as John Demos and Lloyd De Mause have done likewise. These scholars view children as being agents of

²¹ Peter Beatson, *The Disability Revolution in New Zealand: A Social Map* (Palmerston North: Dunmore Press, 2000), p14.

²² Dennis McEldowney, *The World Regained* (London: Chapman and Hall, 1957), p. 24.

²³ For the full discussion on the language and definition of disability see Peter Beatson, *The Disability Revolution in New Zealand* pp.14-20. Also *Disability in Aotearoa New Zealand*

²⁴ Phillipe Ariés, *Centuries of Childhood; A Social History of Family Life*: Translated from the French by Robert Baldick (New York: Knopf 1962).

²⁵ Joseph M. Hawes and N. Ray Hiner, *American Childhood: A Research Guide and Historical Handbook* (Westport: Greenwood Press, 1985), p.3.

cultural change instead of merely reflections of it. In the modern history of childhood the American scholars, Hawes and Hiner have defined the child's roles in society and they theorise about the importance of family.²⁶ This approach is indicative of the new trend in childhood studies, which differs from the traditional psychological perspective presented by the likes of Eriksson, Demos and DeMause.

Hawes and Hiner describe key determinants of childhood experience, several of which are relevant to my study. The first of these explores the attitude of adults towards the children around them and how these attitudes impact upon childhood experience. Investigating records such as letters and diaries can give an indication of thoughts regarding children; however there should be some caution when using such sources, as thought and reality are not necessarily identical. Hawes and Hiner also deal with conditions shaping the development of childhood. They examine this by studying institutions in which children spent their time, investigating factors shaping the duration of 'childhood', or exploring family relations. Ultimately, children are important in themselves and not merely indicators of changing societies. Finally, Hawes and Hiner ask historians to examine the subjective experience of childhood.²⁷

This dissertation is divided into three broadly chronological themes. As this is a historical endeavour there is a focus on the major shifts over time in popular health, welfare and medical approaches to disability. The first chapter 'The Cause of the Crippled Child: The inception of the Crippled Children Society and its social context 1935-45' explores the pre Second World War conceptualisations of disability and child health. The context for this chapter is social upheaval caused by epidemics, global depression, changing ideas about welfare, and finally world war. The second chapter, entitled 'Crippling is more than an illness: Rehabilitation as a primary focus in the care of disabled children 1945-60' concentrates, as the title suggests, on the role of rehabilitation in the lives of

²⁶ The disabled child is a part of a family dynamic. The family is important to my study, as it is the first point of social development and teaching. Hawes and Hiner, *American Childhood*, p.5. Eriksson, Demos and DeMause are all mentioned by Hawes and Hiner, p.4.

²⁷ J. Hawes and N. Ray Hiner, *Growing Up in America* (Chicago: University of Illinois Press, 1985) pp. xx-xxii.

disabled children. This rehabilitation was not considered in isolation but included such areas as education, family life and socialisation. Through the study of various sources I convey the nature of the relationship between voluntary and state agencies associated with the area of disability, and particularly disability in children. My final chapter 'Training for a useful life: education and physically disabled children 1960-1980s' explores the beginning of modern special education. In this chapter I will examine the way in which Special Education has moved from its emphasis upon social utility to a rights based notion of education. Education is becoming important, as educational historians shift their focus from the institutional view of education to one greater emphasising the importance of the needs of individual children.

The combination of studying children and disabled people is problematic as both these groups have traditionally been without any real voice. In an attempt to counteract this I have used published life stories. Despite the fact that the majority of these are published retrospectively or by parents, I have included these as a source as they offer a unique perspective of disability that might be difficult to obtain from other sources. The personal accounts cover the period to the early 1960s for the most part, as these individuals are grown and are looking back upon earlier experience.²⁸ These narratives illustrate the major discussions and topic areas discussed in this dissertation.

Whilst society has made great 'progress' since 1935 and has become more attuned to the needs of those with physical differences there is still a degree of negativity ascribed to the experience of disability. The negative view of disabled children is highlighted and reinforced by stories such as *The Secret Garden* or *Heidi*. Disabled and non-disabled children alike read both these novels and are exposed to their depictions of disability. Furthermore, it seems that society does all it can to prevent children with disabilities being born at all. Children who 'slip through'

²⁸ The stories I am using include: Shelley West, *Shelley has a Baby: The remarkable story of Shelley West*, (Auckland: Bateman, 1997); Barbara Spencer, *Peter John* (Christchurch: Whitcombe and Tombs, 1969); Angela Muir Van Etten, *Dwarfs Don't live in Dolls Houses* (New York: Adaptive Living, 1988); Karen Butterworth ed. *Mind over Muscle: Surviving Polio in New Zealand* (Palmerston North: Dunmore Press, 1994); Julia Millen, *Brave Little Girls Don't Cry* (Auckland: Solent, 1992); Dennis McEldowney, *The World Regained* (London: Chapman and Hall, 1957).

this process are then treated by whatever means are available; it is interesting that the word orthopaedic itself means 'child correction'.²⁹ This serves as a reminder that although much surrounding disabled experience has changed, the emphasis on effecting a cure remains.

²⁹ *Growing Up with a Disability*, Carol Robinson and Kirsten Stalker eds. (London: Jessica Kingsley Publishers, 1998), pp.19-21.

Chapter One

'The Cause of the Crippled Child': The inception of the Crippled Children Society and its social context 1935-45.

In 1941 the New Zealand Crippled Children Society identified its purpose as being the 'cause of the crippled child'.¹ This statement provides a useful focal point for this chapter, which encompasses the years between the 1930s and the end of the Second World War. This chapter concentrates on the impact of the Crippled Children Society upon the lives of those with disabilities. This is important, as the Society was the first group to be solely interested in the affairs of physically disabled children and young people. It explores the role of the Society in relation to existing institutions such as the Departments of Education and Health as well as the introduction of new services such as travelling orthopaedic clinics. This chapter demonstrates that during 1930s and 1940s in New Zealand there was an increasing awareness of the needs of different groups within society. This new consciousness led to the development of the Crippled Children Society and the services it provided. In addition to this, Polio, and the debates surrounding it catapulted childhood disability into the public sphere, (as it was devastating and affected all walks of life). Changing ideas about health and the growing importance that was placed upon child health undoubtedly had an impact upon the direction of disability treatment.

The Crippled Children Society was the first group concerned with more than a single disability, such as blindness. Instead is catered to a myriad of differing physical conditions. The history of the Crippled Children Society's involvement with other agencies associated with disability, such as the Health and Education Departments, provides a key to understanding ideas and issues surrounding disability in the pre Second World War period. This chapter utilises a variety of primary and secondary sources examining issues concerning Polio, changing ideas about health and the early years of Orthopaedic practice. The sources, including

¹ New Zealand Crippled Children Society, *Policy and Lines Upon Which We Work* (Wellington: Crippled Children Society, 1941).

institutional histories, contemporary newspapers and personal accounts, are used in the examination of official and personal responses to disability in New Zealand.

SOCIAL SECURITY AND THE DISABLED

The concerns of New Zealand society in the 1930s arose out of a sustained period of high unemployment and economic depression, (resulting in obvious poverty). It became clear to society in general and the Labour Party in particular, that it was necessary for the government to provide support and provisions for those in need. This realisation and the election of the 1935 Labour government, lead to widespread changes to the then limited pension system, encompassing many different sectors of society. The most important change was the introduction of the Invalid's Benefit in 1936, which was consolidated in the 1938 Social Security Act. 'Invalids' were not the first group of disabled people besides war veterans to be granted a pension by the government. There had been provisions for the Blind since 1924.² McClure asserts that lobbying was an important factor in Blind Pension establishment, whereas the official view in *The Growth and Development of Social Security* published in 1951 was that it was a natural precursor to the 1936 Invalid's pension.³

Debate over the introduction of disability pensions had been taking place for some time. However, until the introduction of the 1936 Act, the care and support of the disabled rested solely with the family, few of which had adequate time or finances. An example of early 20th century governmental attitude is made clear by Richard Seddon's comment in 1905 that care for the disabled was the responsibility of the family and local institutions.⁴

² Margaret McClure, *A Civilised Community: A History of Social Security in New Zealand, 1898-1998*. (Auckland: Auckland University Press, 1998), p 36. It has been asserted that this provision was more as a result of lobbying than humanitarianism.

³ Departments of Social Security and Health, *Growth and Development of Social Security in New Zealand* (Wellington: Departments of Social Security and Health, 1950) p.29; McClure, p.36.

⁴ McClure, p.36.

In 1938 the Social Security system divided benefits into three categories, medical, hospital and pharmaceutical.⁵ The division of the *1938 Social Security Act* into these categories reflects this. As a result of the changes children could gain subsidised access to the doctor and receive hospital care when they needed it. Furthermore, any medicines which were needed were also to be provided free of charge. Medical professionals both in the general practices and hospitals were bound to provide the best service they could for any given patient. This would be provided irrespective of patient background.⁶ For the first time all citizens were afforded the same treatment at the same cost. This meant that those with particular health needs had free access to the necessary treatments. Despite differing political viewpoints, modern welfare scholars agree that the Social Security Act, with its pensions and health benefits, emerged from a climate of economic insecurity. The visible want of the depression created the motivation to put in place a system that would guard against such an event occurring in the future.

The election in 1935 of the first Labour government was an important step in the direction of the welfare state generally and in particular the position of the 'invalid'. Labour held that there should be protections against social hazard. These 'hazards' included such circumstances as illness, unemployment, disability and old age. The Labour government argued that the risks of these problems were universal and that the solution should be universal also.⁷ As a result of this pensions designed to protect against these hazards, such as the Invalid's pension, were administered to all who fell within that category regardless of wealth. The introduction of an Invalid's pension meant that those with disabilities but who were able to live independently now had means to do so. Labour used this as part of their campaign for the 1935 election. These actions infer recognition that those with disabilities had a place in the community and a role to play. This theme of a community role or social utility is something that pervades the history of disability in this period.

⁵ *Social Security Act 1938* (Wellington: New Zealand Government Printer, 1938. rpr.1979,) p.68.

⁶ *Social Security Act 1938*, p.74.

⁷ McClure, p.61.

Government confidence in the success of this system is portrayed by the tone of *Growth and Development of Social Security in New Zealand* (1951) a text produced to examine the first decade of welfare reform. This supported the notion that some form of guarantee against adversity was necessary and it was based on citizenship rights as opposed to other more specific criteria.⁸ This document highlights the confidence placed in the Social Security system by the government of the time. A focus on the family is indicated by the introduction of the universal family benefit in 1941. Originally intended to cater just for the lowest income group, by the 1940s family benefits had become universal. Furthermore, it was direct credited into the family bank account as 'many mothers with young children might find it inconvenient to collect the benefit in cash each month'.⁹ The creation of the family benefit reiterated the assumption that the family was the basic unit upon which society was built.

David Thompson offers a substantially more critical assessment of the steps towards social security, or 'the welfare state' as it is now known. Thompson asserts that the reasons for welfare were two-fold. Firstly, there was the notion that the market economy was unable to distribute wealth adequately, and that the state should intervene as a matter of course. Secondly, after the Depression there was a feeling that it was necessary to avoid such widespread poverty at all costs.¹⁰ Thompson also asserts that perhaps the situation was not as dire as later accounts have made it out to be.¹¹ Pensions catering for eventualities such as disability were an important part of this. Disability, although less common than unemployment as a reason for paucity, tended to be a permanent state and so carried even greater risks of ongoing poverty.

Social Security, with its revolutionary changes and far reaching provisions was related to the realms of medical practice and government assistance. An example of this association is Prime Minister M.J Savage's former membership of the Auckland hospital and charitable aid board, indicating that he had a keen interest

⁸ Departments of Health and Social Security, pp.18-19.

⁹ Departments of Health and Social Security, pp.67-8.

¹⁰ D. Thompson, *Selfish Generations? The ageing of New Zealand's Welfare State* (Wellington: Bridget Williams Books, 1991), pp.10-11.

¹¹ Thompson, pp.11-32.

in health and health issues prior to his prime ministership.¹² New members of parliament from the first Labour Government, such as David McMillan, had medical backgrounds too, although his part in the Social Security planning did little to endear him to his medical counterparts.¹³

Tennant asserts that childhood medical concerns of the period focused on a motif of racial and physical well-being.¹⁴ The key child health concern was the poliomyelitis virus, which catapulted physical disability into the public eye after the first major outbreak in 1916. This was such a concern as it rendered once healthy children physically incapacitated and often less 'socially useful'. The introduction of school medical inspections (1925) and the milk in schools (1936) service are further evidence of the importance of physical health in children. Parent guidebooks such as *Your Child's Health and Physique*¹⁵ elucidate the importance of practices that combat deformity and serve as examples of the emergence of the idea of scientific motherhood from the 1930s.¹⁶

Bronwyn Dalley has examined children in New Zealand society and states that during the 1930s and 1940s the family was the focus of social policy, due to the effects of depression followed by a world war. This can be seen with the introduction of medical benefits as well as family and unemployment benefits. The focus of child welfare was to prevent the appearance of troublesome youths rather than punish them once they had become a problem. The mindset of the Child Welfare Office was that children's behaviour should be 'adjusted' rather than punished. This adjustment at a behavioural level was mirrored by physical adjustment of disabled children.¹⁷

¹² Derek Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995), p.121.

¹³ Dow, p. 122.

¹⁴ M Tennant, 'Disability in New Zealand: A Historical Survey', *New Zealand Journal of Disability Studies* (2), (1996), p.12.

¹⁵ J Renfrew White, *Your Child's Health and Physique*. (Dunedin: Coulls Somerville Wilke, Ltd., 1932)

¹⁶ L. Bryder, 'Perceptions of Plunket' *New Countries Old Medicine.. Proceedings of an International Conference on the History of Medicine and Health*, L Bryder and D. Dow eds. (Auckland: Pyramid Press, 1994)

¹⁷ B. Dalley, *Family Matters: Child Welfare in Twentieth Century New Zealand* (Auckland: Auckland University Press, 1998), pp.93, 97-8.

THE CRIPPLED CHILDREN SOCIETY EMERGES

The Crippled Children Society emerged from a desire to help the 'crippled children' of New Zealand. The plight of disabled children entered public interest after the Polio epidemics of 1916 and 1924-25. However, it was to be another decade before any decisive action was taken. This may have been because the rise in numbers presented a threat to the perception of normal society and highlighted the way in which disability affected a broad spectrum of the community.¹⁸ The Crippled Children Society's Golden Jubilee Publication had this to say about its beginnings.

Dr Gillies became a champion of the cause of better treatment for New Zealand's disabled children. Along with others in the medical profession, he was concerned that there was no organised effort to treat and educate children to take their place in society¹⁹

The Dr Gillies referred to above was (Sir) Alexander Gillies, Red Cross Member and future Chair of the New Zealand Orthopaedic Association and the Rotary Club. Gillies was the driving force in the formation of the Crippled Children's Society. The interest of the Rotary was sparked by Gillies' speech entitled 'The Cripple and Vocational Training for the Physically Defective'. This address was given some five years before the formation of the Crippled Children's Society, but highlighted interest in some sectors of society about the plight of the 'crippled'. He alluded to the lack of knowledge about the numbers of 'cripples' in the country as well as the lack of attention given to them for most periods of their life.²⁰ The speech shows that even before the formation of the society common opinion intended to help the disabled lead *useful* lives.

Campaigning for the rights of the 'crippled' child by Gillies and others like him was in operation in the early 1930s. Gillies stated that the education of the

¹⁸ Maxine Stephenson, 'Eugenics and the Shaping of Citizens' in *Proceedings of the Australia and New Zealand History of Education Society Annual Conference: Voice Vision and Identity in the History of Education, Vol. 2* (Auckland: University of Auckland, 1998), pp.460-61.

¹⁹ *Crippled Children Society News, 50th Anniversary edition* (Auckland: New Zealand Crippled Children Society, 1985), p.1.

²⁰ Report from the *Evening Post*, Tuesday 13 May, 1930, in Rotary Club International, *The Rotary Club in New Zealand: The first 25 Years, 1921-46*, pp.79-80.

disabled was vital as it allowed them to make a living later. The early 1930s saw a rise of support for the aid of crippled children both in New Zealand and abroad. Gillies envisaged an organisation that would cater to the specialist physical needs of the disabled as well as promote public awareness of the needs of 'crippled children'. The proposed society was to provide an information service also; parents and professionals alike would then have a centralised source of information outlining availability and location of services. Also this service should be able to provide information on work done by associated organisations both in New Zealand and abroad.²¹

Popular support for the society was indicated by the response to the initial appeal for branches in areas outside Wellington. Fourteen were formed in six weeks. The desire to work alongside the existing medical and educational establishments can be seen by the way in which branches were not to 'usurp or duplicate' the roles of these groups, and undoubtedly gained them favour in the eyes of these establishments. The aim of the Crippled Children Society was quite simple; it was to 'generally show friendly care and personal interest in the condition and circumstances of every disabled child in New Zealand'.²²

To this end the Society benefited greatly from a £50,000 donation in 1935 from Viscount Nuffield who was deeply concerned about the lack of support for disabled children in New Zealand. Nuffield was more commonly known as William Morris of Morris Motors, and his gift was something of surprise to those receiving it. He gave the following speech outlining his reasons for donating such a large sum:

I think the best way to help any nation is to think of the crippled children. When I think of crippled children I thank God I was not born a cripple myself. I cannot think of anything more dreadful than being born a cripple and not having anyone to put me straight.²³

²¹ *18th Conference of the Rotary Clubs of New Zealand* (CCS Library, no date) pp.82-3.

²² *Crippled Children Society News 50th Anniversary edition*, p.1.

This speech indicates the reason behind helping crippled children was at this time basically humanitarian, although there is certainly a paternalistic attitude implicit in such a speech. This indicates that late nineteenth century ideas about physical difference were still pervasive in the beginning of the twentieth century. There seemed to be a basic premise that crippled children could be 'put right' and that to be anything other than 'normal' was completely unthinkable. This is particularly evident in the treatment of Maori, mentally defective and otherwise different children.²⁴ Sullivan argues that Social Darwinism and eugenics were new forms of prejudice, designed to portray those who were different as degrading the 'stock' of New Zealand society.²⁵ Whilst not coming from a deliberately prejudiced mindset, Nuffield's statement seems to indicate that disabled people were inferior and needed to be set straight. This was so that they could lead useful and 'fulfilled' lives, reinforcing notions of social utility and a desire to 'normalise' society. Dennis McEldowney who grew up disabled during this period expressed up this in his memoirs, *The World Regained*, where he explicitly states, 'it is after all natural to be active and useful. It is unnatural to be inert'.²⁶

The donation of Wilson House in Takapuna, Auckland that cared for disabled children after 1937 was another gift instrumental in the success of work of the Crippled Children Society in New Zealand. A further factor that undoubtedly played some role in the Society's success was that many of the Crippled Children Society's members came from a number of pre-eminent New Zealand groups. These groups included the New Zealand Branch of the British Medical Association, Red Cross, Plunket Society, and Women's Division of the Federated Farmers Union, heads of various church groups as well as prominent legal and medical professionals. This mix ensured the support of the government, the major welfare organizations and to some degree the business community.²⁷

²³ *Evening Post*, March 5, 1935 in Rotary Club International, *The Rotary Club in New Zealand: The first 25 Years, 1921-46*, (CCS Library, no date given) p.83.

²⁴ Stephenson, p.450.

²⁵ M.J. Sullivan, 'Paraplegic Bodies: Self and Society', unpublished Phd Thesis, University of Auckland, 1996, p.88.

²⁶ Dennis McEldowney, *The World Regained* (London: Chapman Hall, 1957) p.24.

²⁷ *Evening Post*, July 11, 1935 in Rotary Club International, *The Rotary Club in New Zealand: The first 25 Years, 1921-46*, p.100.

Despite these developments Gillies recognised that there was still a long way to go in the treatment of 'cripples'. The following quote from Gillies shows his concern about the lack of attention being given to children when a great deal is being given to communication technology:

New Zealand leads the world in the use of telegrams but I can tell you that we cannot persuade ourselves into thinking otherwise that we lag very far behind the world in our hospitalisation of cripples.... All other important countries in the world and some not so important ones have not only orthopaedic wards but also orthopaedic hospitals.²⁸

The Crippled Children's Society was an ardent advocate of the establishment of institutions planned to treat 'cripples'. Watkins in his 1939 *Plea for an Orthopaedic Hospital* lamented the placement of disabled children in general hospitals. He claimed that the 'surroundings and atmosphere of the places are all wrong.'²⁹ He went on to state that the disabled were more at risk of catching diseases. The *Plea* indicates that it was considered a 'wilful sin to place a cripple near infection.'³⁰ Also in the speech berating the position of 'crippled children' Watkins mentions the plight of a child with 'tubercular spine' that was not given any exposure to the sun despite its supposed benefits.³¹ This was considered a further example of the inadequacies of the existing health system.

Despite the perceived benefits of such an institution the plea for an orthopaedic hospital was defeated, in 1939 with no alternative plan being offered.³² While the Society desired an institution to cater to disabled children's orthopaedic needs it did not feel it expedient to establish such institutions themselves. This was because it was felt that the funds belonging to the Society were better spent on the children themselves rather than on administration of an institution. The Society sought to complement and co-operate with state provisions rather than replace them. This cooperation was secured in order to ensure fullness of development of

²⁸ 'We Lag Behind', *Evening Post*, 11 May 1937, p.12

²⁹ L.T. Watkins, *A Plea for an Orthopaedic Hospital with an Occupational Therapy Centre for the Crippled Children* (Wellington: New Zealand Crippled Children Society, 1939), p.4.

³⁰ Watkins, p.4.

³¹ Watkins, p.4.

the 'crippled child's' potential. The Crippled Children Society was also prepared to work with any other volunteer or welfare agencies which had similar interests: if other agencies are already acting on behalf of 'cripples' then the Society decided it was best to let them continue to do so.³³ To this end there was an attempt ensure that all crippled children were 'registered' so that their needs could be evaluated and catered to.³⁴

All the registered 'crippled children' of New Zealand had files opened about them. These files contained such information as type of disability, age, sex, and recommended treatments. It told of the progress of the child as well as their behaviour when undergoing treatments. Esther Keesing-Styles, in her biography *Brave Little Girls Don't Cry* (1992) illustrates that her behaviour during her treatments for polio deformities were entered onto her record. For example, if she made a fuss when being treated this was entered as 'bad' behaviour.³⁵ Esther's experience and even the books title suggests that a certain acceptance about their disability, accompanied by bravery and stoicism in the face of frightening treatments were expected from children. The side affects of polio often resulted in treatment that would be upsetting for an adult but children were expected to bear their upsets with stoicism.

DISABILITY IN 1940s NEW ZEALAND

The final section of this chapter investigates the period from the early 1940s up to 1945. Greater awareness of the Crippled Children Society and its work had been reached by the 1940s as a result of appeals and the co-operation of the Crippled Children Society with government departments. As stated at the outset of this chapter the Crippled Children Society produced a document in 1941 outlining Society policy and aims. This document states the purpose of the Crippled Children Society as being:

³² Watkins, p.8.

³³ Crippled Children Society, *Policy*, p.5.

³⁴ Crippled Children Society, *Policy*, p.2.

³⁵ J. Millen, *Brave Little Girls Don't Cry: The story of Esther Keesing-Styles* (Auckland: Solent Publishing, 1992), p.5.

to take up the cause of the crippled child – to act as it were the guardian of the cripple, fight handicaps under which the crippled child labours, and endeavour in every way possible to obviate or minimise his or her disability and generally to bring within reach of every cripple or potential cripple prompt and efficient treatment, coupled with educational and vocational training to equip him or her to establish themselves as independent self-supporting citizens.³⁶

This quotation highlights the notion that disability can be effectively treated with the end result being a ‘self-supporting’ citizen. It is further entrenchment of the ideology of social worth being based upon contribution to society.

Early Society policy also addressed the question of Maori children. From the Society’s view there seemed to be a certain reluctance of Maori people to co-operate with the Society. It was hoped that ‘Maori prejudice might be overcome and that as education in hygiene extends, better housing conditions are provided, and greater attention to Mother-craft is inculcated’.³⁷ This quote expresses the hope that in the future the society would see a greater degree of co-operation from within the Maori community so that they too could benefit from the Society’s work.³⁸

To illustrate the importance of treating disability, Karen Butterworth’s *Mind over Muscle* provides examples of treatment of disability during the polio epidemics. As polio was the most common cause of disability in children I have elected to use this as an example of treatment of disability as a whole. Early polio treatments involved operations to correct the position of twisted limbs. The following testimony of a polio patient shows this:

My doctor Gillies suggested a corrective operation known as a bone block. This involved taking a chip of bone from the shin and placing it in the form of a wedge at the back of the heel so as to restrict movement of the

³⁶ Crippled Children Society, *Policy*, p.1.

³⁷ Crippled Children Society, *Policy*, p.9.

³⁸ This dissertation has not explored the topic as it relates to Maori children and disability as this requires more research and in its own right and is beyond the scope of this study.

ankle. I had the operation at the end of 1944 and it allowed me to discard my calliper.³⁹

Another polio testimony tells of treatments used to straighten bodies or to prevent paralysis. Some of these such as hot 'spa' treatments were rather pleasant, whereas others were quite frightening. In *Brave Little Girls Don't Cry* one can read about the latter treatments seen through the eyes of Esther: 'she endures frightening treatments which include having to hang suspended from the ceiling. With her head held in a halter she hangs for up to half an hour stretching and straightening'⁴⁰ Once again we see that the emphasis upon 'social usefulness' and improvement of twisted bodies meant that children's comfort came second.

A further indication of the prevailing attitudes of those disseminating ideas about child care can be found in two contemporary texts, *From the Pen of Fredrick Truby King* (1951); and *Your Children's Health and Physique: A Book for Parents* (1932).⁴¹ Truby King, writing in the early part of the twentieth century, was responsible for founding the Plunket Society, the main body disseminating 'Mother-craft' information. The latter text written in 1932 claims that it is through lack of parental concern that disabling conditions occur. This is illustrated in comparisons made between ideal and unhealthy bodies.⁴² The introduction to this text looks at the general health of New Zealand as being superior to those of other countries, as indicated by such factors as longevity and Tuberculosis rate. Even so, Renfrew White argued that children's health was not as good as it could be. This was determined by the state of children's teeth as well as their general physique. For example it was found that only 25% of kindergarten children had a 'perfect' set of teeth unmarred by decay, and in school children this figure dropped to 16%.⁴³ The health of children was such a concern because "many of

³⁹ Karen Butterworth, *Mind over Muscle: Surviving Polio in New Zealand* (Palmerston North: Dunmore Press, 1994), p.59.

⁴⁰ Millen, p.4.

⁴¹ J. Renfrew White, *Your Children's Health and Physique: A Book for Parents* (Dunedin: Coulls Somerville Wilke, Ltd., 1932); Rita F. Snowden, *From the Pen of F. Truby King: Chapters Compiled from the writings and Lectures of the Late Truby King* (Auckland: Whitcombe and Tombs, 1951).

⁴² Renfrew White, Preface.

⁴³ Renfrew White, pp.6-7.

the factors responsible [for ill-health amongst adults] commence their influence in the pre-school, kindergarten and primary school era.”⁴⁴

The answer to the problems of ill health amongst children in particular, and ultimately society at large, was as White argued the application of the science and art of public hygiene. There were calls for the education of the population in healthy practices. This knowledge must first be disseminated to the caregivers of the upcoming generations, and be followed by social and economic change that will result in the fullest application of the principals of hygiene.⁴⁵

Further interest in public health and education are indicated by the government support given to the *Radio Talks on Health* programme. Harry Turbott, the Director of School Hygiene, hosted these from 1941. This programme offered short excerpts on everyday health and hygiene concerns as well as on specialist topics. The advice was often accompanied by poster campaigns that gave visual emphasis to the issues of the day. The advice given was generally in accordance with government thinking; and as a result issues such as abortion were only touched on in the context of how ‘immoral’ they were.⁴⁶ The position Turbott held as director of school hygiene indicates the importance of child health and the relevance it bears to the health of a society.

Closely linked to treatment of disability, Orthopaedics was another burgeoning health sector during this period. The Orthopaedic Association history places the origins of orthopaedic treatment in the hands of Frederick Truby King. Truby King promoted the importance of diet, nutrition and attention to footwear, which prevented possibly disabling conditions later in life.⁴⁷

General orthopaedic practise was only common after the First World War in the larger cities and not until the late 1940s in the provinces.⁴⁸ This was for two

⁴⁴ Renfrew White, p.9.

⁴⁵ Renfrew White, p.11.

⁴⁶ H.B Turbott, *Radio Talks on Health* (Wellington: Whitcombe and Tombs Ltd, 1946), pp.7-89.

⁴⁷ C. Hooker, *Orthopaedics in New Zealand* (Wellington: The New Zealand Orthopaedic Association, 1996), p.9; See R.F Snowden, *From the Pen of Frederick Truby King* for further information on the work and opinions of King.

⁴⁸ Hooker, pp.22, 29.

reasons, the first was the Polio virus, which pre-empted a need for specialist rehabilitative care, and the second was the advent of the Second World War. By the 1940s it was recognised that there needed to be specialist orthopaedic institutions for children. This was because these children needed long-term care that was not well suited to the contemporary hospital environment. *The Royal Commission of the Wellington Public Hospital* (1939) found that many of the orthopaedic cases could be housed separately in a location such as the seaside, and that this could be achieved economically if the example of an existing Australian hospital was followed. The Commission suggested that it should be a joint venture between the hospital boards of the lower North and Upper South Islands, with supervision being given by orthopaedic specialists from these areas.⁴⁹

The Crippled Children Society served the newly recognised need to look after the disabled children of New Zealand. The politics of the time were also focused on 'social responsibility' or taking care of those less able members of society, an ideology well suited to the work and vision of the Crippled Children Society. New ideas about the health and well being of children were circulating during this period. The society worked within these paradigms, and the organisations disseminating them, focussing on the creation of as near normal children as possible who were ready to play an active part in society. The formation of the society was a combination of generosity and paternalistic motives, with a definite emphasis on the medical model of disability that places an emphasis on the purely physical manifestations and effects of disability.

The Society included members from other welfare organisations. It was a part of the governing philosophy to work with the government to provide services, not replace them. The climate of political and welfare changes that occurred during the same period saw increased awareness of social need and special groups in society. This was addressed with a view to improving the disabled person's ability to participate in society. Disabled children were no exception with every effort being made to prevent further disabling conditions as well as treating the conditions that existed. This chapter has discussed the origins of the Crippled

⁴⁹ Watkins, p.3.

Children Society and has argued that it emerged at a time of social change and awareness of need. It was also affected by polio epidemics that resulted in large numbers of children becoming disabled. My next chapter focuses on rehabilitation of disabled children and the concept of rehabilitation to 'lead a useful life', a logical step from preventative focus of the earliest years of the society discussed here.

Chapter Two

Crippling is more than an illness: Rehabilitation as a primary focus in the care of disabled children 1945-60.

The previous chapter explored the social and political context for the formation of the New Zealand Crippled Children Society. It argued that by the early 1940s 'social utility' had emerged as a key concept in discussions surrounding disability and children in New Zealand. This chapter revisits these ideas and addresses the role of rehabilitation in the treatment of disabling conditions. It demonstrates that disability is not just about illness, but how to cope with its implications. Crippling was not regarded as merely an illness by 1940s New Zealand society, but as something requiring both physical and emotional treatment. Such ideas are explored here through the examination of contemporary sources such as *Bringing Up Crippled Children*, a guide for parents and teachers published in 1951 by the Crippled Children Society.¹ The 1949 Carlson Report that followed the visit to New Zealand by Cerebral Palsy specialist Dr Earl Carlson also addresses these issues.

The rehabilitation theme, central to the lives of disabled children, was echoed in wider society. The field of Rehabilitation was a major campaign issue for the Labour government in the 1940s elections. Soldiers returning from war after 1942 were quickly placed into rehabilitation to aid the promise of a better life². The early Crippled Children Society history demonstrates the overseas influence in the field of disability, with many of the rehabilitative techniques being already practiced in the United Kingdom.³ Techniques developed to serve this group could be implemented in the treatment of disabled youngsters. Advances in medical technology and knowledge that took place during the 1945-60 period reinforced a changing medical and social environment, in which to develop

¹ M.V Kennedy and H.D.C. Somerset, *Bringing Up Crippled Children: suggestions for parents, teachers and nurses* (Wellington: Crippled Children Society, 1951).

² Robert Chapman, 'From Labour to National' in *Oxford History of New Zealand 2nd ed.* Geoffrey Rice ed. (Auckland: Oxford University Press, 1997), p.369.

rehabilitation for the disabled. Dorothy Porter states that in America the wartime experience generated new enthusiasm for changing medical services and government funded health programmes.⁴ The expansions to the New Zealand health system at that time also reflect this trend.

The previous decade had seen the inception of the Social Security system, with its health and social benefits. By the late 1940s the nature of the health and pharmaceutical benefits were established, although there were some who were sceptical about their efficiency.⁵ For disabled children the emergence of free health care meant that they could more readily gain access to the hospital treatment they required, although the availability of free equipment such as wheel chairs was still some time away.⁶ Rehabilitation is mirrored in the stories of people who were children during this period. This chapter explores these stories and discusses their relevance to the themes and concerns in medicine and society during the period 1945-1960.

National health concerns at the close of the Second World War can be captured using the *1947-49 New Zealand Yearbook* as an indicator. The 1947 book has health issues divided into three main sections, social health issues (including concerns such as Sexually Transmitted Diseases), environmental issues (looking at sanitation) and public health; which was concerned with the declaration of diseases that were a risk to the public. A list of such diseases can be found in the 1947-9 yearbook.⁷ Public health was regulated at a local level, with each local government being responsible for ensuring that their residents had access to conditions that complied with health and sanitation standards. These measures indicate that the immediate post-war New Zealand society was anxious to prevent disease and any side effects that might ensue. Except where it is linked to disease,

³ H.E. Carey, *New Zealand Crippled Children Society History, 1935-60* (Crippled Children Society, 1961), p.33.

⁴ Dorothy Porter, *Health Civilisation and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), p.227.

⁵ Alexander Lexington Jones, *Social Security in New Zealand: Medical Hospital and other related Benefits* (Wellington, 1949)

⁶ *Crippled Children Society News 50th Anniversary Edition* (Auckland: Crippled Children Society, 1985) states that free wheel chairs were not available as of right until the 1970s. pp.5-8.

⁷ *Official New Zealand Year Book 1947-9* (Wellington: Department of Statistics, 1949), pp.108-120.

disability remained largely invisible. Despite this, in the world of disability, orthopaedics and rehabilitation were important themes.

ORTHOPAEDICS

The coming of age of orthopaedic practice during the 1945-60 period was a substantial influence on the development of disability treatment. One of the key developments was the establishment of the Orthopaedic Association in 1950, and the subsequent spread of Orthopaedic treatment to rural centres. Prior to the end of World War Two there were only ten practicing Orthopaedic surgeons in the entire country. However there were a number of others who had received orthopaedic training. The majority of New Zealand Orthopaedic specialists were trained in the United Kingdom, and so many British ideas about Orthopaedics were disseminated in New Zealand. Increasing numbers of surgeons turned to solely orthopaedic practices, partially out of increased demand but also from a desire to see their field advanced. The increase in surgeons meant that Orthopaedic specialists were available in the major rural centres as well as in urban areas.⁸

From the beginning of widespread orthopaedic practice in New Zealand, there was a link between Orthopaedics, the Crippled Children Society and the treatment of disabled children. Alexander Gillies, founder of the Crippled Children Society, was also heavily involved in the development of the Orthopaedic Association, and an active Red Cross member. His involvement in all of these broadly related areas represents the types of influences upon those defining the medical experience of disability.⁹

Hospital Orthopaedic units and specialist Orthopaedic clinics emerged from development and expansion of Orthopaedics during the period after 1945. These served to enhance the importance of the profession to the sphere of rehabilitation. The *Crippled Children Society News 50th Anniversary Edition* states that from

⁸ Colin Hooker, *Orthopaedics in New Zealand: The first 90 years* (Wellington: The New Zealand Orthopaedic Association, 1996), pp.29, 40-41, 48.

⁹ *Who's Who*, 11th ed (Wellington: A.H and A.W Reed, 1978), p.113.; Hooker, p.30.

1945 there was a full time occupational therapist attached to the Auckland branch, as well as speech therapy facilities on a partial basis.¹⁰ This arrangement highlights the importance of improving the motor and speech skills of children so that they were better equipped to participate in the outside world and lead a 'useful' life. It also indicates the way in which crippling was not just an illness but something that required ongoing treatment, best coupled with education.

An important step in the rehabilitation process was the examination of children by medical personnel. As a precursor and later support to hospital clinics travelling orthopaedic units that operated from 1939 were designed to help children in rural areas who had little or no access to hospital services. These were organised by the Crippled Children Association and this was often the service they were recognised for in rural New Zealand. In some South Island areas travelling clinics pre-date the establishment of the Orthopaedic Association and widespread Orthopaedic practice by ten years, indicating a concern for child rehabilitation and a belief that orthopaedics was useful in this. By the 1945-60 period travelling clinics were operating in the North Island also. The clinics saw mainly children deemed curable and gave advice for treatment. They assessed the progress of children that had been patients previously and dismissed them when they were 'cured' or nothing more could be done for them. Governmental co-operation and support for the clinics can be seen by the gift of £1000 in 1939 to facilitate the establishment of Travelling Clinics.¹¹

Finding crippled children and assisting them was the primary goal of the Crippled Children Society. Until 1940 this was achieved through the use of voluntary workers but after 1940 field officers were employed to go into the homes of the children to assess them while offering advice and assistance to their parents. These officers were the 'face' of the Crippled Children Society and as such provided a vital link between the wider community, the Crippled Children Society and the medical and educational professions. Alongside the idea of bringing actual treatment to the patient stood the notion that after-care was essential to ensure that

¹⁰ *Crippled Children Society News*, p.2.

¹¹ Carey, pp.33-5, 37.

the patients were recovering properly and doing what was necessary to recover as quickly and fully as possible. This system was still in place in the 1980s.¹²

The Field Officers had to fulfil a certain number of criteria. The Crippled Children Society definition and criteria taken from the 25th Anniversary History are noted below.¹³ These officers were to be considered as similar to district nurses, and were act as an advisor on matters concerning the state and the individual child. Their role was an essentially supportive one, with an element of supervision of the child's condition included.

A rehabilitative focus is illustrated by the story of Shelley West in her autobiography *Shelley Has a Baby* (1997).¹⁴ Shelley developed a condition called rheumatoid arthritis in the early 1960s when she was about eighteen months old. Shelley was the youngest person with her condition in the Southern Hemisphere, as a result little was known about the ongoing effects of her condition. She spent a year in hospital undergoing treatment and it became apparent that she would need treatment for the rest of her life. Rehabilitation was considered worthwhile despite any pain of inconvenience involved. Any improvement was worth the associated cost. Shelley's progress towards walking unaided, which is explained in her autobiography, illustrates this. 'I was once again walking; I had undergone two operations to straighten my legs. My knees were more or less locked into one position but at least I could walk under my own steam.'¹⁵

The ongoing consequences of rehabilitation were almost as important as the actual treatments themselves. While treatments were effective in relieving the conditions they were prescribed for occasionally they had disastrous consequences. The Shelley West story is a pertinent demonstration of this. In

¹² Due to my disability, I was a Crippled Children Society client and seen by 'field officers' up until about my early teens.

¹³ Carey, pp.51-2. While teaching or nursing experience was desired common sense and sympathy were considered more important. They were expected to find cases of crippling early on and follow them up accordingly. Officers were expected to act as support and advisor to parents and assist with such aspects of life as hospital admittance. Furthermore, they were expected to work in tandem with guidance officers and be well versed in occupational and educational opportunities.

¹⁴ Shelley West, *Shelley Has a Baby: The remarkable story of Shelley West* (Auckland: Bateman, 1997).

¹⁵ West, pp 14-15.

Shelley's case the two-year course of Prednisone she took as a toddler caused cataracts in her eyes a decade later:

The doctors told me the cataracts would continue to grow until they fully obscured my eyesight and that there was nothing anyone could do about them until they were big enough to be removed; that probably wouldn't happen until I was in my early twenties because they were growing very slowly.¹⁶

Rehabilitation was doubly important during this period, as polio was still rife. The vaccine was not developed until 1956 and so children were still contracting the virus and living with the consequences. Rehabilitation as a result of the disease was a major concern throughout the 1945-60 period, as large numbers of previously healthy children suddenly became disabled and needed to re-adjust to the world. Additionally, returning war veterans provided a new group that needed rehabilitation. The needs of the disabled adult veterans whilst very different to those of a disabled child shared commonalities and so the treatments used with one group might be adapted to help the other.

Growing up with a disability often meant numerous hospital trips and operations. Some children regarded these aspects of disabled experience as facts of life. An example of this is the way in which Peter Spencer says to his mother 'I was just discussing my various operations with Heather and I think I made her feel a bit crook, she said she didn't really like to look at them much but they were jolly good carving!'¹⁷ Peter's surgery involved heart operations, resulting in scarring across his chest, making him appear 'carved'. Comments such as Peter's indicate the stoicism with which young disabled children faced their conditions and associated rehabilitation.

Angela Muir, born with Larsen's Disease affecting the bones and joints, combined with dwarfism, was another child well acquainted with the consequences of

¹⁶ West, p.17.

¹⁷ Barbara Spencer, *Peter John: a remarkable story of love and courage* (Christchurch: Whitcombe and Tombs, 1969), p.69.

rehabilitation. Angela was born with almost every bone in her body dislocated; as a result she underwent a great deal of surgery as a child. This was an undoubtedly traumatic situation that was exacerbated by the absence of parents as her recovery period was spent in Wilson Home, a long way from her family home.¹⁸

As a result of limited parental contact during infancy, Angela had social adjustment difficulties when she was released from treatment and allowed to return home. For a long period of time she reacted badly to her parents and cried a great deal when left with them. This shows the traumatic effects of treatment that would not find their way into the medical mindset, but were also as important in the rehabilitative process.¹⁹ These stories demonstrate the way in which treatment of disability not only impacted upon children physically but also emotionally, reinforcing ideas from both Dr Earl Carlson and Millicent V. Kennedy and Professor H.D.C. Somerset's text *Bringing Up Crippled Children*.

CEREBRAL PALSY: A CASE STUDY IN REHABILITATION AS A DISABILITY TREATMENT.

In the post-war period Cerebral Palsy was a major concern for those involved in the treatment and care of the disabled. It was, and has remained, an important focus for the study of disability in New Zealand and internationally. After Polio, Cerebral Palsy was the single biggest cause of physical disability in New Zealand, and as such is central to the history of disabled children in this period.²⁰ The visit in 1949 of Dr Earl Carlson was a turning point in the treatment of cerebral palsy in New Zealand. His clinical experience in America and his personal experience as a Cerebral Palsy sufferer meant that he was able to offer unique insights into treatments and assess the current methods being employed. As a result of his visit there was recognition amongst the Cerebral Palsied community that they were not alone. His visit also resulted in the commencement of a publication entitled *New Zealand Spastic*, which provided a link for Cerebral Palsied adults and advice to

¹⁸ Angela Muir van Etten, *Dwarfs Don't Live in Doll's Houses* (New York: Adaptive Living, 1988), p.1.

¹⁹ Muir van Etten, pp.3-5.

²⁰ *Crippled Children Society News*, p.4.

parents.²¹ Carlson advocated the opening of specialised schools to cater to the needs to Cerebral Palsied children. Five such schools were operating by the end of the period located in Auckland, Wellington, and Christchurch.²² During his visit Carlson made a number of suggestions about the way in which the treatment of Cerebral Palsied children could be improved. The Carlson Report, written as a result of his visit, suggests a number of areas that need to be included in successful treatment of Cerebral Palsy. These include physical, emotional and educational treatment, an indication that crippling was indeed considered more than an illness.

The Carlson Report includes a diagram (See Appendix 4) outlining the ideal relationship between rehabilitation and education services for the Cerebral Palsied. This was mirrored in the wider disabled children's community. In 1947 the number of Cerebral Palsied children who were registered with the Crippled Children Society numbered 514. This was without returns from some areas, and probably without all Cerebral Palsied children being registered in areas where there were returns. A table indicating numbers with Cerebral Palsy can be seen in Appendix 5.²³

Carlson's report identified three main types of Cerebral Palsy, each with differing characteristics and requiring slightly different treatment methods. The first, Spasticity, manifests itself in the stiffness of certain muscles and difficulty of movement of limbs. The second, Athetosis, is characterised by a squirming movement, accompanied by facial grimaces, often giving an impression of mental impairment. The final type, Ataxia, results in unbalanced action between muscle groups and clumsy movement.²⁴

Carlson's recommendations fell under the following categories: simultaneous education and medical treatment, mental assessment, speech therapy, physical and

²¹ *New Zealand Woman's Weekly*, 25 January 1951, p.15.

²² *Special Education for the Handicapped, Appendices to the Journal of the House of Representatives* (Wellington: R.E. Owen, Government Printer, 1960), E-1, pp.20-1.

²³ Dr. Earl Carlson, *Report to the New Zealand Government and New Zealand Crippled Children Society on the Problem of Cerebral Palsy* (Wellington: Crippled Children Society, 1949), p.1

²⁴ Carlson, p.2

occupational therapy, other therapies and education.²⁵ One section of the report dealt with the crucial nature of employing the correct methods of therapy. Cerebral Palsy was not, and is not, a homogenous condition. There was no one correct treatment as the symptoms differed radically depending on the combination of 'types' of Cerebral Palsy a person had.

The first factor to be considered when deciding on the appropriate treatment of Cerebral Palsy is the relevancy of the treatment to the patient's condition. However, some techniques such as relation of muscles and visual training (to avoid distractions) are of benefit to all children with this disability.²⁶ It is also important that the physiotherapist relates well to their patients. Carlson pointed out that surgery while useful in some cases was not in others, he stated that it could often be avoided by the correct use of splinting as well as physiotherapy.²⁷

Carlson also warned of the difficulties of drug therapy that inhibits muscle control, worsening rather than ameliorating a child's condition. However, drugs may have proved helpful for children predisposed to having fits. Speech therapy was another integral part of the rehabilitation process. Carlson pointed out that in order to be understood children needed to learn how to speak with clarity. For some children overcoming a speech impediment, to improve life in the outside world, required much practice and specialized training. In some instances this required the ability to block out distractions to allow concentration on communication.²⁸

It was asserted by Carlson that Cerebral Palsied children suffered from disordered emotions as readily as unruly muscles. In fact, one condition aggravates the other. This necessitated education as a form of therapy. Education in this case is not only strictly academic but also involved learning to cope with each individual handicap. In order that this education and rehabilitation be successful there was a need to ascertain the child's mental capabilities. This often bore no relationship to physical difficulties. For example, if the frontal lobe was damaged but other areas

²⁵ Carlson, pp.3-14.

²⁶ Carlson, p.7.

²⁷ Carlson, pp.7-8.

were not then an almost 'normal' looking child may be less mentally capable than a more physically affected child.²⁹

Finally, in keeping with the ideas surrounding rehabilitation and its relationship to education Carlson placed a great deal of importance on learning. He said it was the most effective factor in the amelioration of the disability. He stated that the skills gained during academic training were useful for overcoming physical difficulty also. He stated that parents were often surprised at the progress made by their children after starting school. However, Carlson acknowledged the additional difficulties of multiple disabilities that made the usual aids for teaching difficult to use. In order to make the most of education Carlson said that physical therapy was an essential source of release of mental tension. This point illustrates the reciprocal relationship between physical treatment and educational treatment.³⁰

He also outlined the responsibility for various groups concerned with the welfare of Cerebral Palsied Children. These were, in this case, the New Zealand Government and the Crippled Children Society. He raised the question of responsibility to provide trained specialists to cater to the specific needs of disabled children, as well as diagnostic and training centres where this training could be used.³¹

Carlson's approach to the treatment of Cerebral Palsy was informed by the notion that crippling was concerned not just with physical difficulties. He considered skills used in other areas of life could be readily utilised in the overcoming of disability. Different types of Cerebral Palsy created different needs. Carlson recognised that these needs had to be effectively diagnosed so that the correct treatments could be given, yielding the best result for the child in question. His methods called upon the co-operation of a number of fields including the emerging field of orthopaedics, as well as education and general medical practice.

²⁸ Carlson, p.8.

²⁹ Carlson, p.4.

³⁰ Carlson, pp.3-11.

³¹ Carlson, pp.17-18.

Carlson's points provide a pertinent example of the way in which 'crippling was more than an illness'.

CONTEMPORARY NOTIONS ABOUT REHABILITATION

As illustrated, Carlson's report had an important impact upon the care of disabled children in New Zealand. Another significant source from this period is the caregivers guide *Bringing Up Crippled Children*. This text was praised both in New Zealand and overseas, and extensively used in New Zealand and Australia and was even translated into Dutch.³² *Bringing Up Crippled Children* was written for teachers, parents, nurses and social workers, all people who were concerned with the daily welfare of 'cripples'.³³ This text can be used to ascertain what those in daily contact with disabled children were being 'taught' and what types of ideas shaped their interaction with disabled children.

The book explored a number of physical and psychological aspects of bringing up crippled children. In keeping with the attitude of the day, and indeed of New Zealand at the time, the importance of sunshine and fresh air was emphasised. It was thought important that the disabled child should mix with their peers as far as was possible. The book was divided into chapters each outlining an aspect of care. Within each chapter are scenarios of types of situations that might arise in relation to the topic. Some of these were warnings about the dangers of raising a child badly and other showed the positive outcomes of suitably taught 'crippled children'.

The basic precepts for the treatment of disabled children advocated were: sunshine and rest; play using weakened limbs, education and socialising. *Bringing Up Crippled Children* also includes a section on helpful aids at home, so that the rehabilitation of disability is not confined to the hospital but is taken into the home. The book was meant as a kind of support guide, and offers advice on how to incorporate the disabled child into the family routine. The text encouraged parents not to infantilise their children and to treat them as 'normally' as possible.

³² Carey, p.72.

³³ Kennedy and Somerset, p.11.

The story of Angela Muir Van Etten, mentioned earlier, is an example of this theory in practice. Her parents treated her as normally as possible, often with the result being considered overly harsh by casual outsiders. To illustrate this Angela tells of the way in which people would tell her mother not to punish such a small child. To which the mother would reply: 'She is old enough to know perfectly well what she is doing'.³⁴ While Kennedy and Somerset advocated 'normalisation' of disabled children they thought that children should be made to acknowledge their limitations. Being raised with unrealistic expectations would only bring greater disillusionment later in life. It was claimed that others who had not been brought up this way suffered mental collapse when they could be leading 'useful' lives.³⁵

Being treated as much like other children as possible goes hand in hand with ideas about inclusion. Kennedy and Somerset argued that inclusion is essential to the mental health of any child, and disabled children in particular. Teachers are asked to find ways of including disabled children in normal school life, and treat children with disabilities as normally as possible. This type of approach is as relevant today as it was in the 1950s. Despite the inclusion motif that existed there was still a notion of the fragility of the 'cripple'. This can be seen by the inclusion of advice in care manuals such as *Bringing Up Crippled Children*, which relate to the importance of rest in the day of a disabled child. It was thought that children with disabilities should be provided with stretchers and blankets and encouraged to rest during the day. This idea of rest-time is one which is employed with very young children (6 and under), and so the extension of this to older disabled children seems to imply that in some sense their disabilities infantilised them as far as physical stamina is concerned.³⁶

The example of 'Fred' used in *Bringing Up Crippled Children* shows the push toward further educational development of disabled children. It was thought that this would lead to greater contentment and ability to adjust to their condition. When stifled, it seems Fred reacted by behaving badly as a kind of rebellion

³⁴ Muir Van Etten, p.5.

³⁵ Kennedy and Somerset, p.48

³⁶ Kennedy and Somerset, p.51.

against his condition. In order to prevent this, Kennedy and Somerset argue that mental stimulation and new challenges are a necessary part of life, as they give a sense of fulfilment not gained by mere entertainment.³⁷ These contrasting yet simultaneously held notions about 'pushing' disabled children yet catering to their 'lesser' stamina indicates that although children were expected to perform as adequately as possible this was not always expected to be at the same level as their peers.

Education was one very important rehabilitation device used with children. Much of the literature dealing with disabled children looks at ways they could be given at least a rudimentary education. Vocational training was also seen as very important in the life of the disabled.³⁸ *Bringing Up Crippled Children* states that as far as possible children should be educated in state schools. However, in many cases this was not possible, and so the Correspondence School played a vital role in the rehabilitation and education of young disabled people. The Correspondence School was and remains a state school where children are educated from their homes via lessons sent to them, which they re-mailed for grading. Barbara Spencer's book *Peter John*, illustrates the importance of the Correspondence school to the life of her young disabled son.³⁹

In many respects *Bringing Up Crippled Children* echoed the ideas presented by Carlson several years before. There is a focus not only on treatment of the child's physical condition but also on their educational and mental needs. Somerset also deploys the motif of usefulness, stating that this is essential for the mental and emotional well-being of the children in question. There was still a pervasive notion that 'crippled' children were indeed invalids and needed extra rest and care. Whilst in many cases this might have been true it was not always so.

Crippling is more than an illness and its treatment can be seen not only in a medical context but also as preparation for a useful life. In the case of Cerebral Palsy the condition was recognised as different in each case and thus required

³⁷ Kennedy and Somerset, pp.41-3.

³⁸ *Crippled Children Society News*, p.7.

³⁹ Spencer, p.71.

different treatments, although the general principles behind these were the same. The post-war focus on rehabilitation combined with the development of Orthopaedics and the visit to New Zealand of Cerebral Palsy specialist Dr Earl Carlson, focused the attention of those caring for the disabled firmly upon the process of curative medicine. The Carlson Report, guides such as *Bringing Up Crippled Children* and individual stories such as Angela Muir's, highlight the multi-faceted nature of rehabilitation. The idea conveyed is that disabled experience goes beyond the physical condition, and also encompasses emotional and mental conditions. Education played an important part in treating the latter aspects of disabled experience, although the way in which this was achieved has altered radically over time. My final chapter examines the developments in Special Education between 1960 and the 1980s tracing the change from social utility-based education to child-centred rights based education.

Chapter Three

Training for a 'useful life': Education and physically disabled children 1960 – 1980s.

The previous chapter examined rehabilitation and introduced the idea that education, as an aspect of mid-century rehabilitation, played a vital role in assisting disabled children to live 'useful' lives. This chapter examines the role education has played in the lives of disabled children since 1960. It was not until about 1960 that there was nationwide and international recognition of the need to cater to the needs of disabled children in specific ways. Concepts surrounding the change from education for social utility to education as a right will be explored in this chapter. Perceptions about the education of disabled children changed gradually over the period between 1960 and the late 1980s.

At the heart of this change was the emphasis on the needs of the child, and the right to education. At the beginning of the 1960s it was thought by society that education should be carried out in as near 'normal' an environment as possible. In contrast to this, by the 1980s education policy focussed upon changing of the environment to suit the child's needs.¹ Children became integrated into the classes with the aid of support teachers, specialised equipment and individually tailored programmes. This presented a stark contrast to being expected to fit in with a minimum of special assistance, although the 1960 report *Special Education for the Handicapped*² illustrated that embryonic services existed at that time.

In order to provide a 'snapshot' of education at the beginning of the period I will discuss documents related to special schools such as reports in the *Appendices to the Journal of the House of Representatives* for 1960, and the Education

¹ Principles behind this change and ideas about the 'right' to education can be seen in the 1990 *Bill of Human Rights*, The *Human Rights Act* of 1993 and the *Health and Disability Act* of 1994 that were subsequent but outside the scope of this investigation.

² Minister of Education, 'Special Education for the Handicapped' in *Appendices to the Journal of the House of Representatives*. (AJHR) (Wellington: R.E. Owen Government Printer, 1960), E.1., pp.5-24.

Department report of 1962. Following this it is necessary to examine policies involving the integration of disabled children into regular schools and the effect of mainstreaming on both attitudes towards, and experiences of, disabled children. Largely drawing upon reports, interviews and CCS archival information, this chapter seeks to investigate the changes in both official and popular attitudes to the education of disabled people. This dissertation draws upon a number of personal accounts to express the experience of disability from a human perspective. The final section of this chapter discusses some of the problems for special education which mainstreaming presented.

SPECIAL EDUCATION

The history of special education in New Zealand is as long as that of compulsory education itself. Schools were established for specific groups of disabled people such as the deaf and the blind in the nineteenth century. It was not until some 50 years later and the visit of Dr Earl Carlson in 1949, explored in the previous chapter that schools were established which catered to other types of disability. This chapter covers the period after 1960 as a number of radical changes occurred at this time. A book outlining issues in Special Education in the 1960s claimed the provision of special education for handicapped children was recognition of their right to attain their fullest potential as well as the value the society in question places on such children.³ The notion that disabled children required education to gain their fullest value to society shows the dominance of ideas surrounding the 'social utility' of the disabled. While there was some recognition of right, social utility provided much of the focus and impetus driving early special education initiatives.

There were several key transitions in the history of Special Education in the two and a half decades examined by this chapter. These were influenced by the Education Department that traditionally assumed responsibility for the establishment and maintenance of special education. The Department was significantly aided by agencies that dealt with the children in question, and there

³ D.H. Ross, 'Special Education: Retrospect and Prospect' in *Issues in New Zealand Special Education* (Auckland: Hodder and Stroughton, 1972), p.17.

were a small number of private schools run by these agencies.⁴ The changes demonstrate the way in which education has become increasingly based upon the 'right' of the child to be taught at an appropriate level for them. Inclusion with support and co-operating services was advocated so that those with different needs were fully catered for in the classroom, creating maximum learning potential both for them and those around them. Families became increasingly involved in planning education, as they were deemed to know the children's needs best.⁵ The primary factors affecting these transitions have included overseas influence, socio-political circumstance, advocacy on the part of disabled children, knowledge about cause and treatment of disability and finally administration of services and professional leadership.⁶

A useful starting point for assessing Special Education during this period is the Report from the 1960 *Appendices to the Journal of the House of Representatives*. The report shows that New Zealand was, at that time, nominally inclusive regarding the education of those with special needs.⁷ This sentiment is echoed in discussions regarding the introduction of full mainstreaming, where it was said that this policy was easier to adopt in New Zealand due to a relative reluctance to segregate children.⁸

The report compares New Zealand to the United Kingdom, where many contemporary disability policies originated. The report claimed that unlike New Zealand the British Health Department undertook policies that tended to provide separate schools as opposed to separate classes, and separate administration of services such as speech therapy. In New Zealand specialist teachers trained in speech therapy taught these classes.⁹ Keith Ballard supports this notion in a

⁴ One example is Wilson Home, a residential school run by the Crippled Children Society from 1937.

⁵ D. Mitchell, 'The History of Special Education in New Zealand' in *Exceptional Children in New Zealand*, David Mitchell and Nirbhay Singh eds. (Palmerston North: Keeling and Mundy, 1983), pp.27-8.

⁶ Mitchell, 'The History of Special Education in New Zealand', pp.28-33.

⁷ *AJHR*, 1960, E.1, p.7.

⁸ *AJHR*, 1960, E.1, p.7.

⁹ *AJHR*, 1960, E.1, p.7.

recent article, and asserts the importance of the British influence in New Zealand Special Education policy.¹⁰

Until 1989 there was no legal duty to provide special education services in New Zealand. The 1964 *Education Amendment Act* makes permissive rather than mandatory stipulations for special education.¹¹ Much of the early Special Education Service endeavours catered to 'backward' or learning disabled children. In 1960 there were sixty-seven classes providing for these children compared to just two catering to the needs of the physically disabled. For table indicating types of school and their numbers see Appendix 8. These special classes, especially where older children were involved, provide the learning of social and vocational skills in addition to purely academic ones.¹² This indicates the 'social utility' focus prevalent in education, those who were able were expected to contribute and were trained so that they would could undertake a 'socially constructive' vocation.

The report signifies the need to cater to the differences apparent in disabled children. It suggested that this be achieved by having class work supplemented by a specialist such as psychologist or speech therapist depending on the disability present. A section examining these services was included in the 1960 Report indicating they were an integral part of Education Department policy.¹³ This is interesting as it hints at the direction that Special Education was to take in the future. The report also asserted that teachers were being trained to recognise and cope with disabilities or special abilities in their pupils, leading to a greater retention rate of disabled children in ordinary classes.¹⁴

The Correspondence School also provided education for those who could not be provided for elsewhere. This is particularly the case for those from rural backgrounds or children physically unable to attend school. The role of the Correspondence School can be seen in the story of Peter John, who attended Correspondence School prior to enrolment in ordinary classes. Born with a heart

¹⁰ K. Ballard, 'Inclusive Education in New Zealand: Culture, Context and Ideology', *Cambridge Journal of Education* 26:1 (March 1996), p.33.

¹¹ *Education Act*, 1964.

¹² *AJHR*, E.1, p.13.

¹³ *AJHR*, E.1, pp.6, 8-12.

defect, Peter was deemed too fragile to start regular school and so was in the Correspondence School system for a number of years. However, there seemed to be a feeling that the Correspondence School was not a 'real' school, and this made Peter stand out in situations where he did interact with his peers.¹⁵

The 1960 *AJHR* Report suggested that special education in New Zealand was the result of successful co-operation between a number of departments and voluntary organisations.¹⁶ The involvement of medical specialists as well as teachers and disability workers in the education of physically disabled children is evidence of this. The report used parental willingness to send their children where advised to imply confidence in the special education system. Even so, the report stated that an extension of services in rural areas was needed. It also indicated a desire to keep abreast of developments to ensure that the quality of services remained on par with those elsewhere.¹⁷ New Zealand prided itself on its special education services and although they were to be much improved, at the beginning of the 1960s New Zealand compared favourably to countries such as the United Kingdom.

INCLUSION

The 50th Anniversary publication of the Crippled Children Society discusses the introduction of special facilities catering to physically disabled students.¹⁸ Initially there were private initiatives such as Wilson Home - a residential facility for disabled children - and a number of Cerebral Palsy schools from the 1940s. There were also two Crippled Children Society residential schools in Christchurch, although not as large as Wilson Home.¹⁹ Despite these early efforts concerted steps towards integration did not occur until just prior to 1960. The Mount Street School in Auckland established in 1951 brought groups of disabled

¹⁴ *AJHR*, E.1, p.8.

¹⁵ Barbara Spencer, *Peter John : A story of love and courage* (Christchurch: Whitcombe and Toombs, 1969), p.82.

¹⁶ *AJHR*, E.1, p.23

¹⁷ *AJHR*, E.1, pp.23-4

¹⁸ *Crippled Children Society News 50th Anniversary Edition* (Auckland: Crippled Children Society, 1985), pp.5-6.

children together, and it was from this base that the integrated unit at a Remuera Primary began in 1962.²⁰ Five years later there was a fully operational integrated unit operating at Mt Roskill Primary School, which was extended to secondary education in the 1970s. In a newsletter dated June 1967 the Crippled Children Society stated that:

This marks the removal of the final educational barrier when the words "normal" and "crippled" lose most of their significance and when children who are physically handicapped and those who are fortunately whole work and play together for mutual benefit.²¹

The pre-school sector was also making moves towards integrated learning with mobile kindergartens and integrated kindergartens operation from the 1970s.²²

The late 1970s and 1980s period heralded recognition of the needs of children with multiple disabilities. Attempts were made to include their requirements in New Zealand's education system that had traditionally focused on meeting the needs of children in relation to their category of handicap. The changing educational sector saw tendency to treat disability on a functional level, blurring distinctions between service provisions. The Continuing Education Radio New Zealand publication *Your Child is Different* (first published 1979,) was a self-help book for parents of handicapped children circulated in the late 1970s and early 1980s.²³ It was designed to accompany radio broadcasts, indicating an ever-increasing awareness of the need for parents to be informed about the needs of their children. The introduction of the book stresses the importance of family and early intervention in the education and treatment of children with special needs. This is a theme that recurs throughout much of the literature.²⁴

¹⁹ *AJHR*, E.1, p.14.

²⁰ *Crippled Children Society News 50th Anniversary Edition* (Auckland: Crippled Children Society, 1985), p.2.

²¹ *Newsletter* (Auckland: Crippled Children Society, 1967), p.2.

²² *Crippled Children Society News*, p.9.

²³ D. Mitchell, ed. *Your Child is Different: A handbook for parents of young children with special needs* (Wellington: Continuing Education Radio New Zealand, 1981), pp.4-5.

²⁴ M. Parker, *Parents as Teachers of Their Handicapped Children* (Hamilton: Project PATH, Department of Education, University of Waikato, 1980); *Joining In, a summary, a study of mainstreaming children with educational handicaps into mainstream kindergartens and playcentres* (Wellington: New Zealand Council of Education Research, 1987); *SNAP: Special*

Autobiographical accounts such as Angela Muir's portray ideas of inclusion in schools long before the phrase 'mainstreaming' was coined. Starting school in the early 1960s Muir points out that her family life was always 'ordinary' and it was expected that she would attend school much as her siblings had done. However, with this came different treatment by her peers. This treatment is illustrated in the following extract from Angela's autobiography:

Starting school was traumatic, and learning how to deal with teasing and taunting came to me sooner than I would have liked. I was already conscious of being different and accustomed to people staring, but at school I had to handle a whole group of onlookers by myself.²⁵

Stories such as Angela's illustrate the difficulties concerning inclusion. Children were made to cope with adverse reactions to their differences. The very idea of difference is highlighted by experiences such as Angela's. The disabled child was treated as something other than the normal, and their differences are a point of questioning and often teasing. The ability of learning to cope with the reactions of others is an important part of the process of education for disabled children as it assists them in dealing with similar situations in their later life. A report by J Medland given at the 1980 National Conference on Exceptional Children indicates that this type of response is typical of non-handicapped children's reactions to their handicapped peers. It was noted that the relationship between the two types of child does not start from a 'level playing field'. The relationship was already defined on both sides, with each child having an idea of their 'position' in relation to the other. In addition to this, visible handicaps might create anxiety in non-handicapped children, further inhibiting the relationship.²⁶

Needs Assessment and Programming: a school based in service programme (Wellington: Department of Education, 1987).

²⁵ Angela Muir Van Etten, *Dwarfs Don't Live in Dolls Houses* (New York: Adaptive Living, 1988), p.35.

²⁶ J Medland, The Social integration of Physically Handicapped and Non Handicapped children in a Primary School, in *1st National Conference on Exceptional Children: Papers Volume 1*, Compiled by D.R Mitchell (Hamilton, 1980), p.177.

It is interesting to note that once acceptance is gained their peers did not treat children all that differently. In general physically handicapped children were chosen to participate in activities in close proportion to their normal counterparts, although the more seriously disabled might be chosen less often. Additionally, the study showed that physically disabled children saw a friendship with a non-disabled counterpart as being the most desirable and lasting.²⁷

A study by Karen Dickinson in 1995 addresses sibling relations where one sibling is disabled and the others are not. This is important to the education of disabled children as she found that some 80% of disabled children had at least one non-disabled sibling. The relationship between the two tended to differ depending on factors such as age difference and degree of disability. If the child was seriously disabled or much younger their sibling took on a much more parental type role. Even in cases where the situation was not as marked this happened to some degree.²⁸ This type of relationship might be due to an internalised feeling that disabled children are fragile and need protecting.

MAINSTREAMING

Mainstreaming can be defined as 'the process of educating exceptional children in settings where they have the maximum association, consistent with their interests, with other children.'²⁹ As a consequence there was a decreased focus on the exceptional person as a 'deviant'. Instead policy concentrated on the factors which hindered the growth of exceptional children and stopped them participating in 'main-stream' society. *Your Child is Different* explores the notion that handicapped children were increasingly exploring options previously deemed impossible. The belief that disabled children were incapable of participating in life fully was fast becoming obsolete. These new expectations and opportunities brought with them new obligations for parents, a part of this was the need to

²⁷ Medland, p.181.

²⁸ K Dickson, 'Fairness Perceptions, Disability and Sibling Relationships', unpublished M.Soc Sci Dissertation, University of Waikato, 1995, p.17.

ascertain realistic goals for their children with disabilities.³⁰ However, these expectations were ideals and the reality sometimes differed.

Despite receiving support from the 1970s, mainstreaming did not become widely practiced until the late 1980s. From as early as 1971, as indicated below, there were reports indicating the need to properly integrate handicapped children into state schools.³¹ Integration by no means occurred simultaneously for all types of disability. The first children to be placed into integrated settings were the partially sighted (1949) and it was not until 1977 that those with physical disabilities were offered placements in integrated settings.³² Studies on integration tended to look at the social impacts of the policy as opposed to its role in achieving the goals of the New Zealand curriculum. Educationalists David Mitchell and Jill Mitchell argued that a shift in focus might result in parents and teachers regarding integration as more useful as an educational tool³³. A report in 1985 indicated the imminence of the shift towards this policy citing the desire of parents to see their children educated in a normal classroom regardless of disability. They argued that, with extra help, children are much better to be in a regular classroom both from the perspective of educational and social development.³⁴

By 1980 there was a realisation that Special Education should not focus upon segregating disabled children from their peers but should aim to keep children afloat in the normal world.³⁵ There were a number of basic principles that were

²⁹ J and D Mitchell, 'Integration/Mainstreaming' in *Exceptional Children in New Zealand*, p.107.

³⁰ *Your Child is Different*, p.5.

³¹ These include the Committee on Health and Social Education, *Report of the Committee on Health and Social Education* (Wellington: Department of Education, 1977) Committee of Enquiry into Pre-School Education, *Report of the Committee into Pre School Education* (Wellington: Department of Education, 1971). I.H. Boyd and J.D. Pankhurst, *Psychological, Guidance and Support Services and Children with Special Needs: a Report Prepared for the working party on improving Learning and teaching of the Educational Development Conference* (Wellington, 1974) *Education Development Conference: Regional Report* (Palmerston North: Department of Education, Massey University, 1974) Committee on Health and Social Education *Growing Sharing Learning: Report of the Committee on Health and Social Education* (Wellington: Department of Education, 1977).

³² Mitchell and Mitchell, pp.109-110, 112.

³³ Mitchell and Mitchell, pp.112-3.

³⁴ New Zealand Education Institute, *Report on Special Education* (Wellington: NZEI, 1985), Section C Mainstreaming.

³⁵ For a bibliography of case studies into integration of special needs children into ordinary classes up to 1982 see C.C. Jackson. For a similar bibliography relating to secondary education see

applied to education to ensure that this occurred. These included the clarification of learning objectives and adequate training of staff and sufficient specialised equipment. Programmes were designed to give the students a feeling of relative equality with their peers. To ensure healthy relationships students and teachers were trained and prepared for the introduction of a person with special needs.³⁶

In 1983, an Education Department report to the OECD outlines principles that were remarkably similar to those espoused in the 1973-74 New Zealand Education Review, particularly relating to rights-based education. This was encapsulated in the following principle that underlay education in the 1980s: 'Appropriate education should be available to all children irrespective of the type or severity of their handicap.'³⁷ There was a growing feeling that the community, parents and teachers needed to co-operate to consider the needs of the disabled children in the community. There was a tendency to steer away from stereotypes based on disability labels and focus on the individual child, and their needs as early as possible.³⁸ 1980s New Zealand witnessed a firm shift towards child-centred learning, which aimed to ensure individual children's needs were met. This is indicated by the following principle from the Report to the OECD 'Teaching programmes for the handicapped should be specific to individual needs, and evaluation techniques should be appropriate to individually tailored objectives established.'³⁹

Even as ideas about mainstreaming were being discussed, people such as Christine Riding were asserting that there was a place for 'segregation' of the disabled as a stepping-stone to integration into normal schooling.⁴⁰ To this end the Crippled Children Society had established day cares as early as 1955. Initially these catered for cerebral palsied children unable to attend elsewhere, and had by

D.Mitchell, *Bibliography, One in Seven Project*, (Hamilton: Department of Education, Waikato University, 1987).

³⁶ S.J. Havill, 'Keeping them afloat in the mainstream' in *Issues in New Zealand Special Education*, pp.222-5.

³⁷ OECD Report, p.114

³⁸ A Milne and D. Brown, Provisions for Special Education in New Zealand in *Exceptional Children*, p.41. Taken from Report to OECD by Education Department, 1983.

³⁹ OECD Report, p.114.

⁴⁰ C. Riding, 'Segregation - A Springboard to Success', *1st National Conference on Exceptional Children*, p.202.

the 1980s, evolved into a service catering to a multiplicity of disabilities. The pre-school centre seems to have value in that it gives children a place where they could develop at their own speed or catch up on developmental steps omitted as a result of illness or hospitalisation. It seems that the transition rate into state organised educational facilities was relatively high, with 76% of children were placed in the traditional school system and 18% in special institutions run by the Education Department.⁴¹

One of the issues, arising from greater numbers of disabled children in ordinary classes, was the idea of support for teachers. Teachers interacted with children on daily basis and provided ongoing educational programmes. Consequently they required support and training to accommodate the needs of those who required extra attention. A 1984 report concerning the attitudes of teachers teaching children with special needs, found that teachers were more likely to have a positive response to those children who had 'organic' impairments as opposed to mental or emotional ones. The teachers and the size of the class involved also impacted upon the attitudes of teachers to their disabled pupils.⁴² The New Zealand Education Institute report of 1985 argued that many children with special needs in normal classes were not identified and thus not catered for. Besides integrating a number of those in special school, Mainstreaming also aimed to address this issue.⁴³

The 1984 survey also found that teachers had generally favourable responses when asked about the effects of physically disabled children in the class upon the other class members and upon themselves. While these children tended to take up comparatively more of the teachers time it was not to the same extent as children with other types of special needs.⁴⁴

⁴¹ Ridding, p.203.

⁴² Helen Norman, Eloise Sritheran, Christine Riding, *Teachers' Perceptions of Children with Special Needs: A national survey of primary school teachers concerning children with special needs in regular classes* (Wellington: Department of Education, 1984), pp.12,14.

⁴³ NZEI, Section C: Mainstreaming, 9.0.

⁴⁴ Norman et al., pp.159-60.

FAMILIES AND EDUCATION

Parents and families played, and continue to play, an important role in special education, as they best know the intricacies of their child's condition. One aspect of this role was consultation with schools regarding programmes for their children. Special interest groups who may have specialist knowledge about a specific disability type were also consulted. Whilst professionals seem to have the interests of others at heart, in some cases the professionals failed to anticipate the needs of the child or family correctly. These created frustration as specialists controlled the resources and retained 'power' over those they advised.⁴⁵

Although placement of disabled children in the classroom had occurred throughout the history of special education, by the 1980s it was an active part of education policy. It was advised that children be mainstreamed only after it was ensured that adequate provisions for their needs were put into place. There were difficulties when parents insisted on enrolling their children into a normal school without ensuring these provisions existed. Some schools were reluctant to allocate resources to special needs if they were faced with pressures due to declining student numbers. It has been found that the multi disciplinary approach was the most successful to ensure successful integration. This involved a number of different groups such as teachers, parents, and therapists and in some cases psychologists in the programme creation and implementation.

Some parents however, are more cautious about sending their children to regular state schools. An example of this is Barbara Spencer author of *Peter John*. Spencer explains the dilemma she faced when initially trying Peter at a regular school.

If you take him away from school you deprive him from the
Companionship of his classmate – the spirit of adventure and the

⁴⁵ Sue Wartmann, *Building Blocks and Barriers: the transition from Kindergarten to School for children with special needs* (Christchurch, Education Department University of Canterbury, 1997), p.5.

something new of setting off for school each day. . . . Then again if you leave him at school he will be ostracised, and treated as different.⁴⁶

Whilst the primary focus of this chapter has been on 'formal' education I have indicated the importance of interactions that take place on a family level. This can be seen in ideas about learning found in numerous texts, both primary and secondary.⁴⁷ Agencies such as the Crippled Children Society have long espoused the importance of family relationships in the developmental processes of disabled children. This is indicated by publications such as *Bringing Up Crippled Children*. Three decades later the basic principles governing the advice given in this publication were still being applied.⁴⁸ This indicates that ideas such as inclusion and education and being aware of the needs of your child were still considered valid. These ideas might have been modified to fit in with differing ideas about society and the language to describe disability may have changed but advice being given at a practical level remained similar.

Inclusive education, with its changes to the classroom was not unanimously supported in New Zealand Special Education. The traditional role of special education was to 'fix' those with abnormalities. This type of treatment was often not compatible with normal class routine, and so children with special needs were treated differently from other children. The support for this separated learning can be seen in the 1987 Draft report on Special Education. Some parents might feel that the mainstream was a more 'restrictive' setting for their child and so advocated placing them in an environment where their needs were specially attended.⁴⁹

Another problem of the modern competitive climate is a clash of interests. The Special Education Service is only allocated a finite amount of resources that it must then distribute to those under its auspices. Some sections of the Special Education community see separation of their group as essential to retaining their identity; an

⁴⁶ Spencer, p.70.

⁴⁷ *Bringing Up Crippled Children* (1951), *Growing Learning Sharing* (1977), *1st National Conference On Exceptional Children* (1980), *Your Child is Different* (1981), *Joining in* (1987).

⁴⁸ *Your Child is Different*, pp.15-16.

⁴⁹ Ballard, p37.

example of this might be the Maori Community. This separation ensures that the different groups are not seen as a homogenous entity and illustrate that segregation does have some merit. A publication by M.Cahill for the Equal Opportunity Development Unit suggested the traditional perception of the disabled as infantile, asexual, pitiable and dependant was (and still is) accentuated by such practices. Furthermore, J. Neale in a study of parents of disabled fourth formers found that only 2.9% considered further education for their children compared to over 50% for parents of non-disabled children.⁵⁰

Whilst Special education has always been implicitly supported within New Zealand there was no real legal recognition until fairly recently. An important piece of legislation in the development of Special Education was the 1989 Education Act. This was a revision of the 1964 Act and finally made the provisions for Special Education that had been previously omitted. Ballard cites two passages in particular as being indicative of the commitment to inclusive education. These are sections three and eight which state that children have the right to attend an educational institution free of charge from their fifth until their nineteenth birthdays. This right is the same regardless of any special educational needs a person might have.⁵¹ Whilst slightly outside the scope of my study, I have included information about rights, disability and children in the 1990s below.⁵²

This chapter has traced the development of a more general policy of integration using sources including legislation, government reports, surveys and autobiographical material. . Although suggestions that children should be brought up as 'normally' as possible date right from the earliest part of the period beginning in 1960, the way this was achieved and the reasons behind inclusive

⁵⁰ M Cahill, *Exploring the Experience of Disability*, (Wellington: Health Services Equal Opportunity Development Unit, 1991), p.10; J Neale *Where Next? A Survey of the parents of disabled fourth form students* (Wellington: Further Education Group, 1984), p.27.

⁵¹ Ballard, p.33; 1989 Education Act, Sections 3,8.

⁵² I have found the following website provides a useful summary of Human Rights in Special Education: Special Education and Human Rights: <http://www.hrc.co.nz/act/factsheet9>; Also helpful are the policy guidelines on Special Education, these can be located by accessing the following site: <http://www.minedu.govt.nz> and then selecting the area on Special Education. The 1993 Human Rights Act that outlawed discrimination on the basis of disability further supports this right, as does the Health and Disability Act of the following year.

treatment differed. In the initial period the reason for education of the disabled was strongly based upon a principal of social utility. Education was vocationally based, and designed to improve the disabled person's value to and in 'ordinary' society. From the 1980s the education of those with special needs has been rights based, as later statutes exploring issues such as Human Rights suggest. In the earlier part of this period, children were expected to 'cope' in the ordinary class alongside their able-bodied peers. There were some provision for physically disabled children but these were often in strictly segregated environments. The introduction of mainstreaming and the accompanying support roles has meant the classes being adapted to suit the needs of the child rather than the reverse. The shift in emphasis suggests that disabled children have value over and above social utility.

CONCLUSION

In the decades between 1935 and the mid-1980s a number of significant changes occurred in the field of childhood disability in New Zealand. This dissertation has traced these changes to provide an overview of the history of childhood disability in this country.

This dissertation has identified a lacuna in the historical and medical literature on childhood and disability. Whilst sociological studies of disability are becoming increasingly popular there is still a dearth of historical work on this theme. This in particular applies to the field of the history of disabled children. To address this, the study has utilised a variety of sources, including official government reports and papers, a variety of commissioned studies, parental guides, personal accounts as well as material provided by the New Zealand CCS. This material was used to examine themes important in the history of physically disabled children in New Zealand since 1935 such as the development of the Crippled Children Society, rehabilitation between 1945 and 1960 and education between 1960 and the 1980s.

The stories of children that this dissertation utilises offer a unique perspective on the study of disabled childhood. They give an insight into disabled experience at differing times between 1935 and the 1980s. Although written retrospectively or by parents these personal accounts highlight and support the main themes surrounding the study of disability. They show the impact of disability regarding early disability treatments, effects of rehabilitation and education.

As a part of the changing nature of disability studies, the language and dominant model used to explain and understand disability within society has changed. 1930s understandings of disability were from a purely medical and functional level and focused on the impairments of the individual. More recently scholars have tended towards explaining disability in terms of social construction. This second theory surmises that society creates barriers that create the disabled experience and so

disability itself. The dissertation reflects the complexity of definitions of both 'disability' and 'childhood'

The introduction to this study tackled the difficulties in defining childhood. Phillipe Ariés in his *Centuries of Childhood* characterises the changing nature of childhood throughout history and argues that childhood, as we know it, is a relatively recent construction. He also theorises that children were treated as miniature adults once they had passed the period of infancy.¹ Other historians disagree with this although they concur with the notion that childhood roles have changed throughout history. This dissertation defines childhood as the period before leaving schooling and partaking in the adult world, a period characterised by financial and legal dependence on a caretaker figure.

The first chapter of the dissertation explains the radical changes in the spheres of medical and social provision New Zealand society underwent in the period between 1930 and 1945. During this period there was an economic depression, a world war and, more positively, the development of the Social Security system. Particularly important to this topic was the marked shift in the level of state provision by the end of World War Two. New Zealanders were provided for as a result of 'citizenship' not wealth, and those who were not affluent had greater access to health care than previously. For the purposes of this dissertation these changes meant that children with disabilities were more readily able to gain access to the care that their conditions required.

As this study has shown, children with disabilities became a greater health concern after poliomyelitis epidemics left thousands of children with permanent impairments and need of ongoing support. In the 1930s people began to recognise the need for an agency to assist those with disabilities and their families. Generous donations from overseas indicate that this recognition was not limited to New Zealand. The Crippled Children Society (later New Zealand CCS) arose out of this recognition and from the enthusiasm of members of the community such as (Sir) Alexander Gillies. The Society was comprised of members from a number of

¹ Phillipe Ariés, *Centuries of Childhood, A Social History of the Family*, Translated by Robert Baldick (New York: Knopf, 1962)

influential social and economic groups, ensuring that its endeavours would be well supported. The Society's position as an aid rather than an alternative to state provisions encouraged government support. The donation given to fund the Travelling Orthopaedic Clinics, which saw and treated disabled children in rural areas after 1939, was an example of this.

The idea of 'usefulness' was pervasive in discussions around disability, informing the spheres of rehabilitation and education up until the 1980s. The period between 1945 and 1960 was characterised by a number of developments in the field of rehabilitation, as discussed in the second chapter of this dissertation. The aim of the Crippled Children Society and other groups working with disabled children was the creation of socially useful citizens ready to take their place in society. The texts used here state that quality of life as well as self-esteem all stem from the ability to be seen as useful. In keeping with this parents are warned not to lament their child's condition in their hearing for fear it might have an adverse effect on self-image.² A further support to the rehabilitative focus of the 1950s was the establishment of the Orthopaedic Association in 1950, amongst its members was Gillies, founder of the Crippled Children Society. Such linkages ensured that the two, closely related bodies would co-operate in the provision of treatment for the disabled children of New Zealand.

Rehabilitation was inextricably linked to the notion of a more 'useful' life that involved contributing to the community at large. The rehabilitative and other services offered by the Crippled Children Society were popularised by the 1948 visit of Dr Earl Carlson, himself a Cerebral Palsy sufferer. His visit impacted upon the services provided for this disability and were noted in such 'popular' publications as the *Women's Weekly*. It also united people with Cerebral Palsy who were unaware that others with similar conditions existed.³ He posited the idea that facilities such as the Disabled Returned Servicemen's Rehabilitation

²M.V. Kennedy and H.D.C Somerset, *Bringing Up Crippled Children: suggestions for parents, teachers and nurses* (Wellington: Crippled Children Society, 1951), p.21.

³*New Zealand Woman's Weekly*, 25 January 1951, pp.15, 48.

Centre could be utilised by disabled children when ex-servicemen no longer needed them.⁴

The emphasis on education as a means towards rehabilitation originated with the visit of Dr Carlson. He advocated 'education above all' as a means to overcoming the hurdles that disability creates.⁵ While it was first highlighted in the late 1940s, education dominated the history of disabled children in the period after 1960. The 1960 report 'Special Education for the Handicapped' presents a useful launching pad for the study of this topic. It compares the situation in New Zealand with that of countries such as the United Kingdom and gives an account of the special education services used.⁶

During the period since 1960 there have been a number of changes in the sphere of special education. More recently these changes have become entrenched in law such as the 1989 Education Act and Human Rights legislation of the 1990s. These developments were the culmination of years of changing ideas and expectations surrounding education. Initially there was little provision for physically disabled children and they were educated in the regular classroom as long as they did not prove disruptive. From the late 1960s and into the 1970s there were moves to provide special facilities for children who could not be adequately catered for in the existing system. From these facilities and as technology allowed there were increasing calls for mainstreaming of disabled children into ordinary classes with support teachers and special equipment also provided.

The family was another important part of the education of disabled children. This was often the first place where education took place, and in the case of Correspondance school children it was even more so. From the 1980s parents were consulted in the planning of their children's education alongside childhood specialists, this was because they were supposed to know the needs of their child the best. The development of the Toy Library System in 1978 combined learning

⁴ Dr Earl Carlson, *Report to the New Zealand Government and New Zealand Crippled Children Society On the Problem of Cerebral Palsy* (Wellington: Crippled Children Society, 1949), p.15.

⁵ *New Zealand Free Lance*, March 17, 1948, p.6.

⁶ Minister of Education, 'Special Education for the Handicapped' in *Appendices to the Journal of the House of Representatives* (Wellington: R.E. Owen, Government Printer, 1960), E.1., pp.1-24.

in the home with therapy using toys and games. These were transported to the homes of disabled children and were swapped at regular intervals for new toys that stretched and challenged the children in an enjoyable way. This was a popular type of 'therapy', in 1979 there were 120 Toy Library users, by 1985 there were 600.⁷ As the Toy Library facility came to children in their homes, families were also able to benefit from it.

Finally, a major contribution of this study has been the reading and contextualising of key sources. Contemporary parental and teaching guides such as the texts used here, including *Bringing Up Crippled Children* (1951), used in New Zealand as well as overseas, broached important issues surrounding disability and focused on the importance of social interaction and 'normality' as far as possible. However, these also identified the dangers of high expectations of disabled children.⁸ The CCS Library archival material is a rich resource for historians. Using such materials, further studies need to be conducted on topics outside the scope of this dissertation, including recent shifts in educational and social policy and the experiences of Maori children with disabilities.

⁷ *Crippled Children Society News, 50th Anniversary edition* (Auckland: Crippled Children Society, 1985), p.9. As a toy library user during the 1980s I can vouch for the enjoyment and education the Toy Library encouraged.

⁸ Kennedy and Somerset, pp.54-60.

Appendix 1

Original CCS Logo, depicts the idea of 'crippled children' in a visual way.



Crippled Children Society, *Information Pamphlet* (Auckland: New Zealand Crippled Children Society, 1983), p.7.

Appendix 2

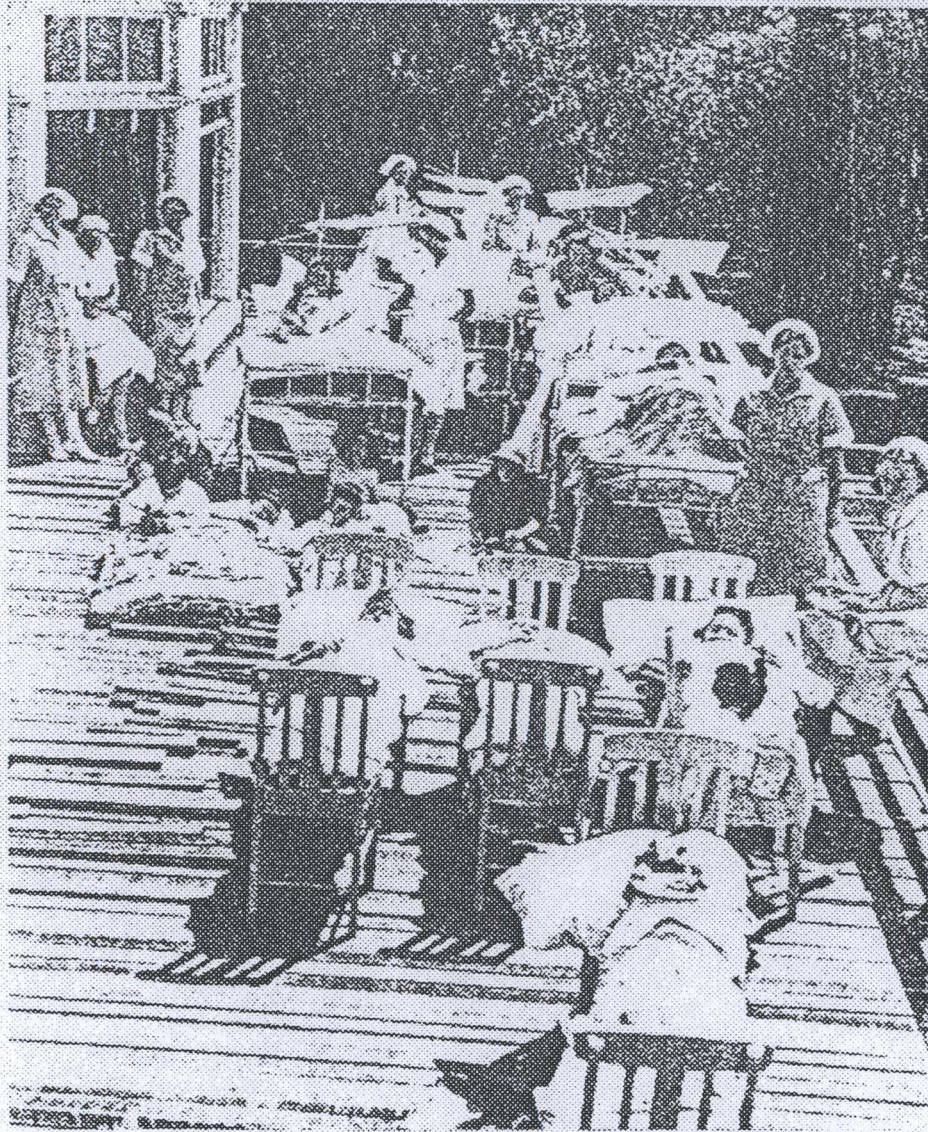
Current CCS Logo



Crippled Children Society, *Philosophy and Policy*, (Wellington: Crippled Children Society, 1994), cover page.

Appendix 3

Wilson House: Children resting in the sunshine



CRIPPLED CHILDREN IN THE SUNSHINE

The sun-platform built at the Wilson Home for Crippled Children at Takapuna, Auckland, was used for the first time last Wednesday, when beds were taken out into the bright sunshine.

Crippled Children Society, *Crippled Children in the Sunshine* (Wellington: CCS Library, no date given).

Appendix 5

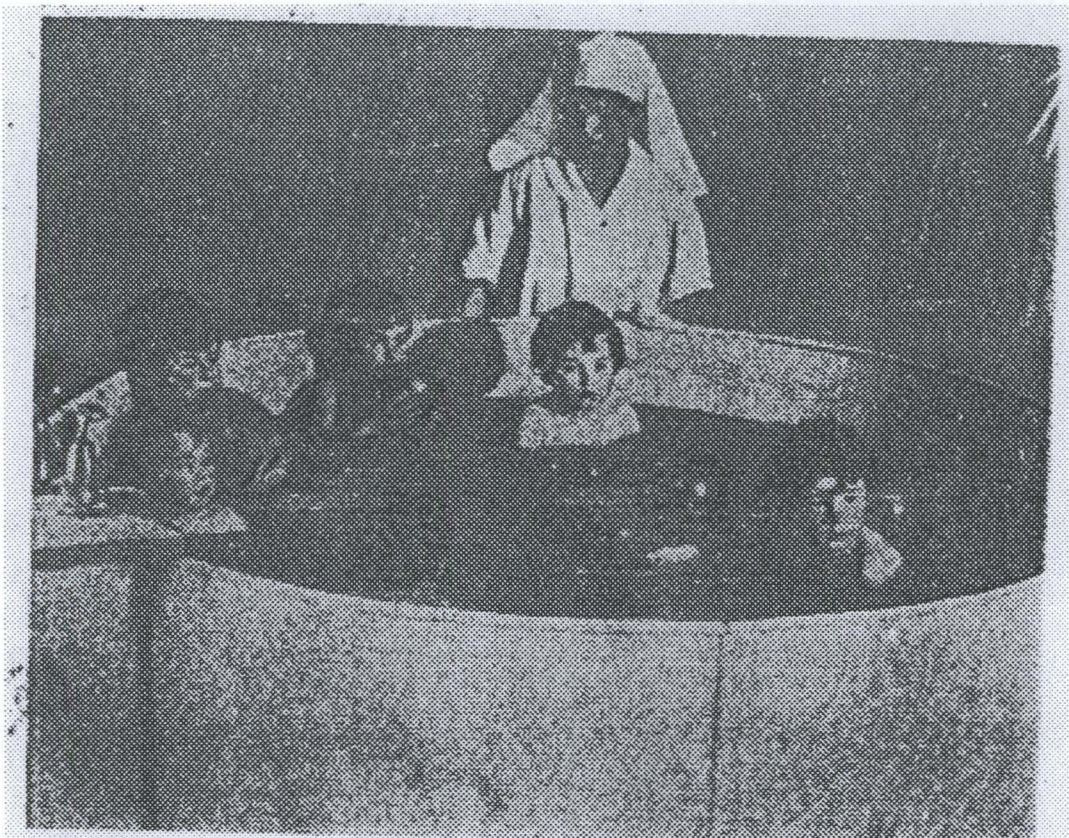
Cerebral Palsy Cases Registered with Crippled Children Society, 1947

Branch	No. of Cerebral Palsy Cases	
	Male	Female
Auckland...	99	82
Canterbury and Westland	40	36
South Canterbury	7	7
Dunedin ...	34	24
+ Gisborne	-	-
Hawke's Bay	4	8
Nelson ...	10	12
New Plymouth	8	8
North Otago	4	-
Manawatu...	4	13
Marlborough	2	4
South Taranaki...	1	3
Southland	11	14
Stratford	2	-
Wanganui...	14	3
Wairarapa	5	4
Wellington	30	21
TOTAL:	275	239
+ Returns not received		

Dr Earl Carlson, *Report to the New Zealand Government and New Zealand Crippled Children Society on the Problem of Cerebral Palsy* (Wellington: Crippled Children Society, 1949), p.1.

Appendix 6

Children in bath, Example of treatment



Christchurch Times, March 28, 1935 (Wellington: CCS Library).

Appendix 7

Disabilities by type, 1960

STATISTICAL REVIEW

Retrospective—Since the incorporation of the Society on 29th May 1935, the following table indicates the number of cases registered with the Branch as shown at each Annual Meeting:

Year	Number of cases registered
First .. 1936	92
Second .. 1937	155
Third .. 1938	246
Fourth .. 1939	336
Fifth .. 1940	462
Sixth .. 1941	468
Seventh .. 1942	492
Eighth .. 1943	558
Ninth .. 1944	639
Tenth .. 1945	642
Eleventh .. 1946	686
Twelfth .. 1947	709
Thirteenth .. 1948	712
Fourteenth .. 1949	721
Fifteenth .. 1950	727
Sixteenth .. 1951	715
Seventeenth .. 1952	761
Eighteenth .. 1953	734
Nineteenth .. 1954	704
Twentieth .. 1955	696
Twenty-first .. 1956	660
Twenty-second .. 1957	634
Twenty-third .. 1958	600
Twenty-fourth .. 1959	508
Twenty-fifth .. 1960	419
Twenty-sixth .. 1961	440
Twenty-seventh .. 1962	469
Twenty-eighth .. 1963	471
Twenty-ninth .. 1964	457
Thirtieth .. 1965	511
Thirty-first .. 1966	530
Thirty-second .. (31st December .. 1966)	546

1st April 1966 to 31st December 1966.

Cases registered 31 March 1966	530
Cured	13
Transferred to other Branches	4
Address Unknown	16
Died	3
Withdrawn	3
Over 21 years of age	7
	45
New Registrations	485
	01
Total cases registered as at 31 December 1966	546

Disabilities Registered

Congenital deformities:	
Cleft Palate	52
Club Foot	108
Dislocated Hip	66
Spina Bifida	12
Other congenital deformities	51
	289
T.B. Bone and Joints	3
Other forms of Bone Disease	10
Other forms of Joint Disease	34
Poliomyelitis	34
Cerebral Palsy	115
Muscular Dystrophy	5
Amputees	14
Disabilities due to injury, fractures, burns, etc.	10
Defects of stance, growth and development	12
Other conditions	20
TOTAL	546

New Zealand Crippled Children's Society, *New Zealand Crippled Children Society Thirty-third Annual Report* (Wellington: Crippled Children Society, 1967)

Appendix 8

Special Schools in New Zealand 1960.

E. 1

6

The range and extent of the work in special education are indicated in the following table:

	Number of Schools, Classes, or Clinics	Number of Pupils	Number of Teachers
<i>Blind and partially sighted children</i>			
Special classes for partially sighted children ..	6	67	6
N.Z. Foundation for the Blind School* ..	1	66	7
<i>Deaf and partially deaf children</i>			
Special class for partially deaf children ..	1	9	1
Special class for severely deaf children ..	1	6	1
Schools for the deaf† ..	2	296	39
Specialist visiting teachers for school for the deaf†	..	..	8
<i>Physically handicapped and delicate children</i>			
Cerebral palsy schools	6	117	31
Health camp schools	7	317	15
Hospital classes	42	549	42
Special classes and schools for physically handi- capped children	4	96	9
<i>Speech defective children</i>			
Speech clinics	60	1,717	60
<i>Mentally backward children</i>			
Special classes for backward children ..	67	949	67
Special schools for backward children† ..	2	111	9
<i>Intellectually handicapped children</i>			
Occupation centres	12	365	37
Occupation groups‡	11	99	..
<i>Educationally retarded children</i>			
Remedial classes and clinics	7	115	7
Special class for maladjusted children ..	1	14	1
<i>Prisons and Institutions for delinquent children</i>			
Prison classes†	7	165	7
Schools and classes for delinquents	2	46	3
<i>Handicapped children not able to attend school</i>			
Correspondence School†	1	154	5
<i>Guidance services</i>			
Psychological service‡ .. .. .	..	..	21
Visiting teachers .. .. .	..	..	27
Reading consultant† .. .. .	..	..	2

Unless otherwise indicated immediate control of the classes, schools, and services listed above is in the hands of education boards.

*Residential school under the control of the New Zealand Foundation for the Blind. The total cost of the education of the children is met by the Department of Education.

†Includes special education services directly under the control of the Department of Education.

‡Private part- or full-time units operated by the parents for small numbers of intellectually handicapped children. They receive annual grants-in-aid from the Department of Education.

Minister of Education, 'Special Education for the Handicapped', *Appendices to the Journals of the House of Representatives* (Wellington: R.E. Owen Government Printer, 1960), E.1. p.6.

LIST OF SOURCES

I have divided the following sources into primary and secondary material. Within each I have devised a number of sections. Primary sources are divided into Official Government Sources (acts and reports), CCS Related Sources (CCS Library Sources and CCS related material) and autobiographical material. The secondary source section is divided into books, (general and disability related), articles, unpublished material and Internet sources.

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