Accommodation and Employment Policies and Services for People with Disabilities

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Jill Hardwick, Jenny James and Fiona Brown

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FOREWORD

This report analyses service provisions for disabled people by the Commonwealth Government and the State Governments of New South Wales, South Australia and Victoria. The main government departments and agencies responsible for those provisions are identified, the forms of such provisions are described, and data on program expenditure and other relevant aspects are presented and analysed. As explained in the Introduction, the services discussed in this report are categorised into those relating to accommodation of disabled people and those whose main focus is on their employment. The report brings together a large volume of data and information which assist an understanding of the needs of the disabled and how governments are responding to those needs. It also highlights differences in developments in the three States included in the analysis and how well State services relate to, and complement, those provided by the Commonwealth.

Chapter Two summarises available information on the demographic characteristics of disabled people, focusing on their accommodation and employment status. Chapter Three describes services provided for disabled people by the Commonwealth Government, and the next three chapters describe and evaluate provisions by the governments of New South Wales, South Australia and Victoria, respectively. The main conclusions and comparisons are summarised in Chapter Seven in relation to how these provisions are meeting the needs of people with intellectual, psychiatric and physical disabilities, respectively.

The report complements research undertaken in the Centre on the extra costs borne by families who have a child with a disability, recently published as Report No.68 in the SWRC Reports and Proceedings series. Together, these two reports extend knowledge of the circumstances of disabled persons and their families and identify the crucial role of government service provisions for the disabled. This is an important, but still relatively neglected, aspect of social welfare research. It is an area of research that the Centre intends to continue to pursue in the years ahead.

Peter Saunders
Director
Social Welfare Research Centre

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A number of people have contributed to the production of this report to whom we would like to express our appreciation. Jane O'Brien deserves special mention for typing this report (and numerous drafts) with such care, skill and cheerfulness. Sue Warth from the Commonwealth Department of Community Services was involved in the original definition of the project and provided support during the early stages. Many people within State Government departments gave willingly of their time to discuss the project and provide information. It would be difficult to thank these people individually but without their help this report would not have been possible.

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CHAPTER 1: INTRODUCTION

The current period is one of change in the provision of services for people with disabling conditions.[1] These changes are occurring at both the Federal and State level at a time of fiscal constraint and changing philosophies towards service delivery. This report looks specifically at accommodation and employment policies and services for all groups of people with disabling conditions i.e. people with physical disabilities, intellectual disabilities and psychiatric disabilities.[2] It reviews services or programs offered at

1. The authors recognise that people with disabling conditions prefer use of this terminology when reference is made to them. However in order to be more concise, this will sometimes be abbreviated to 'people with disabilities' or 'disabled people' throughout the remainder of this report.

2. Persons with a physical disability include those who are restricted by a physical condition such as paraplegia, quadriplegia, loss of limbs, arthritis, visual impairment, hearing impairment.

Persons with an intellectual disability include those with a chronic intellectual or physical impairment, or combination of both, which is likely to continue indefinitely and result in functional limitations in areas of major life activity such as self care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, economic self sufficiency. Examples of such disabilities include intellectual handicap, autism, Down's syndrome, severe epilepsy. Other terms which are used instead of intellectual disability are developmental disability, mental retardation.

Persons with a psychiatric disability are those with a mental disorder such as dementia, anxiety states, manic depression, schizophrenia. Another term which may be used instead of psychiatric disability is mental illness. Psychiatric services may be called mental health services.

Often there is confusion between intellectual disability and psychiatric disability with the result that these persons are often grouped together. However there are substantial differences between the two groups. Persons with intellectual disabilities are not sick but rather their development is delayed. Persons with psychiatric disabilities, on the other hand, have actually acquired a mental illness which may be acute or chronic in its form.

The Australian Bureau of Statistics distinguishes between a disabled person and a handicapped person. A disabled person is defined as a person who had one or more disabilities or impairments (from a list of twelve conditions). A handicapped person is defined as a disabled person aged 5 years or more who was further identified as being limited to some degree in his or her ability to perform certain activities or tasks in relation to one or more of the following five areas: self care, mobility, communication, schooling, employment. (A.B.S., 1982:xvi).

the Commonwealth level and in three States, New South Wales, South Australia and Victoria. The study originated from one of the findings of the Handicapped Programs Review[3], namely, that the current segregation of Commonwealth and State funding fosters parallel systems of services. To help rectify this situation, the Report of the Review, New Directions, recommended:

> '. a joint Commonwealth/State government program of special services for people with disabilities - with complementary legislation, cost sharing and effective co-ordination links to generic services;
>
> . a clearer definition of the respective roles of the Commonwealth and the States with regard to services for people with disabilities; and
>
> . establishing broadly representative Commonwealth/State planning and program review mechanisms, with particular emphasis on consumer involvement at the State, regional and local levels.' (DCS, 1985:121)

However, comparative information on State policies, services and expenditure is not readily available, making it difficult to conceive how this Commonwealth-State co-operation will take place. This study aims to help fill this gap by examining the main Commonwealth program which funds services for people with disabling conditions, namely the Disability Services Program, and comparing it to similar services which are provided by the States.

The Commonwealth government's role in programs for people with disabling conditions can be divided into two main areas: income support and service provision. The Department of Social Security provides income support through direct cash payments to disabled people, such as the Invalid Pension, Sickness Benefit, Handicapped Child's Allowance, Rehabilitation Allowance and Mobility Allowance. The Department of Community Services currently

---

2. (continued) Technically speaking, in this report we are referring primarily to severely handicapped people. However because the term 'handicapped' is generally disliked we use the term 'people with disabling conditions.' For a fuller discussion of definitions, see Matthews (forthcoming).

3. The Review was initiated by Senator Don Grimes, Minister for Social Security, in September 1983. A report entitled New Directions was released in May 1985 detailing the findings of the Review. At this time Senator Grimes was Minister for the newly-created Department of Community Services.

administers four programs which fund services for people with disabilities: the Disability Services Program (previously known as the Handicapped Persons Welfare Program), the Print Handicapped Scheme, Program of Aids for Disabled People and the Commonwealth Rehabilitation Service.[4]

TABLE 1.1: PROGRAMS FOR PEOPLE WITH DISABILITIES FUNDED BY THE COMMONWEALTH DEPARTMENT OF COMMUNITY SERVICES

Program	Expenditure 1985-86 $('000)
Disability Services Program	109,079
Grants Print Handicapped	795
Program Aids for Disabled	13,944
Rehabilitation Services	5,523

Source: DCS, Programs for people with disabilities, Canberra, AGPS, 1986.

The most important program, in financial terms, is the Disability Services Program as shown in Table 1.1. This program funds services which include accommodation support - i.e. community-based long term residential accommodation; respite care; supported employment in a variety of settings and according to a number of different models; competitive employment training and placement; independent living training; (recently it expanded to include advocacy and information; and recreation.) Broadly, these services can be grouped into two types: accommodation and employment.

The aim in this study is to review the provision of similar services provided or funded by the State governments. This includes services provided directly and those provided indirectly in the form of subsidies to non-government organisations. Policies and programs are described and operating costs for the year 1984-85 are estimated. Comparisons are made between the States in terms of a number of key issues. The relationship of State services to Commonwealth services is addressed. Estimates are made of per capita expenditure per disabled person, which give a basic quantitative measure of some of the qualititative differences in service provision by State.

4. The Commonwealth Rehabilitation Service has recently been integrated into the Disability Services Program.

Fundamental to the discussion is the way the data have been structured and analysed. In the presentation of material there is a separation of institutional services from community services. Institutional services refer to hospitals, nursing homes, or any other form of large scale institution where people with disabilities live on a long term basis. Community services are small scale, decentralised services which are widely available on a local area basis. Community based accommodation services include, for example, group homes which are houses of usually no more than four or five people which may or may not have live-in staff (depending upon the dependency of the occupants); single accommodation for which occupant support may be provided by an attendant carer who comes in daily or lives adjacently; foster care where a carer is paid to provide board for a person with a disability. Community based employment and vocational services include sheltered workshops, reverse integration projects (which allow a mix of disabled and non-disabled workers in the same setting), normal work sites with appropriate support, day training programs for social skills or independent living training.

In addition to the community accommodation services, there are also a range of community support services which may assist people to live as independently as possible in the community. These include personal care services (home help; meals on wheels), home nursing (bathing; medications), non-medical services (physiotherapy; ococupational therapy; speech therapy; counselling; group therapy), and respite care[5].

This distinction between institutional and community services is central to any discussion about policies and services for people with disabling conditions because it is the most overt manifestation of the philosophy underlying the provision of services. In particular it refers to the extent to which there is evidence of the application, in practice, of the principles of normalisation, least restrictive environment and deinstitutionalisation. These principles are inter-related and form the basis of arguments aimed at restructuring services for people with disabling conditions. The discussion in the following chapters shows that there appears to be unanimous support

5. Very little information is provided in this Report on these community support services. The only services of this nature included in our expenditure estimates are those services provided specifically for a particular disabled group.

for these principles, in theory or policy terms, but there is wide variation in the extent to which implementation has occurred. In order to show how these principles are related to the nature of service provision, they will be discussed briefly here.

The concept of normalisation was developed and articulated by Bengt Nirje in 1969 in Sweden. It was first espoused in relation to mentally retarded people but has since been more widely applied to all disabled and devalued people (e.g. older people).

> 'The normalisation principle means making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society' (Nirje, 1976:231).

Bank-Mikkelsen (1976:27-28) describes normalisation as meaning the acceptance of the mentally retarded with their handicap, offering them the same conditions as are offered to other citizens, including the treatment, education and training needed to provide for optimal development. Implicit in the principle of normalisation is the concept that mentally retarded people are entitled to the same rights and opportunities available to others in their society, including opportunities to exercise personal preferences and freedom of choice.[6]

A corollary to the principle of normalisation is the concept of least restrictive environment. This term

> 'requires that the level and type of assistance made available to a person does not exaggerate that person's need for such assistance and support' (Le Breton, 1985b:2-4.)

Both of these principles lend support to the policy of deinstitutionalisation which is pursued widely in Australia and overseas. Basically this means 'moving people out of institutions'. The original arguments for such a process related to the notion that it was far more humane to care for people with disabilities in their own communities rather than in large, impersonal institutions - hence the relationship to the terms normalisation and least restrictive environment. However, the experience of deinstitutionalisation

6. For a fuller discussion of the development of this concept by people such as Wolfensberger, see Perrin and Nirje (1985).

overseas, especially in the United States and Britain, has shown that it is not a synonym for 'community care' in the sense that it does not necessarily imply the automatic provision of a range of community-based services. One of the issues pursued in this study is the extent to which the process of deinstitutionalisation has resulted in the provision of adequate community services. Hence the focus in the presentation of data and information on the balance between institutional and community services.

The accommodation and employment services provided by the Commonwealth government under the Disability Services Program, are primarily for people under the age of sixty five with severely disabling conditions[7]. In reviewing the State services, we have tried to focus solely on services for this group but in many instances it is hard to differentiate services strictly on the basis of age and level of handicap, or, more especially, to isolate the cost of services for different age and disability groups.[8]

Time and resources have restricted this study to the examination of policies and services in three States: New South Wales, South Australia and Victoria. There is no expectation that these three States reflect the full range which exists in the level of service provision. Rather, we suspect that they probably represent the progressive end of the spectrum in terms of their policies and level of expenditure.

Our method of collecting data was to visit the relevant State departments and ask for information. We avoided undertaking formal surveys so as not to place extra work on departmental officers. Most of the information was culled from existing documents and statistical collections. However, in the case of the New South Wales Department of Health, some of the information was not available centrally, so it was necessary to visit the three metropolitan

7. A person with severely handicapping conditions, defined according to the ABS Handicapped Persons Australia 1981 survey, is someone aged 5 years or more who requires personal help or supervision or is unable to perform one or more activities in the following five areas: self care, mobility, communication, schooling, employment.

8. By definition, most disabled people in sheltered employment or supported accommodation are severely disabled. However some of the services provided by the Departments of Housing in various States, for example, include people with disabilities of varying levels of severity. It has not been possible to identify the actual level of disability of services recipients.

regions and write to the eight country regions requesting data. A structured form was developed in an attempt to ensure some uniformity in the data collection.

There are six remaining chapters in this report. Chapter 2 contains estimates of the numbers of people with severely disabling conditions, where they live and their employment status. Chapter 3 reviews and critiques the services provided by the Commonwealth government through the Disability Services Program. Although the program has existed in some form or another since 1963, it was recently expanded with the passing of new legislation at the end of 1986. One of the key components of this expansion is the availability of funds for competitive employment training services, so in this chapter we also look briefly at such programs currently provided by the Commonwealth Department of Employment and Industrial Relations. Chapters 4, 5 and 6 describe policies and services in New South Wales, South Australia and Victoria provided by the Departments of Health, Housing and Community Services. Originally we also planned to review programs provided by State Departments of Employment. However, it proved too difficult to disentangle State programs from Commonwealth programs, especially when they were jointly administered. Furthermore, very little expenditure data are available on State employment programs for people with disabilities. Chapter 7 discusses the major issues following from the description of Commonwealth and State policies and services. Included are such issues as State differences in expenditure per disabled person, the administrative service delivery structures, deinstitutionalisation and the balance of institutional and community services, co-ordination at the intra-State and Commonwealth-State levels, and the role of non-government organisations, all of which impact on future Commonwealth and State co-operation.

CHAPTER 2: DEMOGRAPHIC CHARACTERISTICS OF DISABLED PEOPLE

2.1 Who are the people with disabling conditions?

Apart from a number of health surveys[1] which tend to focus on illness rather than disability or handicap, the only national estimate of handicap in the community before 1982 was provided by the 1976 Population Census. Persons were asked if they were handicapped by a serious long term illness or by physical or mental condition. The response revealed that five percent of the population had one or more handicaps. However, a follow-up survey aimed at checking the accuracy of the Census information cast serious doubt on the quality of the Census data (ABS, 1982:xv).

In 1982, results were released of a national survey undertaken in 1981, providing statistics on the number of disabled and handicapped people, causes of handicap, disabling conditions, services, aids, accommodation, employment, income, transport, recreation and institutional care[2]. Although these statistics are a vast improvement over what existed prior to 1982, it is important to note that there have been some criticisms of the adequacy of this national survey. It has been argued that the sample size was too small, which means the data cannot be too finely disaggregated, and consequently there are no reliable regional statistics available (Gain, Ellis and Gray, 1983). In addition, there has been criticism of the definitions used and the inadequate coverage of some conditions, especially psychiatric conditions. Also diagnoses are based on self reporting, so there may be inconsistencies in the data.

The 1981 Handicapped Persons Survey provides a picture of the handicapped population at one point in time. No time series data exists to assess changes over time (although another survey of handicapped persons is planned

1. ABS Chronic Illness Survey, 1968 and 1974; ABS Australian Health Survey, 1977-78.

2. The distinction between disabled people and handicapped people is discussed in Chapter 1, footnote 2. Because people with disabilities prefer not to be described as handicapped, we have tried not to use this term throughout the report except when we are using ABS estimates of the severely handicapped population.

for 1988). The 1981 survey estimated that 1,942,000 persons (13.2 percent of the population) were disabled. Of these, 1,264,600 persons (8.6 percent of the population) were handicapped, i.e. limited to some degree in their ability to perform certain activities or tasks in relation to self care, mobility, communication, schooling or employment.

About half a million people (514,000) were severely handicapped i.e. personal help or supervision is required or the person is unable to perform one or more of the activities defined. Of these, 271,000 were severely handicapped and under 65 years of age. In the Introductory Chapter, we indicated that it is probably this younger severely handicapped population group who receive the services we are describing, so in the presentation of the following statistical information we will make the distinction between characteristics of the under 65 group and the 65 and over group.

Of total disabling conditions for the severely handicapped group, physical conditions dominate, accounting for 73 percent. Psychiatric conditions (mental disorders) represent 17 percent and the remaining 10 percent of disabling conditions have been categorised as mental retardation. (Table 2.1). Figure 2.1 shows that roughly half the people with severe physically disabling conditions are under 65; half those with severe psychiatric conditions are under 65. However over three quarters of persons with severe mental retardation are under 65, related to a shorter life expectancy[3]. Table 2.1 gives the numbers of people with these conditions in each State: there are no major variations in the proportionate distribution of these people by State.

2.2 Accommodation status

Eighty percent of all severely handicapped people (413,100 persons) live in private households (Table 2.2). This varies depending upon the disabling condition and age: over 90 percent of people under 65 with physical disabilities live in private households; 80 percent of the people under 65 with psychiatric disabilities live in private households; 66 percent of the mentally retarded population under 65 live in private households. This

3. Refer back to Chapter 1, footnote 2 for a discussion of the differences between physically disabling conditions, psychiatrically disabling conditions and intellectually disabling conditions or mental retardation.

TABLE 2.1 SEVERELY DISABLED PERSONS WHO ARE HANDICAPPED: TYPE OF DISABLING CONDITION BY AGE AND BY STATE.

	TYPE OF DISABLING CONDITION											
	Mental Retardation			Psychiatric Conditions			Physical Conditions			Total[(a)] Severely Handicapped Persons		
State	<65	65 and over	Total	<65	65 and over	Total	<65	65 and over	Total	<65	65 and over	Total
	('000)			('000)			('000)			('000)		
N.S.W.	15.9	5.9	21.8	19.5	18.6	38.1	79.8	86.2	166.0	91.0	88.1	179.1
VIC	14.8	3.2	18.0	17.8	12.7	30.5	60.8	57.2	118.0	71.2	58.9	130.1
QLD	5.8	3.2	9.0	7.0	8.1	15.1	38.9	39.8	78.7	44.3	40.8	85.1
S.A.	4.4	2.9	7.3	4.8	5.5	10.3	23.6	22.4	46.0	28.0	23.1	51.1
W.A.	*	*	6.0	3.9	5.2	9.1	21.0	21.7	42.7	23.9	21.9	45.8
TAS	*	*	2.3	1.2	1.5	2.7	6.8	8.1	14.9	7.7	8.3	16.0
N.T.	*	*	*	*	*	*	*	*	*	*	*	*
A.C.T.	*	*	*	*	*	*	*	*	4.9	*	*	5.5
Total	50.5	14.3	64.8	55.1	51.8	106.9	235.4	237.2	472.6	271.1	242.9	514.0

* data suppressed due to high relative standard error.

Source: Table constructed from unpublished data provided by the Australian Bureau of Statistics 1981 Handicapped Persons Survey

Notes: (a) Those with a primary condition which had both a mental and physical manifestation are shown against both the mental and physical components of the table, although they are included only once in the total. Hence the total is less than the sum of its components.

TABLE 2.2 SEVERELY HANDICAPPED PERSONS BY PLACE OF RESIDENCE

STATE	Type of disabling condition																Total[(a)] Severely Handicapped Persons					
	Mental retardation						Psychiatric conditions						Physical conditions									
	< 65		65 and over		Total		< 65		65 and over		Total		< 65		65 and over		Total		< 65		65 and over		Total	
	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.	h/h	inst.
	('000)						('000)						('000)						('000)					
N.S.W	9.7	6.2	*	4.7	10.9	10.9	15.6	4.0	7.6	10.9	23.2	14.9	72.7	7.2	63.8	22.3	136.5	29.5	80.8	10.2	64.1	24.0	144.9	34.2
VIC	10.8	4.0	*	2.1	11.9	6.1	14.9	2.9	4.3	8.4	19.2	11.3	56.6	4.2	41.0	16.2	97.6	20.4	64.9	6.5	41.9	16.9	106.8	23.4
QLD	3.0	2.8	*	2.0	4.2	4.8	4.8	1.5	*	6.2	7.4	7.7	35.8	3.1	27.4	12.4	63.2	15.5	40.2	4.2	27.7	13.0	67.9	17.2
S.A.	2.7	1.7	*	1.1	4.4	2.8	3.1	1.1	*	4.2	5.0	5.3	21.7	1.9	13.8	8.6	35.5	10.5	25.3	2.7	14.2	8.9	39.5	11.6
W.A.	*	1.4	*	1.1	3.4	2.5	2.9	0.7	*	3.4	5.0	4.1	19.2	1.9	14.0	7.6	33.2	9.5	21.7	2.4	14.0	7.8	35.7	10.2
TAS	*	*	*	*	*	1.1	*	0.4	*	1.1	*	1.5	5.9	0.9	5.6	2.5	11.5	3.4	6.7	1.0	5.6	2.7	12.3	3.7
N.T.	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
A.C.T.	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	4.4	0.5	*	*	*	*	4.9	0.6
Total	33.6	16.9	*	11.5	36.4	28.4	44.4	10.7	17.3	34.5	61.7	45.2	216.1	19.2	167.0	70.3	383.1	89.5	244.2	27.1	168.9	73.9	413.1	101.0

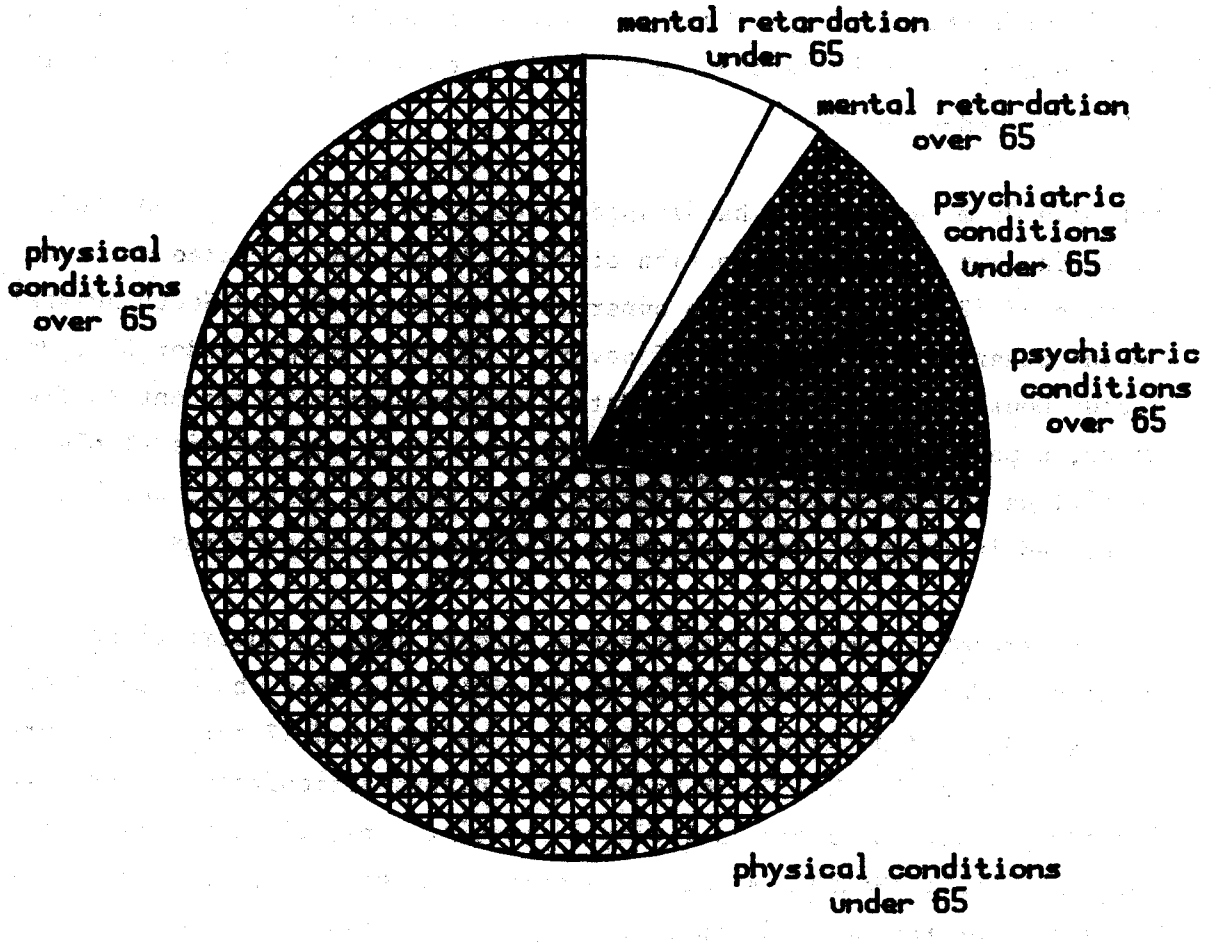
* data suppressed due to high relative standard error

h/h = household inst. = institution

Source: Table constructed from unpublished data provided by the Australian Bureau of Statistics, 1981 Handicapped Persons Survey.

Notes: (a) Those with a primary condition which had both a mental and physical manifestation are shown against both the mental and physical components of the table, although they are included only once in the total. Hence the total is less than the sum of its components.

Figure 2.1
Severely Handicapped Persons By Type of Disabling Condition and Age



Source: Table 2.1

pattern changes dramatically for the population over 65, with much lower proportions living in private households (70 percent of the physically disabled, 33 percent of the psychiatrically disabled and virtually none of the people with mental retardation). This pattern is related to lack of care-givers (mothers, spouses) combined with the social expectation that old age indicates the need for institutional care.

Of interest here is the extent to which the proportion of handicapped people under 65 who live in private households, varies by State. Figure 2.2 indicates little variation for the physically handicapped population. However, the proportion of psychiatrically disabled persons under 65 living in private households varies from 74 percent in South Australia to 84 percent in Victoria (Figure 2.3). Only 52 percent of mentally retarded persons under 65 live in private households in Queensland compared with 73 percent in Victoria (Figure 2.4).

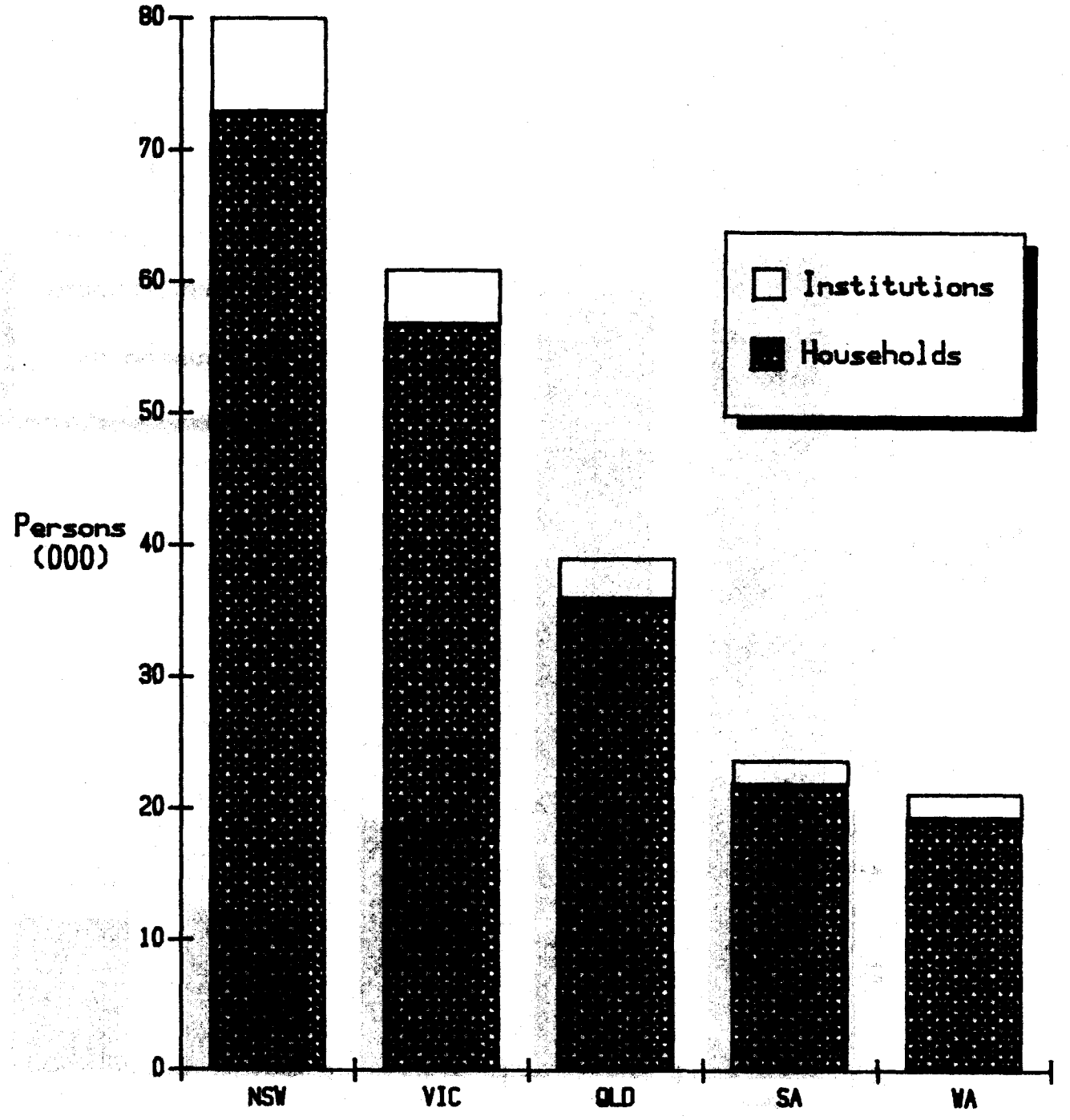
Not only do more severely handicapped people live in private households in Victoria, but a larger proportion of them (78 percent compared with an average of 72 percent) live in owner-occupied housing. In South Australia, on the other hand, 19 percent of severely disabled people under 65 live in rented Housing Commission accommodation compared with 12 percent in New South Wales, 6 percent in Queensland, and only 3 percent in Victoria (Table 2.3). It will be interesting to see whether State housing policies, which are discussed in the next three chapters, influence these patterns.

Twenty percent of severely handicapped persons live in institutions[4]. Many of those under the age of 65 live in handicapped persons homes and hostels (40 percent), 33 percent in psychiatric hospitals and 17 percent in nursing homes (Table 2.4). New South Wales has a disproportionately higher number of handicapped persons under 65 living in nursing homes (27 percent); Victoria has 13 percent; South Australia has only 3 percent. This pattern is very different for the over 65 population. Only 3 percent of those in institutions live in handicapped persons homes and hostels; the majority live in nursing homes (56 percent) and aged persons homes (21 percent). In

4. An institution is defined as a handicapped persons home or hostel, general hospital, psychiatric hospital, nursing home, aged persons home (excluding those retirement villages containing only self contained units). (ABS, 1982:xvii).

Figure 2.2
Severely Handicapped Persons Under 65 By Place of Residence

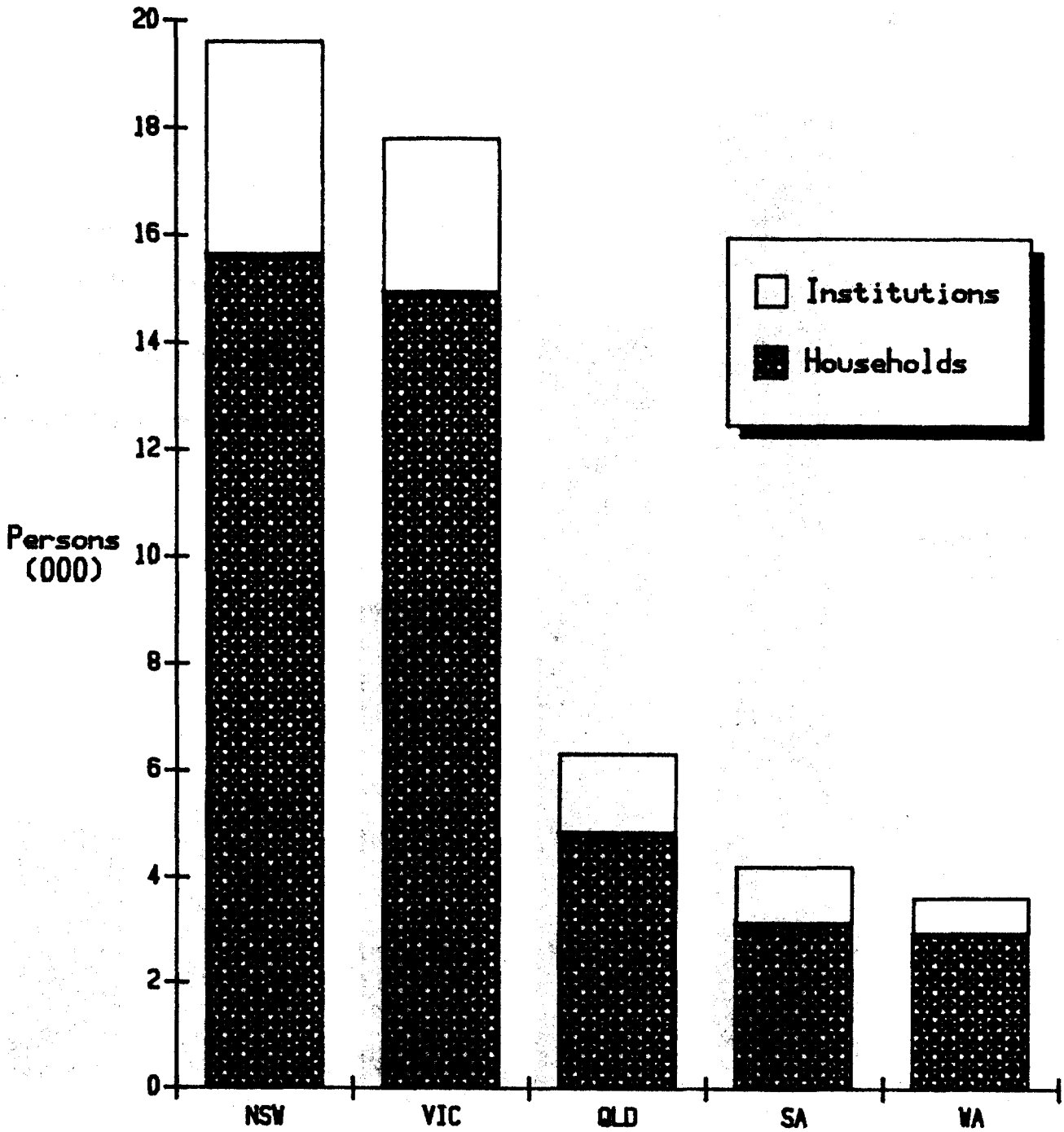
Physical Conditions



Source: Table 2.2

Figure 2.3
Severely Handicapped Persons Under 65 By Place of Residence

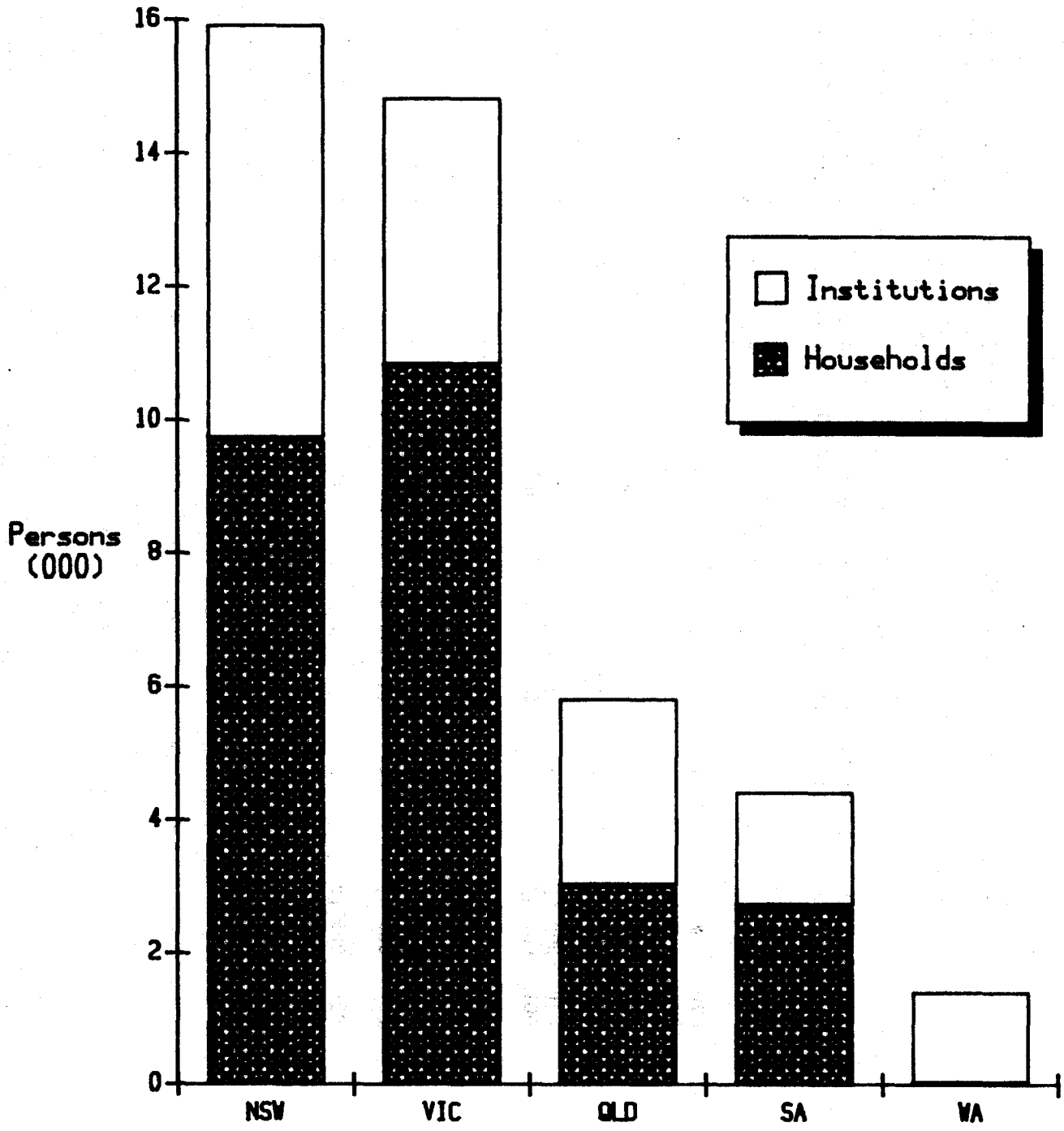
Psychiatric Conditions



Source: Table 2.2

Figure 2.4
Severely Handicapped Persons Under 65 By Place of Residence

Mental Retardation



Source: Table 2.2

TABLE 2.3 SEVERELY HANDICAPPED POPULATION LIVING IN HOUSEHOLDS BY TENURE BY STATE AND BY AGE

STATE		OWNER OUTRIGHT		OWNER PURCHASING		OWNER TOTAL		RENTER HOUSING COMMISSION		RENTER PRIVATE		RENTER TOTAL		OTHER		TOTAL	
		NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
N.S.W.	<65	34,300	43	22,900	28	57,300	71	9,300	12	7,400	9	17,500	22	4,400	6	80,800	100
	65 and over	51,800	81	*		53,900	84	4,400	7	*		7,200	11	*		64,100	100
VIC	<65	30,200	47	20,500	32	50,800	78	*	-	6,700	10	8,600	13	*	-	64,900	100
	65 and over	30,700	73	4,800	11	35,400	84	*	-	*		*		*		41,900	100
QLD	<65	18,400	48	8,800	22	26,900	67	2,500	6	6,100	15	10,300	26	*	-	40,200	100
	65 and over	21,600	78	*		21,900	79	*		3,300	12	4,300	16	*	-	27,700	100
S.A.	<65	10,600	42	5,600	22	18,000	71	4,700	19	*	-	6,300	25	*	-	25,300	100
	65 and over	8,100	57	*	-	9,200	65	2,100	15	*	-	3,500	25	*	-	14,200	100
W.A.	<65	8,000	37	7,400	34	15,400	71	*	-	2,700	12	5,500	25	*	-	21,700	100
	65 and over	9,300	66	*	-	10,100	72	*	-	*	-	3,100	22	*	-	14,000	100
TAS	<65	2,500	37	*	-	4,500	67	*	-	*	-	*	-	*	-	6,700	100
	65 and over	3,800	68	*	-	3,900	70	*	-	*	-	*	-	*	-	5,600	100
N.T.	<65	*	-	*	-	*	-	*	-	*	-	*	-	*	-	*	100
	65 and over	*	-	*	-	*	-	*	-	*	-	*	-	*	-	*	100
A.C.T.	<65	*	-	*	-	1,900	70	*	-	*	-	*	-	*	-	2,700	100
	65 and over	*	-	*	-	*	-	*	-	*	-	*	-	*	-	*	100
AUSTRALIA	<65	105,100	43	70,900	29	176,100	72	23,200	10	31,200	13	54,400	22	9,600	4	244,200	100
	65 and over	126,100	75	9,200	5	135,300	80	10,800	6	11,500	7	22,300	13	8,600	5	168,900	100

* data suppressed due to high relative standard error.

Source: Table constructed from unpublished data provided by the Australian Bureau of Statistics from the 1981 Handicapped Persons Survey.

Notes: (a) Some of the state totals do not equal the sum of their parts due to data suppression in some of the

TABLE 2.4 SEVERELY HANDICAPPED POPULATION LIVING IN INSTITUTIONS BY STATE BY AGE BY TYPE OF INSTITUTION

STATE		GENERAL HOSPITALS		NURSING HOMES		PERSON HOME		AGED TIREMENT VILLAGE		RE- PSYCHIATRIC HOSPITALS		HANDICAPPED PERSONS HOMES & HOSTELS		TOTAL(a)	
		NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
N.S.W.	<65	600	6	2,700	27	300	3	200	3	2,800	28	3,500	35	10,200	100
	65 and over	1,300	5	17,300	72	2,600	11	1,200	5	800	3	900	4	24,000	100
VIC	<65	400	6	800	13	100	2	0	2	2,600	40	2,500	39	6,500	100
	65 and over	1,400	8	10,100	60	2,900	17	800	5	1,100	7	700	4	16,900	100
QLD	<65	300	6	500	11	300	9	0	-	1,400	34	1,200	26	4,200	100
	65 and over	2,000	16	5,100	39	4,600	35	700	5	*	-	*	-	13,000	100
S.A.	<65	100	3	100	3	100	-	*	-	1,100	40	1,100	47	2,700	100
	65 and over	1,200	13	3,400	38	3,200	36			900	10	*		8,900	100
W.A.	<65	100	7	400	15	0	-	0	4	*	-	1,000	41	2,400	100
	65 and over	800	10	4,400	56	1,600	21	600	8	*	-	*	-	7,800	100
TAS	<65	*	-	200	9	0	-	*	-	500	55	*	-	1,000	100
	65 and over	*	-	900	33	800	30	*	-	*	-	*	-	2,700	100
N.T.	<65	*	-	*	-	*	-	*	-	*	-	*	-	*	100
	65 and over	*	-			*	-	*	-	*	-	*	-	*	100
A.C.T.	<65	*	-	*	-	*	-	*	-	*	-	*	-	*	100
	65 and over	*	-			*	-	*	-	*	-	*	-	*	100
AUSTRALIA	<65	1,500	6	4,700	17	800	0.3	200	2	9,000	33	10,700	40	27,100	100
	65 and over	7,100	10	41,500	56	15,800	21	3,600	5	3,900	5	2,200	3	73,900	100

Source: Table constructed from unpublished data provided by the Australian Bureau of Statistics, 1981 Handicapped Persons Survey

Notes: (a) Some of the state totals do not equal the sum of their parts due to data suppression in some

Queensland, a higher than average proportion of elderly people live in general hospitals.

It is important to note at this point that the definition of 'institution' in the ABS survey includes all forms of accommodation other than a private household. As discussed in Chapter 1, we make a distinction in this report between 'institutional' services and 'community' services, referring primarily to hospitals and nursing homes in the former category and group homes, hostels and other forms of supported accommodation in the latter category. This needs to be borne in mind when assessing service provision at the State level. For instance, we noted in our discussion of Table 2.2 that there is variation by State in the proportion of severely handicapped persons under 65 living in households. This variation deserves greater scrutiny. South Australia has a relatively low proportion of severely handicapped people under 65 living in households. However, South Australia also has a lower proportion of people living in hospitals and nursing homes (institutions, in our terms) and a relatively higher proportion in handicapped persons homes and hostels i.e. community based accommodation, in our terms. (Table 2.4.)

2.3 Employment status

Most of the information on employment of handicapped persons in the ABS Handicapped Persons Survey refers to persons resident in households and in the competitive labour force. Of the 651,700 handicapped people living in households and of employment age (15 to 64 years), 226,100 are employed. The majority of these people are wage and salary earners (75 percent), another 21 percent are self employed and 10,700 or 5 percent are sheltered workshop employees. The only information available for institutionalised handicapped persons is the number in sheltered workshops. Of the 22,400 institutionalised handicapped persons aged 15-64 years, 5,200 (23 percent) work in sheltered workshops.

Of the 206,100 severely handicapped persons living in households and of employment age, approximately 30 percent are in the labour force (61,100) and 90 percent of these people are employed (55,200) (Table 2.5). Both of these proportions vary by State. The proportion of the severely handicapped population in the labour force varies from 25 percent in New South Wales to

TABLE 2.5 SEVERELY HANDICAPPED PERSONS LIVING IN HOUSEHOLDS AGED 15-64 BY EMPLOYMENT STATUS

State	Total severely handicapped population 15-64 years ('000)	Severely handicapped population aged 15-64 years in the labour force[a]				
		Number ('000)	% of total severely handicapped population 15-64 years	Employed		Employment rate[b]
				Number ('000)	Percentage	Percentage
N.S.W.	69.7	17.1	25	14.7	86	21
VIC	54.3	18.6	34	17.3	93	32
QLD	34.5	10.2	30	9.5	93	28
S.A.	21.2	7.0	33	6.5	93	31
W.A.	17.4	5.5	32	4.8	87	28
TAS	-	*	-	*	-	-
N.T.	*	*	-	*	-	-
A.C.T.	*	*	-	*	-	-
TOTAL	206.1	61.1	30	55.2	90	27

* data suppressed due to high relative standard error

Source: Constructed from unpublished data provided by the Australian Bureau of Statistics 1981 Handicapped Persons Survey.

Notes: (a) The labour force includes persons who are employed and persons who are unemployed and actively seeking work.
(b) The employment rate is the number of severely handicapped persons employed as a percentage of the total severely handicapped population.

34 percent in Victoria. Likewise, the number of persons in the labour force who are employed varies from 86 percent in New South Wales to 93 percent in Victoria, Queensland and South Australia. The employment rate (the number of severely handicapped people employed as a proportion of the total severely handicapped population) varies from 21 percent in New South Wales to 32 percent in Victoria. Nearly two thirds of these employed people work on a full-time basis. Unfortunately, it is not possible to break down these data according to the type of disabling condition.

Although we do not have a breakdown of the severely handicapped population working in sheltered workshops, it cannot be more than 10,700 persons, the total number of handicapped persons working in sheltered workshops. This represents only 39 percent of the institutionalised severely handicapped population aged 15-64.

CHAPTER 3: SERVICES PROVIDED BY THE COMMONWEALTH GOVERNMENT

This chapter focuses specifically on the Disability Services Program[1] provided by the Commonwealth Department of Community Services[2]. In financial terms, this is the largest Commonwealth program, (excluding income support programs) for people with disabling conditions and its aim is to fund non-profit community-based organisations and local government authorities to provide a range of supported accommodation and employment services.

3.1 History of the Disability Services Program

The program has been operating in some form or another since 1963, albeit under a different name. Initially, subsidies to organisations were for the capital cost of residential accommodation or sheltered workshops (Disabled Persons Accommodation Act 1963). In 1967 this was replaced by the Sheltered Employment (Assistance) Act which enabled subsidies to be paid on a $2 for $1 basis to eligible organisations towards the capital cost of new sheltered workshops, extensions or alterations to existing ones; rental for three years where rental premiums were used to provide sheltered employment; and the cost of equipment needed to operate a sheltered workshop or to increase a workshop's efficiency, including the cost of installing the equipment.

In December 1974, the Sheltered Employment (Assistance) Act was repealed and replaced by the Handicapped Persons Assistance Act (HPAA). The Handicapped Persons Welfare Program, encompassed by the Act, was designed to assist voluntary organisations providing approved programs including sheltered employment, activity therapy and training centres, accommodation facilities and associated ancillary rehabilitation and recreation programs.

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1. This program used to be called the Handicapped Persons Welfare Program under the Handicapped Persons Assistance Act. The name was changed to the Disability Services Program with the passing of new legislation in December 1986. The new Act is the Disability Services Act.

2. This Department offers other programs for people with disabilities: Program of Aids for Disabled People (PADP), Commonwealth Rehabilitation Service (CRS), Print Handicapped Scheme. In addition this Department offers the Home and Community Care Program (HACC) which is targeted primarily to the elderly population but has always intended to cater to the young disabled population as well. None of these programs are reviewed in this Report.

The aims of the program were defined as follows:

- 'to promote the productive employment of handicapped people, wherever possible in open employment, or within sheltered conditions;

- to promote the personal, social and intellectual development of handicapped people;

- to provide residential accommodation services for handicapped people.' (DSS, 1980:41).

Changes made in the Handicapped Persons Assistance Act compared with existing legislation included a rise to $4 for every $1 towards capital and equipment costs, and maintenance or rental costs of establishing sheltered workshops, training centres and hostels for handicapped people; a $4 to $1 subsidy towards the development of recreational and rehabilitation facilities that were ancillary to either the sheltered workshop, training centre or activity centre (including residential and holiday accommodation); and salary subsidies (formerly available only for sheltered workshop staff) paid towards the cost of staff at all approved premises, generally at the rate of 50%, although 100% subsidies could be paid for periods of up to two years in the case of new ventures.

A feature of the 1974 legislation was the introduction of activity therapy centres, designed to promote the development of people with disabilities who were not dependent upon constant care. All existing sheltered workshops were given the opportunity to be reclassified, and as a consequence, half were.

The 1974 Act subsequently led to considerable expansion of facilities for people with disabilities, and this trend is continuing. Table 3.1 shows the level of Commonwealth expenditure provided under this Act since 1974. Expenditure has increased from $14.9m in 1974-75 to $91.3m in 1984-85 (the year for which expenditure comparisons are made in this study). This is more than double the initial amount in real terms. Since 1984-85, expenditure has continued to increase in real terms - by 12 percent in 1985-86 and by 10 per cent in 1986-87. In June 1985, organisations providing services for over 31,000 disabled people were being subsidised. These organisations included:

TABLE 3.1 COMMONWEALTH EXPENDITURE UNDER THE HANDICAPPED PERSONS ASSISTANCE ACT 1974-75 TO 1986-87

Year	Expenditure ($'000)	Expenditure in 1984/85 dollars(a) ($'000)	Expenditure in real terms as a proportion of 1984/85 expenditure
1974-75	14,932.8	38,584.6	42
1975-76	29,991.5	66,548.9	73
1976-77	29,984.3	59,854.3	66
1977-78	37,869.9	69,746.3	76
1978-79	47,599.3	82,174.2	90
1979-80	39,321.8	61,774.5	68
1980-81	51,137.6	72,637.6	79
1981-82	59,853.2	76,137.1	83
1982-83	69,602.8	79,756.4	87
1983-84	75,403.3	80,310.9	88
1984-85	91,344.1	91,344.1	100
1985-86	109,079(b)	102,002	112
1986-87 (appropriation)	125,957(b)	111,105	122

Source: Expenditure figures were obtained from
Department of Community Services, Statistical Supplement to the Report for the period 13 December 1984 to 30 June 1985, AGPS, Canberra 1986. Table 8, p.7.
Department of Community Services, Annual Report 1985-86, Table 3b, p.113

Notes:
(a) Expenditure conversion to 1984/85 dollars (column 3) was done using the gross non-farm product deflater ABS Quarterly Estimates of National Income and Expenditure, Australia, December Quarter 1986 Cat. No. 5206.0 p.43.
(b) These figures refer to the allocation made under the new Disability Services Program which includes expenditure under the Handicapped Persons Assistance Act, HPA Program Upgrading, Community Disability Services Program.

567 Residential facilities
247 Activity therapy centres
246 Sheltered workshops
200 Adult training centres
84 Other

(DCS, 1986a:6)

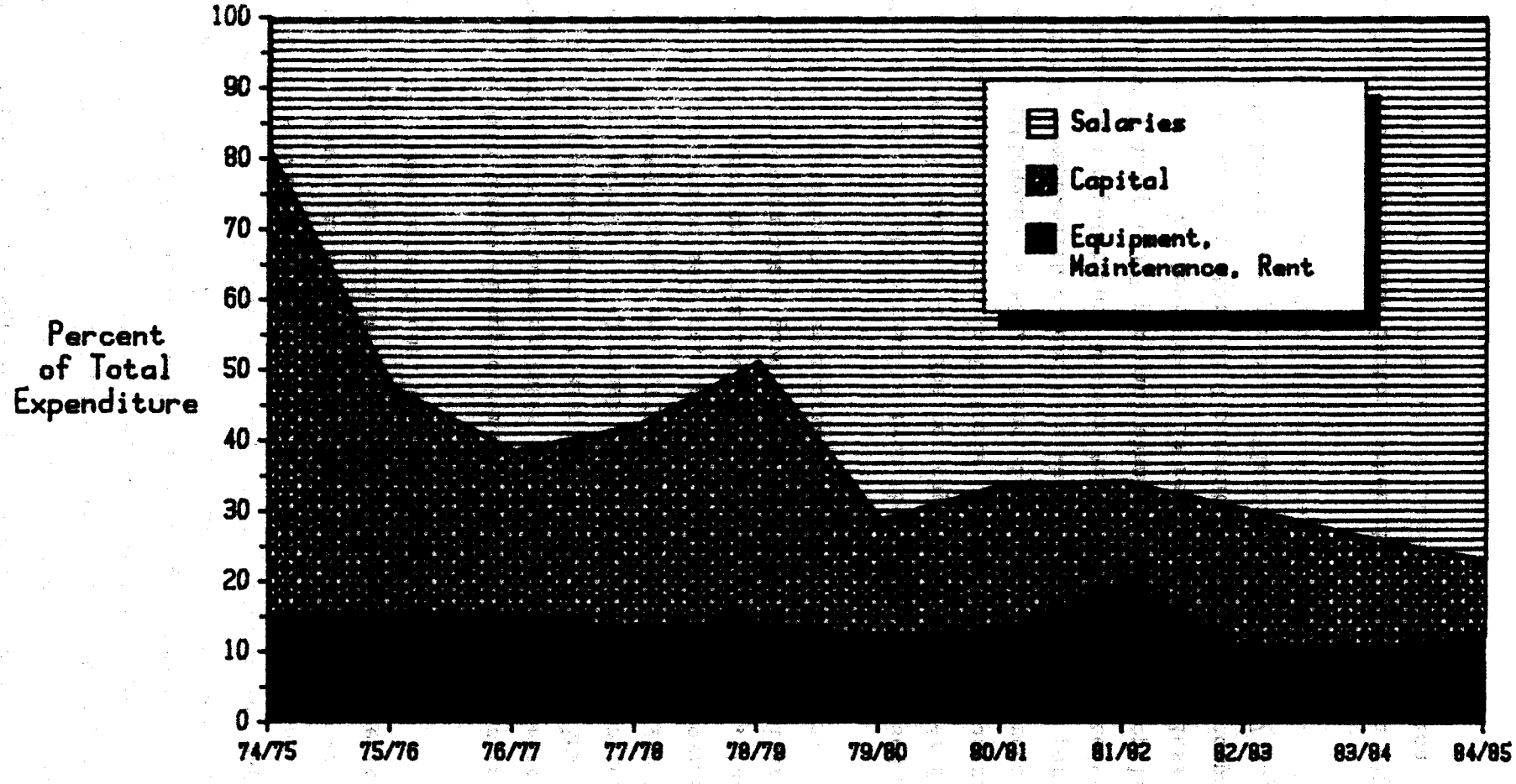
However, there has been a shift in the nature of the subsidy over this time (Figure 3.1). In 1974-75, 66 per cent of total expenditure was for capital subsidies; in 1984-85 only 6 per cent of total expenditure was of a capital nature. Expenditure for salaries was 77 per cent of the total in 1984-85, compared to 19 per cent in 1974-75.

This trend is surprising given that the Handicapped Persons Welfare Program is biased in favour of capital expenditure (an 80 percent subsidy for capital spending compared to 50 per cent for salaries). However, this trend could suggest that it is the same organisations which receive funding from one year to the next: it is possible that in 1974-75, the majority of organisations would have sought capital funding to build their organisational infrastructures, but by 1984-85 they would be better established and required salary subsidies to continue operation. This suggestion is partially confirmed by data which show that 78 percent of total expenditure under the Handicapped Persons Welfare Program in 1984-85 was for 'on-going projects'. Such inflexibility is one result of a submission-based model of funding.

Furthermore, by providing only partial subsidies (80 percent for capital, 50 percent for salaries) the program favours large well-established organisations who are more likely to have their own fund-raising source or have better political connections enabling them to obtain funds from State governments (Graycar and Silver, 1982). The Handicapped Programs Review indicated there was general agreement that these funding arrangements 'almost automatically excluded Aboriginal, ethnic, women's or rural organisations from being funded because of their limited ability to match these funds from a small fund-raising base' (DCS, 1985:95).

In 1981, the concept of the least restrictive alternative was introduced in the Department's Annual Reports, as a means of explaining the increase in the Commonwealth funded projects providing non-institutional residential accommodation (DSS 1982a:66). In 1984, the government endorsed the principle

Figure 3.1
Proportion of Commonwealth Expenditure Under HPAA by Subsidy Type 1974–75 to 1984–85



Source : Dept of Community Services, Statistical supplement to the report for the period 13 December 1984 to 30 June 1985, Table 8, p.7.

of the least restrictive alternative as the criterion for funding services for disabled people. The stated aim was 'to promote a range of options for people with disabilities which will maximise their individual potential and facilitate their integration into the community at large' (DSS 1983:80). This signified an explicit policy decision by the government to favour community services rather than institutional services. However, as the funding formula is biased in favour of capital expenditure (as explained earlier), there is (was) an incentive to develop large organisational infrastructures, which (as we have seen above) are locked into an on-going funding arrangement. This situation does not provide the scope for a substantial shift from institutional to community-based care.

Another problem with the Handicapped Persons Welfare Program is that the submission-based nature of funding takes the initiative for service provision out of the hands of government. It also means that the resulting allocation of services is not equitable. Although the booklet **Information for Applicants** (DCS, 1986d) states that all submissions must demonstrate that a need exists for a proposed service, there are no guidelines showing how this is to be done, nor what criteria indicate 'need'. Furthermore, there is no formal co-ordination with State governments to develop such criteria, or even to describe what constitutes an appropriate network of services.

The inevitable disparity which results from this submission-based method of funding is apparent in Table 3.2. The per capita subsidy varies from $182 per severely handicapped person in Victoria to $298 in South Australia. The average subsidy nationwide is $212. Thus, South Australia is receiving 13.9 percent of total Commonwealth expenditure when it only has 9.9 percent of the severely handicapped population. Western Australia is also receiving a greater share of funding (10.7 percent) than its handicapped population would suggest (8.9 percent). New South Wales is receiving slightly less than its population share would indicate: 33.0 percent of expenditure compared to a handicapped population of 34.8 percent. Victoria receives 21.7 percent of expenditure yet has 25.3 percent of the handicapped population.

This inequity would suggest that factors other than 'need', are also important in the allocation of funds, in particular, organisation size,

TABLE 3.2 DISTRIBUTION OF COMMONWEALTH EXPENDITURE UNDER THE HANDICAPPED PERSONS ASSISTANCE ACT BY STATE 1985-86

State	No. of severely handicapped person 1981 ('000)	% of total severely handicapped population	Total Commonwealth expenditure 1985-86 ($'000)	% of total expenditure 1985-86	Commonwealth expenditure per capita severely disabled person[a] $
N.S.W.	179.1	34.8	35,967	33.0	201
VIC	130.1	25.3	23,696	21.7	182
QLD	85.1	16.6	16,314	15.0	192
S.A.	51.1	9.9	15,209	13.9	298
W.A.	45.8	8.9	11,710	10.7	256
TAS	16.0	3.1	3,318	3.0	207
ACT	*	*	2,154	2.0	*
NT	5.5	1.1	711	0.7	129
Total	514.0	100.0	109,079	100.0	212

Source: Expenditure breakdown by state: DCS Annual Report 1985-86
This State breakdown was not available for 1984-85, the year for which other expenditure data is given.

Handicapped population numbers: unpublished data provided by the Australian Bureau of Statistics 1981 Handicapped Persons Survey

Notes: (a) Per capita expenditure was obtained by dividing Commonwealth expenditure for 1985-86 by the number of severely handicapped persons in 1981 (the latest year for which estimates of the handicapped population are available). Although the numbers of handicapped people may have increased between 1981 and 1985, the State proportions of handicapped people are probably the same as they were in 1981. Hence the relative State differences in the per capita estimates should be reasonably accurate.

political connections and as we suggest later in the case of South Australia, Commonwealth and State government co-ordination.

Finally, the Handicapped Persons Welfare Program has, until now, only funded organisations providing services for physically and intellectually disabled persons. Services for the psychiatrically disabled are provided solely by the States. It is not clear why this informal division was necessary or indeed, appropriate.

3.2 Proposed Changes

Many changes to the Handicapped Persons Welfare Program are imminent following the Handicapped Programs Review and the November 1986 passage of the new Disability Services Act. When the then Minister for Community Services, Senator Don Grimes, introduced the legislation into the Senate, he said it 'provides a new deal for people with disabilities - one in which there is a strong legislatively sanctioned framework for the maximisation of their potential'.

One of the key features of the new legislation is its client-oriented focus. This is reflected in the inclusion of a comprehensive statement of Principles and Objectives which accompany the Act. Four of the seven Principles include statements on

- the rights of people with disabilities to services which will realise individual capacity for physical, social, emotional and intellectual development;

- the rights of people with disabilities to participate in decisions which affect their lives;

- the rights of people with disabilities to the least restrictive alternative in the services they receive;

- the rights of people with disabilities, whatever the origin, nature, type and degree of disability to the same fundamental rights as all members of Australian society.

The seven Principles have been translated into a series of fourteen Objectives for service delivery which include

- a focus on the achievement of positive outcomes for people with disabilities;

- the creation of services for people with disabilities which ensure the conditions of everyday life are the same as, or as close as possible to, norms and patterns which are valued in the general community;

- local, co-ordinated service delivery systems which are integrated with generic services wherever possible;

- services which reflect the needs of people with disabilities who experience double disadvantage as a result of sex, ethnic origin, or Aboriginality. (DCS, 1986f).

For the first time, concepts such as normalisation and least restrictive alternative have actually been built into the legislation.

The new Act, which took effect from July 1 1987, allows for a broader range of services than those provided under the Handicapped Persons Welfare Program. It does not prescribe discrete service categories such as sheltered employment or activity therapy. Rather, it has more general service categories such as supported employment and accommodation support which are more flexible and allow more options. For example, supported employment means 'paid work in a variety of settings, particularly normal work sites, for people who, because of their disability, need intensive ongoing employment support to perform in a work setting' (DCS, 1987a:2). It can include sheltered workshops, reverse integration projects (which allow a mix of disabled and non-disabled workers in the same setting), normal work sites with appropriate support, contract work paid on the basis of productivity, work enclaves, work crews and work stations.[3]

3. These last three types of working arrangements are ideas which are to be explored in demonstration projects:
   - work 'enclaves' occur in open industry, such as manufacturing, where a small group of disabled workers is given special training, supervision and modified work targets.
   - work 'crews' are groups of disabled workers who form part of an

Accommodation support also has a broader definition under the new legislation[4]:

> 'Accommodation support does not lock programs into one or two models. It should not be seen as confined to group homes. It should be as flexible as the wide range of living options within the community generally and the many ways which could be used to provide support to individuals in those living situations e.g. share houses or flats, co-tenancy or live-in arrangements, independent or married living situations, or drop-in support models.' (DCS, 1987a:1).

This definition is broader and more flexible than the physical description of residential accommodation under the current program:

> 'Approved residential accommodation may consist of hostel-type facilities, cottage type housing for family groups, or self contained attached or detached dwelling units.' (DSS, 1982b:13)

In addition to accommodation support and supported employment, the new Act outlines a number of new eligible service types. These are respite care; competitive employment, training and placement; independent living training; advocacy and information; recreation; and services for people with a print disability. As a means of enabling organisations to develop and try out new services, 177 demonstration projects had been funded under the Disability Services Program by February 1987. Currently funded demonstration projects are being reviewed, starting February 1987.

The Act also empowers the Minister to approve funding for any type of service which furthers the objectives of the Act, including program-related research and development. In addition, the Act provides for joint Commonwealth - State funding of services and projects of mutual interest. The new Act specifies that service providers will be accountable for the services they

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3. (contined) independent business, such as landscaping or cleaning.
   . work 'stations' refer to an individual disabled person who works alongside non-disabled workers, and receives support through extra training and supervision.

4. Examples of housing options included in the demonstration projects are:
   . a tenant support program where, for instance three disabled people occupying flats in a larger development may be given assistance by a staff member living in a fourth flat who would be available at certain times or for certain activities.
   . a group house in the community, with 24 hour staff available.

provide and there will be a formal review of services at least once every five years. In addition, the Act encourages participation by people with disabilities in planning, implementing and reviewing services.

Finally, services are available to all three groups of people with disabilities - people with intellectual disabilities, sensory or physical disability, or psychiatric disabilities. In the original drafting of the Bill, only the first two groups were included, but successful lobbying by advocates for the psychiatrically disabled resulted in their ultimate inclusion. As noted above, under the previous program, organisations providing services for the psychiatrically disabled were not funded.

Furthermore, from 1 July 1987, organisations funded under the new Disability Services Program would be eligible for a 65% base staff salary subsidy, a 15 percent increase in the current 50% subsidy[5]. This is an improvement on the present position but it is not ideal because it militates against the younger, smaller, less well established organisations which find it more difficult to find the balance of funds. In brief, the new Disability Services Act is a dynamic, innovative piece of legislation. However its success still remains to be seen and depends upon its implementation, that is, the extent to which the policy can be put into practice, measured in terms of favourable client outcomes.

Before concluding this chapter, we take a brief look at competitive employment training and placement programs offered by the Department of Employment and Industrial Relations. As this is one of the new services to be funded under the Disability Services Program, it seems appropriate to look at what is already being provided in the area.

3.3 Department of Employment and Industrial Relations Programs

The Commonwealth Department of Employment and Industrial Relations has offered competitive employment programs for people with disabilities for a number of years. These can be classified into two groups: training assistance and job creation schemes. Some of these programs provide direct

5. The Government announced in its 1987 May Economic Statement, that the increase in the salary subsidy from 50 percent to 65 percent has been deferred to January 1 1988.

assistance to people with disabilities, i.e. they are specifically targeted to this group, whereas other programs are oriented to disadvantaged groups, of which people with disabilities are one.

A detailed description of these programs is provided in Appendix A. It is noteworthy that the Commonwealth already spends over $13 million on competitive employment programs specifically for people with disabilities, about 2 per cent of the total expenditure on labour market programs and services.

Table 3.3 shows that the $13.4m is not evenly dispersed to the States, with Western Australian receiving, on average, almost double the amount per handicapped person, aged 15-64, as does New South Wales ($30 compared to $16). Western Australia has 9 percent of the handicapped population, aged 15-64, yet it receives nearly 14 percent of expenditure on labour force programs for the disabled. New South Wales, on the other hand, has 32 percent of the handicapped population but receives only 26 percent of the expenditure. The average amount for Australia as a whole is $20 per person. The figure is is as high as $36 in Tasmania and the Northern Territory.

There are other programs such as the Community Employment Program (CEP) and the Integrated Wage Subsidy Program which do not cater specifically for people with disabilities, but these people are one of their target groups. In New South Wales, 21 percent of people placed under the CEP program in 1984-85 were disabled. The proportion of disabled people in the program was less in other States: 13 per cent in Victoria, 15 per cent in South Australia and only 6 per cent in Western Australia (DEIR, 1985:120-127).

The remainder of the report looks in detail at the services provided by State governments in order to assess how they complement, extend or overlap with supported accommodation and employment services offered by the Commonwealth government. Further, we compare the nature and level of provision in the three States under examination.

TABLE 3.3: EXPENDITURE ON LABOUR FORCE PROGRAMS FOR PEOPLE WITH DISABILITIES BY STATE

State	Total Handicapped population 15-64 years(a) 1981 ('000)	Handicapped population as a % of total population 15-64 years 1981 %	Total expenditure on labour force programs for the disabled(b) 1984-85 $'000	Expenditure by state as a % of total expenditure %	Expenditure per handicapped person 15-64 years(c) $
NSW	218.1	32.2	3,461.0	25.9	15.9
VIC	190.3	28.1	3,433.7	25.7	18.0
QLD	113.1	16.7	2,146.3	16.1	19.0
SA	63.8	9.4	1,621.4	12.1	25.4
WA	62.6	9.2	1,845.6	13.8	29.5
TAS	18.4	2.7	664.7	5.0	36.1
ACT	7.5	1.1	75.8	0.6	10.1
NT	3.2	0.4	117.3	0.9	36.7
TOTAL	677.0	100.0	13,365.7	100.0	19.7

Source: Expenditure data on labour force programs: Department of Employment and Industrial Relations. Handicapped population numbers: unpublished data provided by the Australian Bureau of Statistics 1981 Handicapped Persons survey.

Notes:
(a) The total handicapped population, not the total severely handicapped population, is referred to here because these programs would also apply to the mild and moderately handicapped people.
(b) The labour force programs included here are The Work Preparation Program, Training Allowances, Employment Subsidies, Disabled on The Job scheme. A description of each of these is given in Appendix A.
(c) Per capita expenditure is obtained by dividing expenditure on labour force programs 1984-85 by handicapped population estimates for 1981 because there are no handicapped population estimates for 1984-85. We are assuming that the proportion, and probably the numbers, of handicapped people would not change significantly between 1981 and 1985.

CHAPTER 4: SERVICES PROVIDED BY THE NEW SOUTH WALES GOVERNMENT

The next three chapters look specifically at supported accommodation and employment policies and services for people with disabling conditions offered by three State governments - New South Wales, South Australia and Victoria. The focus is on policies and services offered by the Department of Health, Housing and Community Welfare in these three States[1]. Data are presented on services offered directly by the various Departments and indirectly in the form of subsidies to non-government organisations. As noted in the Introduction, the data have been structured into two parts : institutional services and community services. This breakdown provides the most tangible measure of the extent to which the principles of normalisation and least restrictive environment have been applied. It should be noted that in providing the data on community services we have focused primarily on community accommodation services (group homes, etc.) and employment services (sheltered workshops, day training centres, etc.). However, we have also included, where possible, the community support services which assist people to live as independently as possible in the community. For the most part this means the inclusion of those community support services offered specifically for a particular disabled group (physical, psychiatric, intellectual). It is recognised that there are other generic health and welfare services used by these people, but it was not always possible to determine the extent of usage of these services and to apportion costs accordingly. Hence the expenditure estimates of community services may be underestimates, because for the most part, these other services have not been included.

4.1 New South Wales Department of Health

4.1.1 Policies for People with Development Disabilities and Psychiatric Disabilities

Until 1984, the main form of supported accommodation provided by the New South Wales government for people with disabilities or psychiatric

1. Originally, a description was to be given of policies and services offered by the Departments of Employment in each State also. However, inadequate information and the complex interrelationship of Commonwealth and State Departments of Employment made this task impossible.

disabilities was large psychiatric hospitals and nursing homes. Recognition of the inadequacy of these institutions as long term residences resulted in the establishment in August 1982 by the Health Minister, Mr Laurie Brereton, of an Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled. The Inquiry was chaired by Mr David Richmond, member of the New South Wales Public Service Board. The report of this Inquiry was released in March 1983 and it formed the basis upon which current policies were developed.

The Richmond Report, as it has become known, contains 101 recommendations. The main recommendations (not all of which were adopted) include:

- the development of a system of community-based facilities including community residential units and related support services (day programs, sheltered workshops, community teams);

- a reduction in the size and number of public psychiatric hospitals (Fifth Schedule hospitals);[2]

- the complete separation from each other of services and administration of services for the developmentally disabled and psychiatrically ill;

- the integration of psychiatric and developmental disability services into the general health system under the management of Public Hospital or Area Health Boards;[3]

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2. Public psychiatric hospitals are State-run hospitals covered by the Fifth Schedule of the Public Hospitals Act 1929. They are often referred to as Fifth Schedule hospitals. They need to be distinguished from public hospitals covered by the Second Schedule of the Public Hospitals Act. These are predominantly acute general hospitals and although they may contain psychiatric units, in-patients in these units would have acute conditions and be discharged after a short period of stay. By contrast, in-patients in psychiatric hospitals (Fifth Schedule) may have either acute or chronic conditions. If they have chronic conditions they may be in hospital indefinitely.

3. This refers to the movement of psychiatric and developmental disability services from the Fifth schedule system to the Second schedule system. It does not mean the integration of psychiatric services with developmental disability services. In fact the previous recommendation recommends their complete separation.

- the funding of these new services by re-directing half of one percent of the total hospital budget for three years (approximately $9 million per annum);

- the funding of non-government organisations, where appropriate, to assist in the provision of services and a special allocation for the funding of innovative programs;

- subsequent funding of community services to be made from savings in the operation of existing institutions;

- the transfer of public service staff at psychiatric institutions to the general hospital system (Second Schedule system) under Section 3 of the Health Administration Act;

- staff from psychiatric hospitals be given first opportunity to take up positions in the newly established community services;

- the creation of new categories of worker for developmental disability services, the residential care worker and residential care assistant, who are oriented, more than nurses, towards skill development.

These recommendations were made in the context of a broad service delivery strategy

> '... of decentralisation and deinstitutionalisation, based on a philosophy which emphasises early assessment and intervention, home based care and support for client and family and provision of alternative residential care which is small in scale and homelike in atmosphere' (New South Wales Department of Health, 1983(pt 1):17

Generally, there was widespread acceptance of the recommendation of the Richmond Report by consumer groups and peak community organisations (New South Wales Council for Intellectual Disability, Council of Social Service of New South Wales, Action for Handicapped Citizens, Mental Health Co-ordinating Council). The principles of deinstitutionalisation, decentralisation, normalisation and least restrictive environment were regarded by many as long overdue.

Although accepting the proposals in principle, there were some warnings about the need to ensure that the government did not see the plan as a cost cutting exercise: community care should not be a cheap alternative to institutional care (Bryson and Mowbray, 1983;) and adequate community support services are essential to its success (Moss, 1983). The most vehement opposition came from the health unions, especially the New South Wales Nurses Association who were concerned about their transfer out of the Fifth Schedule System (psychiatric hospitals) to the Second Schedule or public hospital system, and the corresponding loss of public service status and conditions. The nurses also feared job losses as a result of the proposal to employ a new category of worker, the residential care assistant, who would replace the mental retardation nurse (New South Wales Nurses Association, undated; Gainsford, 1984).

In December 1983 the Minister for Health, Mr Brereton announced that the government would begin implementation of the Richmond Report. However, due to the objections of the unions, he made a number of changes to the recommendations. No public servants would be transferred out of the Fifth Schedule system and lose their public service status and conditions. Moreover, he agreed to retain the position of mental retardation nurse.

Eight months and a change of Minister later, the Premier Mr Wran announced that the Cabinet had approved implementation of Phase I of the Richmond Report. This meant approval for the transfer of more than 280 current patients out of the psychiatric institutions to community-based accommodation, and for the development of community services such as living skills training, day centres, and community support teams (Premier of New South Wales, 1984). However, contrary to Mr Brereton's previous statement about employing staff through the Fifth Schedule system, Mr Wran implied that newly created community health positions would be funded through the public hospital system (Second Schedule). Public servants who transferred would retain their conditions.

Funds were committed to the program in the September 1984 Budget and the Richmond Report recommended $9 million seeding funds. In 1984-85, the State government provided $6.5 million and the Commonwealth government provided $3 million in recurrent funds. The targets for achievement in this first phase

were 100 accommodation places and 136 full-time qualified community based staff in the mental health services, 150 to 180 accommodation places in 30 group homes, 70 full time qualified community-based staff, and 4 living skills centres in the developmental disability services (Wootten, 1985).

At this time, a Central Steering Committee, eleven Regional Advisory Councils for developmental disability services and eleven Regional Advisory Councils for mental health services were established by the Department of Health. These councils are ministerially appointed for a two year term and include members from the government and non-government sectors, the Labor Council of New South Wales and consumer groups. Their role is to monitor, review, oversee and report on the implementation program. In addition, a central unit was established within the bureaucracy specifically to implement the proposals. This is known as the Richmond Implementation Unit.

One of the first tasks in the implementation process was the development of policy statements for developmental disability and mental health services.[4] These statements were published in January 1985. They re-iterate the values and principles established in the Richmond Report and provide a concise statement of the main features of an appropriate service. For developmental disability services these include: separation from mental health services; the establishment of regional developmental disability teams to provide assessment and early intervention services; guidelines for the establishment of supported accommodation - namely, group homes, which would accommodate up to six people; information, counselling and advice services; respite care; and day programs.

Mental health services (available on an inpatient and community basis) should be provided, according to the policy document, as an integrated co-ordinated network comprising a 24 hour crisis service, assessment team, inpatient accommodation, outpatient services, support services, residential accommodation (halfway house; group home; hostel; boarding house), day

4. New South Wales Department of Health, Policies for Developmental Disability Services, Department of Health, January 1985:
New South Wales Department of Health, Policies for Mental Health Services, Department of Health, January 1985.

hospital, day centres (living skills; day activity centres), and sheltered employment.

Both policy statements stress the need for co-operation and co-ordination with non-government organisations (NGO) as they envisage their complementary and substantial role in service provision. One possible form of NGO funding by the Health Department was seen to be in the form of contracts for up to three years. Both documents also address the role of the Fifth Schedule hospitals. For developmental disability services they are seen as specialist units either for a defined course of treatment or training, or for long term care which can only be provided by health professionals and is not available elsewhere. For mental health services, Fifth Schedule hospitals would still be used for acute services, rehabilitation services, psychogeriatric services, secure accommodation, drug and alcohol services, child and adolescent services and for other long term services. In addition, the development of acute admission services would continue to be fostered in general public hospitals.

Both of these policy documents were developed in an environment of open consultation and were endorsed by the Steering Committee. The next stage involved translating the policies into practice. Two forward plans were devised for this purpose.[5] They spell out in concrete terms the process of deinstitutionalisation, that is, the development of community residential units and the phasing out of beds in Fifth Schedule hospitals.

A specific amount of funds were made available for the implementation of the Richmond program (Table 4.1). Funding has an operating and a capital component and is administered by the Richmond Implementation Unit. The operating budget also has two components: the funds transferred from the Fifth Schedule hospitals and additional 'seeding' funds. The 'seeding' funds in 1984-85 were $9.5 million, increasing to $12.9 million in 1985-86 and $13.2 million in 1986-87. A formula was devised for unlocking funds from the institutions. This formula can be broadly described as follows: for every client transferred out of a Fifth Schedule hospital in 1984-85, 55 percent of

5. New South Wales Department of Health, Developmental Disability Services, Statewide Plan, Sydney, July 1985.
New South Wales Department of Health, Mental Health Services, Statewide Forward Plan, July 1985.

TABLE 4.1 RICHMOND IMPLEMENTATION - OPERATING PROGRAM, 1983-84 TO 1986-87

	1983-84	1984-85	1985-86	1986-87
		$'000		
Developmental disability services	600.0	4,302.8	5,594.9	5,743.2
Mental health services	495.6	4,305.9	5,482.1	5,666.8
Innovative grants		450.0	550.0	585.0
Grants to NGO's		-	660.0	630.0
Community education		81.3	108.0	115.0
Supra-regional services		160.0	180.0	190.0
Staff training		200.0	291.0	310.0
Total 'seeding' funds	1095.6	9,500.0	12,866.0	13,240.0
Transfers from Fifth Schedule hospitals				
- Developmental disability			2,864.6	
- Mental health			1,476.9	
Total			4,341.5	13,861.0 (est.)

Source: New South Wales Department of Health, Richmond Implementation Unit

gross operating payments should have been transferred for the operation of the new community services[6]. This figure was meant to increase to 60 percent in 1985-86 and 65 percent in 1986-87. In reality, no money was taken from the institutions in 1984-85, despite the movement of roughly 200 clients; a total of $2.9 million was taken in 1985-86 which represented less than the prescribed 60 percent of per capita costs. For 1986-87, the Department of Health has negotiated with individual hospitals and has estimated a recovery figure of $13.9 million. It remains to be seen whether this figure is realised.

4.1.2 Services for people with developmental disabilities

In 1984-85 there were 2423 beds in the Fifth Schedule institutions and 193 beds in Second Schedule institutions for developmentally disabled people giving a total of 2616 beds (Table 4.2) or 0.48 beds per 1000 population. The total operating costs for these institutions was approximately $84 million. The plan is to reduce the beds in the Fifth Schedule hospitals from 2423 to 898 by 1990, a reduction of over 1500 beds. Correspondingly, there will be an increase in the number of community residential units from 25 to 367, or a total of 1782 places by 1990 (Table 4.2). These residential units and associated community support services (regional developmental disability teams for assessment and early intervention, day training programs, respite care) are to be established and funded through savings made available from moving clients out of the institutions together with the Richmond 'seeding' funds (Table 4.1).

4.1.3 Services for people with psychiatric disabilities

In 1984-85 there were 3118 beds in psychiatric institutions (Table 4.3). Just over half of these beds (1722) were for the psychiatrically disabled population under 65. A further 768 beds were psycho-geriatric beds; the remaining 628 beds were for drug and alcohol patients and 'other' beds. If the acute beds in general hospitals were included, the total number of beds (acute and long stay) was 2207 which represented a bed to population ratio of 0.41 beds per 1000. The aim of the Richmond program, as outlined in the

6. Gross operating payments refer to total operating costs before adjusting for revenues from patient fees. (These revenues are negligible).

TABLE 4.2 NEW SOUTH WALES DEVELOPMENTAL DISABILITY SERVICES - DEPARTMENT OF HEALTH

	No. of units	No. of beds places 1984-85	Operating Costs 1984-85 ($'000)	Proposed No. of beds/ places 1990
Institutional Services				
Psychiatric hospitals (Fifth Schedule)	13	2,423	76,884	898
General hospitals (Second Schedule)	5	193	7,000	193
Total	**18**	**2,616**	**83,884**	**1,091**
Community Services				
Community Residential Units	25	N/A	(a)	1,782
Other Community Services	N/A	N/A	(a)	N/A
Total			4,303(b)	
Grants to NGO's				
Richmond			225	
Other grants to NGO's (general)			222	
Other Richmond implementation funds (community education, staff training, supra regional services)			221	
Total			**668**	
TOTAL			**88,855**	

Sources: SWRC Survey of Services, 1985. (Letters were sent to all health regions requesting data on current services).
New South Wales Department of Health, Developmental Disability Services - Statewide Forward Plan, Sydney, July 1985.
Siyali, D. Costing Study - Developmental Disability Services, Sydney,
New South Wales Department of Health, 1985.
New South Wales Department of Health, Richmond Implementation Unit, internal document, 1986.

Notes:
(a) It is not possible to obtain a breakdown of the operating costs of CRU's and other community services
(b) This represents the total amount of Richmond funds allocated for community services in 1984-85. It underestimates the total cost of community services for people with developmental disabilities (see text for discussion)

TABLE 4.3 NEW SOUTH WALES MENTAL HEALTH SERVICES - DEPARTMENT OF HEALTH

Institutional services	No. of hospitals	Type of psychiatric bed - 1984-85					Operating costs 1984-85 ($'000)	Proposed No. of beds/places 1990
		Acute beds	Long stay beds	Psycho-geriatric beds	Other beds	Total		
Psychiatric hospitals	9	632	1090	768	628	3,118[a]	98,052	1487
General hospitals	17	485				485	(b)	N/A
Total	**26**	**1117**	**1090**	**768**	**628**	**3,603**	**98,052**	**1487**

Community Services	No. of places (estab. 1983-85)		
Community Residential Units	200	(c)	1278
Other community services	N/A	(c)	N/A
Total		**4,306**[d]	
Grants to NGO's			
Richmond		225	
Other grants to NGO's (general)		140	
Other Richmond implementation funds (community education, staff training, supra regional services)		221	
Total		**586**	
Total		**102,944**	

Sources: SWRC Survey of Services (Letters were sent to all health regions requesting data on current services)
New South Wales Department of Health, **Mental Health Services - Forward Plan**, Sydney, July 1985.
Siyali, D., **Costing Study - Mental Health Services**, Sydney, New South Wales Department of Health, 1985.
New South Wales Department of Health, Richmond Implementation Unit, internal document, 1986.

Notes: (a) This figures excludes the repatriation beds (188) at Rozelle hospital funded by the Commonwealth government.

(b) It is not possible to estimate the cost of the inpatient psychiatric units at general hospitals.

(c) It is not possible to obtain a breakdown of the operating costs of CRU's and other community services

(d) This represents the total amount of Richmond funds allocated for community services in 1984-85. It underestimates the total cost of community services for people with psychiatric disabilities (see text for discussion).

Forward Plan, is to reduce the number of mental health beds in Fifth Schedule hospitals from over 3000 to just under 1500 by 1990 (Table 4.3). The plan does not specify exactly which beds are to be phased out, but they will predominantly be the acute and long stay beds for the under 65 population. This reduction programme is to be matched by the creation of places in community residential units and a network of support services (living skills centres, sheltered employment, community based teams). Roughly 200 community residential places were established between 1983 and 1985; 145 community based staff and at least 12 living skills/day centres were provided. (New South Wales Department of Health, 1985c:9). An additional 1278 places are planned to be in existence by 1988. These places should cater for 1904 clients.

The total operating costs of the public psychiatric institutions in 1984-85 was $98 million. Like the developmental disability services, the proposed community facilities are to be funded through a transfer of funds from the Fifth schedule hospitals, combined with Richmond 'seeding' funds. (Table 4.1).

4.1.4 People with Physical Disabilities

In New South Wales (as in Victoria and South Australia) policies and services for people with physical disabilities are not clearly identifiable. One reason for this is the vast range of physical disabilities and the specialised needs of each group. For example, people with sensory disabilities (blindness, deafness) have very different needs from people with motor disabilities (paraplegia, quadriplegia), or those with amputations, spinal injuries or brain damage. These differences are further complicated by an age factor and the expected duration of the disability (temporary or permanent). Another reason for these difficulties in identification, and possibly for the lack of provision by the States, is related to the fact that the Commonwealth government has always had a major involvement in the direct provision and funding of services for people with physical and sensory disabilities through the Disability Services Program, Home and Community Care Program (HACC), Program of Aids to Disabled People (PADP), Commonwealth and Rehabilitation Service (CRS), Repatriation Hospitals administered by the

Department of Veterans Affairs. Non-government organisations are also major providers, many receiving funding from the Commonwealth.

For all these reasons, it is difficult to isolate the services for the physically disabled provided directly by the State government, especially for those in the younger age groups. Moreover, policies in the area have been linked to the development of policy for services to the aged, and it was only very recently that the New South Wales Department of Health established a Policy Unit for Physical Disability Services. This Unit is currently undertaking a review of services to people aged 0-65 with physical disabilities provided by the New South Wales Department of Health. The terms of reference for the review are as broad as possible, covering such areas as accommodation, transport, rehabilitation, sexuality, bioethical issues and community support. A working party was convened to oversee the review, comprising departmental, professional, and consumer representatives. Submissions were invited from the public. Furthermore a grant was made available to a non-government organisation to convene a series of public consultations throughout the State. The information gathered from these many sources, together with the expertise and experience of the working party, will form the basis for the development of policy in this area.

Until the information from the review is made available, it is not possible to ascertain the extent of services provided directly by the Department of Health. It is, however, possible to estimate the amount of grants to non-government organisations. In 1984-85, the total budget of grants to NGO's was $1.65 million. Of this total, $0.5 million went to organisations providing accommodation and employment services for people with disabilities. However, the bulk of this amount went to organisations for people with developmental and psychiatric disabilities. Only $260,000 went to organisations providing services for the physically disabled.

4.1.5 A Note on Community Health Services for All People

In addition to services provided specifically for people with disabling conditions, other community support services exist within the generic health system to which people with disabilities have access. Most significant among these are the community health centres. There is a difficulty however, in determining firstly, the extent of the use of these services by people with

disabling conditions because of the absence of an adequate data collection system; and secondly, in allocating costs because of the poor utilisation data and the multitude of funding sources.

To understand the role of community health centres and their relevance to people with disabilities, it is necessary to look at their history. Although a range of community health centres had existed for many years including community mental health clinics (Fry, 1986), the major impetus to community health services occurred in 1973 with the Whitlam Labor Government's Community Health Program. Among its objectives was the provision of preventive services, equal access to primary care and consultation with and participation of potential consumers in both the planning and management of services (National Hospitals and Health Services Commission, 1973).

This was a very radical proposal because it was confronting some of the widely recognised faults of the existing medical system i.e. the unequal access to primary health care services, the dominance of the medical curative model, the unco-ordinated and fragmented nature of services. Initially, Federal funds were made available to the States to establish and develop community health centres. In addition, a separate program was established for the funding of community mental health centres. However, this program was incorporated into the Community Health Program in 1975. In 1974-75, the Federal government provided 100 percent of operating costs. In successive years, this proportion was reduced, with the States providing the remainder, often from a variety of sources. By 1980-81, the Federal contribution was 50 percent and in that year Federal funding ceased altogether and sole financial responsibility for the program was turned over to the States.

A Review of the Program in 1976 revealed that it had spawned 727 projects of which just under half (350) were in New South Wales (Australian Community Health Association, 1986). The style of service provision varied markedly within States and between States. Indeed, the broad goals of the Community Health Program - accessibility, prevention, consultation, co-ordination, integration - meant there was no real prescription for the type of services to be offered nor for how they should be provided. As a result, they were used, for example, to establish a range of services which were as diverse as the Early Childhood Development Program in Victoria; community mental health

centres in New South Wales, Victoria, and South Australia; day centres and hospitals; domiciliary care and rehabilitation units, and generally to 'plug gaps' wherever they were identified (Furler and Howard, 1982).

The Program did not grow significantly between 1976 and 1983, the period of the Liberal-Country Party government. Allomes (1982) showed that the number of projects had only increased to 838 in 1981, compared with 727 in 1976. In 1983, the new Labor government promised the restoration of the program to 1975-76 funding levels. The government used the Medicare Agreement with the States to provide these grants, which represented $18.0 million in 1984-85.

What does this mean for people with physical, psychiatric and intellectual disabilities in New South Wales? Basically it means they have varying degrees of access to a range of support services including medical care, physiotherapy, occupational therapy, speech therapy, podiatry, counselling, group therapy, education, living skills activities, rehabilitation, hydrotherapy, and home nursing.

Of the three identified disabled groups, these community services probably cater best to the psychiatrically disabled population. In fact, the network of community services defined in the 'Policies for Mental Health Services' incorporate these community mental health centres. The less severely physically disabled population are often the clients of the community rehabilitation services. People with developmental disabilities should have equal access to services such as speech therapy, physiotherapy, and counselling, however they may be referred to their own specialised services - a form of rationing of services by staff, or discrimination against these clients. Allomes (1982) estimated that the cost of operating the Community Health Program in New South Wales in 1983-84 was in the order of $54 million. As discussed earlier, it is impossible to allocate costs of these services to the client groups who use them because of the poor data on service utilisation and the intricate and complex funding arrangements.

4.2 New South Wales Department of Housing

Another provider of accommodation for disabled people is the New South Wales Department of Housing. It has, until recently, provided public housing according to a very traditional model. This involved the acquisition of

land, the construction of houses and the direct leasing of these houses, usually to families and aged persons, on low incomes, capable of living independently on a long term basis. This approach to public housing provision was inflexible and restrictive. It has been criticised because it means that public housing estates were often located on the fringes of cities and towns, and were poorly serviced in terms of schools, hospitals, transport, and other amenities. It also means that public housing was not available to single people, to people above a certain income level but still in poverty, to many disabled people who cannot live independently, or to people who required emergency accommodation in times of crisis. In addition, this inflexible approach was compounded by the fact that the management of public housing was centralised, impersonal and could not respond to local community needs.

In the last six or seven years, the Department of Housing began to recognise these problems and attempted to broaden its range of housing services. Its new and developing attitude has been labelled the **community housing approach**[7]. It differs from the traditional model in three important ways:

- location, tenure arrangements and dwelling forms of public housing have been diversified;
- eligibility criteria have been widened;
- management structures have been decentralised and tenant participation and self management has been encouraged.

The specific programs which have been introduced as part of this new approach are:

- the 'spot purchase' program, that is, the purchasing of existing houses on the private market which means they may be located in established and less peripheral sites;

7. Discussion of this new approach can be found in Smith (1984a, 1984b)

- the creation, in 1981, of the **Emergency Accommodation Unit** whose function is the provision of emergency housing, either directly, or by lease, to community organisations;

- the establishment in 1982 of the **Community Tenancy Scheme** which aims to provide secure rental housing for low income groups over a longer term;

- the announcement of a **Singles Housing Policy** in December 1983 which marks an important change in eligibility enabling low income single persons to apply for and be allocated Department of Housing accommodation;

- the commencement of the **Local Government Housing Initiatives Program** in April 1983 which aims to increase local government awareness of housing issues and housing needs through the provision of information, funding of a limited number of Community Housing Officers in Local Councils, financial support for innovative housing projects conducted by local government, and promotion of Joint Ventures between the Department of Housing and local Councils;

- the implementation of a **Women's Housing Program** in 1984-85, whose aim is to provide medium term accommodation (3 to 12 months) to homeless women and their children;

- the announcement in December 1985 of a **Housing Policy for People with Disabilities** and a commitment by the Minister, Mr Frank Walker, to its implementation over the following 12 months.

Before this new approach to public housing provision began, very few disabled people had been obtaining public housing through the normal channels. Eligibility criteria posed a number of problems. First, the income of the disabled person's carer, including a spouse (if a member of the disabled persons's household) was taken into account in determining eligibility. Second, eligibility was dependent upon the applicant being able to cope with independent living or arranging their own support services. This placed disabled people in an impossible situation: they could not arrange support

services without knowing where they were living and they were not eligible for a house until they arranged their own support services. Third, if an applicant was considered 'adequately housed' he or she was not considered to have a housing need and was therefore, not eligible. This criterion placed excessive burdens on the families of disabled people who may have been seeking to relocate their disabled member to a more appropriate form of housing, e.g. movement from the family home to independent accommodation with the transition to adulthood, or movement from a nursing home to a house or flat.

The new Housing Policy for People with Disabilities addresses these problems and others, so that access to public housing by disabled people should improve dramatically as implementation proceeds. However, changes had already begun with the introduction of some of the earlier initiatives which were part of the new community housing approach. For instance, the establishment of the Emergency Accommodation Unit and the leasing of houses to non-government organisations to provide supported accommodation made it possible for people with more severe disabilities to gain access to public housing. Initially, the Emergency Accommodation Unit funded a range of services (women's refuges, youth refuges, group homes for disabled people) under its Special Purpose Housing Program, which in 1984-85 had a budget of $3.5m. Gradually, however, as a result of the establishment of alternative programs for women and youths (Supported Accommodation Assistance Program (SAAP) and its complementary Crisis Accommodation Program (CAP)), the Special Purpose Housing Fund became available almost solely for disabled persons housing. The program for 1985-86 proposed funding be made available for some 50 houses, 43 of which are for people with disabilities. The budget was $4.6 million of which $3.7 million was to be given to non-government organisations for the spot purchase of over twenty 3, 4, or 5 bedroom houses for use as group homes; $228,000 was to be used to renovate and modify nineteen mainstream Housing Department houses for lease to NGOs as group homes; and $235,000 was to be used towards the design and construction of three group homes. Of the 43 homes, 30 were to be for the developmentally disabled, 5 for the developmentally and physically disabled, 3 for the psychiatrically disabled and 5 for the physically disabled. (Table 4.4)

Allocations of properties or the provision of funds for renovations are determined in relation to a number of factors: demographic indicators of need, equity between population groups and across the State, availability of alternative housing options, and the appropriate mix of stock and availability of support services in particular locations[8]. However, from discussions with officers of the Emergency Accommodation Unit, it would appear that the opinions of the recurrent funding bodies (i.e. government departments such as the Commonwealth Department of Community Services) regarding the need for a particular service, are very important in determining which groups are funded.

TABLE 4.4 PROPOSED SPECIAL PURPOSE HOUSING PROGRAM 1985-86

	1985/86 $'000	Number of houses	Number of places
Total Proposed Allocations to NGO's	4,688	50	200
Proposed Allocation to NGO's for disabled persons housing	3,671	43	172

Source: New South Wales Department of Housing, Emergency Accommodation Unit.

Another community housing program which specifically caters for disabled people (among other things) is the Women's Housing Program. Two schemes were funded in the 1984-85 budget: the Charmian Clift Project and the Inner City Psychiatric Scheme. Charmian Clift is a joint Health and Housing Department project (with some funding also from the SAAP program) whose target group is psychiatrically and developmentally disabled women with dependent children in the Blacktown area. It is a three stage program consisting of two 24-hour crisis assessment centres: medium-term supported accommodation for up to 12 months, and independent long term housing with back-up support. The 1984-85 budget allocation was $98,000 in recurrent funds. The Inner City Psychiatric Scheme comprises three houses (total of 12 beds) which provide accommodation for single women with a history of psychiatric problems. Two workers are on

8. See New South Wales Department of Housing, undated.

call in the day and evening to provide support. The total 1984-85 budget allocation was $62,000 in recurrent funds.

It was the Singles Policy which established the principle that the applicant, not the Department of Housing, has the right to decide the adequacy of their existing housing. This has been extended to applicants with a disability. Introduction of the Singles Policy has also generated demand for singles units from people with disabilities. In addition, single people with disabilities have requested access to shared accommodation either in supported or totally independent households.

The release of Housing Policy for People with Disabilities is a very significant step in improving access by disabled people to all forms of housing. This policy document systematically addresses all the problems currently confronting disabled people in the three forms of housing tenure: public rental housing, private rental housing, and home ownership. In terms of public rental housing, the policy removes the barriers restricting eligibility. The incomes of carers (including spouses) will not be considered when assessing eligibility. A minimum of $40 a week (and more if the applicant can provide a documented claim) will be added to eligibility income levels. In principle no application will be refused on the basis of a disabled persons inability to live independently or in the absence of support services. The applicant, rather than the Housing Department, has the right to decide upon the adequacy of their existing house.

A major obstacle to housing people with disabilities is the unsuitability of available dwellings. The new policy claims this can be overcome under the 'spot purchase' program where houses will be purchased on the private market and modified. Designs of new public housing will also be modified. Location is a critical factor for people with disabilities so they are not dislocated from their social environment and necessary support services. Under the new policy, the applicant's preferred location will be a primary consideration. Under the share and single accommodation program, designs will be developed for shared accommodation for adults with disabilities. All future singles construction programs will include self contained units for single people with disabilities. This new policy will be co-ordinated by the Supported Accommodation Unit, within the Housing Department. They will be responsible

for receiving and assessing applications from non-government organisations for the leases on dwellings. The Disability Housing Unit will be responsible for setting policy and priority in this area.

In terms of the private rental housing market, apart from provision of funds to establish an information service for people with disabilities, the main form of assistance to people with disabilities is rental subsidies through the Rental Subsidy Scheme. These subsidies are paid to approved applicants waiting in private rental for an application. Additionally, the Community Tenancy Scheme will have to review its operation to give increased consideration to the needs of people with disabilities.

With regard to home ownership, policy concerns include home modifications which are currently available through the Commonwealth governments' Home and Community Care program (HACC), Home Maintenance and Modification - a program which has just been launched by the New South Wales Department of Housing[9], and access to housing finance. The Department of Housing currently has a home ownership assistance scheme which will be promoted to enable people with disabilities to make greater use of it. In addition, the costs of disability have been recognised by the Department of Housing in determining eligibility for low cost loans. The scope and extent of this new policy is far-reaching, and if implemented in its entirety should bring about significant changes in housing for people with disabilities. The Minister's commitment to successful implementation is indicated by the establishment of the Disability Housing Unit in March 1986 with a staff of seven people.

One of the strengths of the policy is its emphasis on the need for co-ordination of housing and support services. To this end, an Inter-Departmental Committee (I.D.C.) was established with senior officers from State government Departments of Youth and Community Services, Health, and Housing, the Home Care Service of New South Wales, the Disability Services Co-ordination Unit, and the Federal Departments of Social Security, and Community Services. The Committee recommended that the co-ordination and allocation of support services and housing at a regional level should be subsidised by the Commonwealth Department of Community Services. The Minister for Community Services has offered a subsidy for the employment of

9. See Sydney Morning Herald, 20 June 1987:121.

eight regional disability co-ordinators with certain conditions. Negotiations are underway.

Another one of the advantages of the policy is its flexibility, which is related in part to the fact that is not different from the policy for generic services. Rather, it looks towards adapting all available services to the needs of people with disabilities. This means there is flexibility in the type of accommodation (group homes are not the only option) and in the form of tenure (public rental; private rental; home ownership). Because of the far reaching nature of the policy, it is difficult at this stage to estimate the overall cost of its implementation. The only known tangible costs are for the Special Purpose Housing Program and the Women's Housing Program. Many of the proposed changes, such as the widening of eligibility criteria, may not result in extra costs. Rather, the impact will be more apparent in the increased proportion of people with disabilities who are housed.

4.3 New South Wales Department of Youth and Community Services

An agreement was established in 1964 between the Health Department and the Department of Youth and Community Services which says that the Department of Health is responsible for providing services to the severely and profoundly disabled while the Department of Youth and Community Services care for the mild to moderately disabled[10]. Apart from the obvious problems associated with such an arbitrary jurisdictional boundary, it is clear that the Department of Youth and Community Services does not provide a comprehensive range of services to all mild to moderately disabled people. Its primary function (in financial terms) is the provision of residential services to wards or guardians of the Minister, who are mostly people with intellectual disabilities. The other major program is the granting of subsidies to non-government organisations through the Community Welfare Fund.

There are no publicly available policy documents defining the principles and objectives of services for disabled people. Only within the last two years has an identifiable unit been established within the Department to formulate policies specifically for disabled people. This is the Disabled Persons Policy Unit. To date, they have operated according to the Statement of

10. See New South Wales Department of Health (1983, pt 2):19.

Principles and Objectives developed by the Disability Council of New South Wales (1985) and endorsed by the New South Wales government. This Unit is currently developing a policy which defines principles and objectives for services which will allow people to live as independently as possible in the community. This policy document is not yet publicly available.

In 1984-85, the Department of Youth and Community Services operated three large residential complexes catering for intellectually disabled wards who were under the Ministers' guardianship (Le Breton, 1985a). Brush Farm, located at Eastwood, accommodated 28 persons; Werrington Park accommodated approximately 50 persons as well as supporting a number in the community; and Clairvaux at Katoomba accommodated 41 persons.[11] Total operating costs for 1984-85 were $3.4 million (Table 4.5). The Department also operated a sheltered workshop known as Oak Industries at Blacktown in Sydney. This workshop provides work, work training and social skills training for people with intellectual disabilities who were under the Minister's guardianship. In 1984-85, the workshop had 20 places and operating costs totalled $212,000 (Table 4.5).

The community services offered by the Department in 1984-85 included 12 hostels and groups homes with four to six beds each, and one in Wollongong with eight beds, for intellectually disabled children and adults, also under the guardianship of the Minister. With the subsequent purchase of additional houses, this was be increased to 20 community-based residences for intellectually disabled persons. Other community services included centre-based respite care for children 0-12 years at two of the Department's institutions: Brush Farm (20 places for intellectually disabled children) and Mt Penang (6 places) (Table 4.5).

In the Sydney Metropolitan area, a Specialist Section provided casework services to State wards under the Minister's guardianship relating to accommodation, employment, counselling and support. Central Office of the Department also provided a vocational and general advisory service to visually impaired and other people with disabilities. Assistance was

11. Since 1984-85 Brush Farm has been closed and the residents now live in 7 houses in the community.

TABLE 4.5 SERVICES FOR PEOPLE WITH DISABILITIES - NEW SOUTH WALES DEPARTMENT OF YOUTH AND COMMUNITY SERVICES

	Operating Costs 1984-85 ($'000)
Institutional Services	
Large on-campus residential facilities (Brush Farm and Annexes, Werrington Park and Clairvaux)	3,830
Vocational Services (sheltered workshop)	212
Total	4,042
Community Services	
Community based accommodation (hostels, group homes, special care homes)	872
Respite Care	634
Other - community support and casework	95
- licensing/monitoring accommodation and vocational services	113
Total	1,714
Grants to Non-Government Organisations	
Community Welfare Fund (supported accommodation and employment)	731
Total	731
Total	6,487

Source: New South Wales Department of Youth and Community Services, Disabled Persons Policy Unit.

provided in securing employment and accommodation, as was general counselling and advice.

Grants were provided from the Department's Community Welfare Fund to non-government organisations and groups which offered services and assistance to people with disabilities and their families. The type of projects funded under this program include respite care, family support services, early intervention services, co-ordinating bodies, resource centres, developmental play groups, and self help groups. In 1984-85, $3.4 million was allocated to non-government organisations and groups providing services to people with disabilities. Of this sum, nearly three quarters of a million ($731,000) went specifically to organisations providing accommodation services (Table 4.5), the majority of which ($675,000) is for the provision of host family and home based respite care. In 1984-85, sixteen schemes were funded in New South Wales, mainly for children with physical and intellectual disabilities. No vocational services were funded through the Community Welfare Fund.

Additional, related services include adoption and fostering services of wards and other children with disabilities under the guardianship of the Minister and speech pathology services for wards with disabilities, either in Departmental residential units or foster placement. Finally, the Department undertakes the role of licensing the vocational and residential facilities throughout the State. The licensing advisors have the responsibility to inspect, monitor standards, report and advise on standards. In 1984-85, there were approximately 140 (124 licensed) vocational facilities for people with disabilities. Some 7000 people with disabilities attend daily. There were 703 (30 licensed) boarding houses/hostels/group homes identified throughout New South Wales with approximately 20,500 residents, many of whom have disabilities.

In brief, the Department of Youth and Community Services in New South Wales plays a different role to similar departments in other States in its provision of services to people with disabilities. One of its main functions is to provide services to children and adolescents with intellectual disabilities who are wards of the State. This means the separation of services for this particular group from the Department of Health, the main provider of services to people with intellectual disabilities. Youth and

Community Services is also a key provider of grants to non-government organisations who provide services for disabled people and respite care facilities.

4.4 Summary of Issues

The Richmond Program

The Richmond Program has come under increasing criticism from a variety of sources. Some of this criticism stems from confusion over the scope of the program. More specifically, it relates to the fact that the focus of the program to date, has been on moving people who are currently living in institutions out into community residential units with additional support services. This is limited because it ignores provision for the many thousands who have been deinstitutionalised over the last twenty years without adequate community support services.

Table 4.6 shows how patient numbers in psychiatric institutions have fallen from 13,192 in 1965 to 5,039 in 1984 - a drop of over 60 percent. Many of these people have been returned to the community to live with their families, or to live in private boarding houses with no support services, or, with increasing economic hardship, many are left homeless. To relatives and friends of psychiatric patients and to families of children and young adults with intellectual disabilities, the Richmond program was thought initially to be the long awaited solution to the inadequate provision of community services for these people. Bitter disappointment resulted from the realisation that a person is eligible for the new services only if they are currently residing in psychiatric institutions. Although the recommendations in the Richmond Report suggest the need for comprehensive provision of services for both the intellectually and psychiatrically disabled, the implementation so far has focused solely on those in the institutions.

Another criticism of the Richmond program is the limited nature of the options for community residential accommodation. Basically, these are restricted to group homes with standard staffing establishments. Better communication with the Commonwealth government and other State providers such as the Housing Department could present a range of options. Future planning by the Health Department indicates a wider range of options are being

TABLE 4.6 IN-PATIENTS OF PSYCHIATRIC CENTRES IN NEW SOUTH WALES

Year	Patients on the register at the end of the year	Patient as a percentage of patient numbers in 1965
1965	13,192	100
1966	12,650	96
1967	12,101	92
1968	11,728	89
1969	11,253	85
1970	10,489	80
1971	10,104	77
1972	9,473	72
1973	9,039	69
1974	8,685	66
1975	8,574	65
1976	8,101	61
1977	7,610	58
1983	5,256(a)	40
1984	5,039(a)	38

Sources: ABS, Statistics of In-patients in Psychiatric Centres-New South Wales 1976-77; Cat. No. 4302.1
ABS, Census of Mental Health and Long Stay In-patients in Hospitals and Nursing Homes, 1983 and 1984; Cat.No.4310.1

Notes: (a) The patient numbers for 1983 and 1984 were derived from a different source to the figures for 1965 to 1977. Effort was taken to ensure they referred to the same institutions, although they may not be strictly comparable.

considered - hostels for the more transient population and purpose-built units for the confused and disturbed elderly population.

In addition, the Richmond program has been criticised because it has not been properly evaluated. This has contributed to some of the confusion surrounding the aims and scope of the program and it has perpetuated the questions regarding patient outcomes and cost. Finally, it should be noted that the Richmond report recommended the separation of developmentally disabled services from psychiatrically disabled services. Despite some confusion, especially in the media, of the distinction between these groups, this separation of services is very significant and was adopted as Department policy in January 1985.

Co-ordination

Another big issue in New South Wales appears to be one of co-ordination. Apparently, there is very little communication between the Commonwealth Department of Community Services and the State Departments of Health, Housing, and Youth and Community Services. This is manifested in the almost complete separation of services funded by the Commonwealth and those funded by the State. This situation may improve with the establishment of the Office of Disability within the Commonwealth Department of Community Services, especially as its offices are located in Sydney.

Within New South Wales itself there are a number of bodies which are attempting to achieve intra-State coordination. Within the Premier's Department there is the Disability Co-ordination Unit and in the Office of the Minister of Youth and Community Services there is the Disability Council of New South Wales. The latter group are more of an advisory body and lobby group, while the Disability Co-ordination Unit attempts to co-ordinate services across government departments.

To date, these structures have had varying degrees of success. The Disability Co-ordination Unit does not appear to have had a significant impact. This may be attributed to its specific location within the bureaucracy. It may have been more appropriate to have created a co-ordination unit of this nature within a key service department, such as the Department of Health. The Disability Council, on the other hand, has more of

a watchdog or advisory role and it has been important in identifying problems and highlighting their significance. In conjunction with the Disability Services Co-ordination Unit, they recently conducted a phone-in on the respite care needs of people with disabilities, their families and other carers (Nicholls, 1987). This report reveals the inadequacy of respite care facilities in New South Wales. The Council is now undertaking a follow-up study in order to develop more specific recommendations for the appropriate delivery of the different types of respite care, and for the effective co-ordination of these services to better meet the needs of people with disabilities and their carers.

In addition to these co-ordinating bodies, there are a number of Interdepartmental Committees which have been formed in an attempt to facilitate communication between departments. Unfortunately these committees do not appear to have achieved much in the way of co-ordinating service delivery. For example, there is much duplication in the purchasing and renovation of community houses. It appears that it would be much more appropriate if one department, for example the Department of Housing, made these capital purchases, as they have the technical expertise in this area. If purchases were all made by the one department, it would also be easier to develop a much needed register of all supported accommodation facilities for people with disabilities. Similarly, there should be a standard set of criteria for all departments, including Commonwealth departments, regarding the funding of non-government organisations.

Administration

Related to the issue of co-ordination, is the issue of administration of services. Currently in New South Wales it seems anamolous to have the rather arbitrary separation of services provided by the Departments of Health and Youth and Community Services, especially for services to people with intellectual disabilities. This begs the question whether it would not be more appropriate to move all services for people with intellectual disabilities out of the Health bureaucracy, a recommendation that has been the theme of seven out of ten State reports on services for people with intellectual disabilities written since 1977 (Cocks, 1984).

Expenditure

Table 4.7 summarises expenditure by the New South Wales government on accommodation and supported employment services for people with disabilities. The concentration of expenditure (94 percent) is on institutional services for people with intellectual and psychiatric disabilities. This is the case despite the fact that Tables 2.3 and 2.4 show that only a relatively small proportion live in institutions compared to those in private households. Furthermore, people with physical disabilities, who significantly outnumber people with intellectual and psychiatric disabilities, have very few services provided by the State government. Non-government organisations have always been more significant in providing services for people with physical disabilities, although funding for these organisations does not come primarily from the State government. Total State grants to non-government organisations are only in the order of $2 million.

Special Needs Groups

With the exception of the Department of Housing, very little attention is paid to the needs of special groups - children, women, aborigines, migrants and people in rural areas - in the provision of services for people with disabilities. The Richmond Report comments on the necessity of assessing these people's needs separately, however in the implementation of the Richmond program, there does not appear to be special provision for these groups.

TABLE 4.7: SUMMARY OF EXPENDITURE ON SERVICES FOR PEOPLE WITH DISABILITIES - NEW SOUTH WALES - 1984-85

Institutional services	Community services	Grants to NGOs	Total	
Services		$'000		
Intellectual disability	83,884	4,303	668	88,855
Psychiatric disability	98,052	4,306	586	102,944
Physical disability	(a)	(a)	260	260
Unallocated(b)	4,042	1,714	731	6,487
Total(c)	185,978	10,323	2,245	198,546

Source: Tables 4.2, 4.3, 4.6

Notes:
(a) Expenditure on institutional and community services for people with physical disabilities could not be obtained

(b) Unallocated to a particular disability group. Comprises expenditure by the Department of Youth and Community Services

(c) Excludes expenditure by New South Wales Department of Housing

CHAPTER 5: SERVICES PROVIDED BY THE SOUTH AUSTRALIAN GOVERNMENT

In South Australia, as in New South Wales, most supported accommodation and employment services for people with disabilities are provided by the Health Commission. The focus of this Department is on services for the intellectually disabled and the psychiatrically disabled, with less emphasis on services for the physically disabled, especially those aged under 65 years. As in New South Wales, services for the physically disabled are often provided in conjunction with services for elderly people, and because of the diverse nature of physically disabling conditions, the services are more difficult to identify. Non-government organisations play a major role in the provision of services to people with physically disabling conditions.

In this chapter, the policies and services of the three State departments - Health, Housing and Community Welfare - are reviewed. Services provided directly by these departments are described, and expenditure for the year 1984-85 is estimated. Indirect services in the form of grants to non-government organisations are described. The data are structured into two components: institutional services and community services. Such a breakdown enables the reader to clearly identify the focus of government services in terms of service type and target group.

5.1 Intellectually Disabled Services Council (IDSC)

5.1.1 People with Intellectual Disabilities

Services for people with intellectual disabilities in South Australia were traditionally administered by the Health Commission as part of their mental health services program. In 1982, the services were separated from mental health services and in 1984 were incorporated as the Intellectually Disabled Services Council (IDSC). IDSC has a separate constitution, although it is incorporated in accordance with the provision contained within the South Australian Health Commission Act. It has its own Board of Management comprising nine members appointed from government departments, including Attorney Generals, Education, and Community Welfare non-government organisations, and parents of intellectually disabled people. Despite this autonomy, it still has to submit its budget, capital works program, proposed

variations in services and staffing requirements to the South Australia Health Commission for approval.

Policies

Major policy directions of IDSC are outlined in **Development Proposals 1985-86**. In terms of service provision these policies include:

> '. the development of community based services across the state
> . the 'deinstitutionalisation' of existing services
> . provision of community services by generic rather than specialist agencies' (IDSC 1985:4)

Other policy initiatives relate to planning and monitoring of services, a needs-based planning approach, community education, staff training and development.

In addition to a statement of major policy directions, this document lists a series of three to five year goals with broad objectives and priorities within each objective. The broad goals are as follows:

- development of mechanisms for planning, co-ordination and monitoring of service development.
- development of community based services for children and adults.
- development of community living options
- development of country services
- deinstitutionalisation
- staff training and development
- community education

The focus of policy and service provision differs markedly from the situation in New South Wales. In South Australia, the focus is on the development of community-based services, including residential services with less emphasis on deinstitutionalisation per se. In New South Wales, the focus and priority is most directly on deinstitutionalisation and provision of community services primarily for the people previously resident in the institutions. In South Australia much effort is concentrated on joint projects with the

non-government sector. This means that IDSC engages in joint planning with the Commonwealth Department of Community Services to enable development of mutually agreeable criteria for the funding of non-government organisations. The aim is that eventually both government and non-government agencies will be bound by similar guidelines and funding criteria. Furthermore, South Australia allocates a significant portion of its budget (14 percent) as grants to NGOs, compared to 0.4 percent in New South Wales. One of IDSC policy priorities is to ensure access to generic services for intellectually disabled people. In New South Wales, most services for intellectually disabled people are specialised services.

Institutional services

The services provided by IDSC, and their operating costs for 1984-85, are outlined in Table 5.1. At this time, one large institution, Strathmont Centre, provided residential care and training to over 500 adults and children who were severe to profoundly disabled. About 70 clients were children and adolescents under twenty. Strathmont was organised into a series of seventeen villas. Each villa was four home units each accommodating eight residents - a total population per villa of 32. Rua Rua Nursing Home was the other major State institution, with 98 residents with multiple disabilities, aged 4 to 34 years. There were four relief beds for clients who normally live in the community. Residents were totally dependent, with multiple physical handicaps, and generally had profound intellectual disabilities. Strathmont Centre used to operate a number of community units and hostels. Their management has been transferred to the three regions as part of IDSC's recent decentralisation and deinstitutionalisation policy. In 1984-85, there were six community units and hostels, each with about 20 beds. There were a further six group homes with between 4 and 6 beds.

Sheltered workshops are run by Invicta Sheltered Workshops Ltd., a non-profit company formed and registered in 1963. IDSC provides hospital buildings for the workshops and staff (industrial supervisors and occupational therapists), whereas Invicta secures the contracts from industry and government. Invicta has a Board of Directors and a staff of six. It pays

TABLE 5.1 SOUTH AUSTRALIA INTELLECTUAL DISABILITY SERVICES - INTELLECTUALLY DISABLED SERVICES COUNCIL

	Number of units	Number of beds/places	Operating Costs 1984-85 ($'000)
Institutional services			
Major institutions	2	650	18,525
Large residential units	5	95	1,663
Total	7	745	20,188
Community services			
Respite care facilities	1	22	461
Group homes	7	37	158
Sheltered workshops	2	170	294
Day activity centres	5		309
Community teams			
metropolitan regional[a]	3		1,969
country	1		136
Total			3,327
Grants to NGO's			
Minda			3,381
Other			617
Total			3,998
TOTAL			27,513

Source: Intellectually Disabled Services Council, 1985

Notes: (a) These costs include both administrative and direct care costs and contain a component for the administration of group homes and vocational services

the hospital on a monthly basis, who in turn pay the clients in the workshop. Clients are paid according to 'effort and ability' but the maximum wage a client received in 1984-85 was $32.00 a week because, according to one of Invicta's management staff, 'over this amount, it interferes with pension receipt'.

The range of work contracts is quite broad including packaging, assembling, woodwork, collation, industrial packing for the motor industry, and making of domiciliary aids. The major contract in 1984-85 was with the South Australia government for pre-packed hospital items (sterile and non-sterile) for government and private hospitals. Invicta supplies and maintains the machinery in all workshops. Intellectually disabled people work in two Invicta workshops - one at Strathmont Centre which has positions for 80 employees; the other, at the Charles Blaskett Centre, has an average of 90 clients.

Community services

Five day activity centres were funded directly by IDSC in 1984-85, and others were provided by non-government organisations. The three regional offices had a childhood services team providing early intervention services, consultancy and support services. The adult services team primarily offered a consultancy relationship with other agencies, initiating and supporting developments within the region. These developments include projects with other government and non-government agencies. Although not the focus of service activity, IDSC still has as a policy priority a program of deinstitutionalisation which includes the relocation of residents in large community units and hostels into group homes, the relocation of residents of Rua Rua Nursing home and the movement of adolescents and children in Strathmont Centre to community living.

Grants to Non-Government Organisations

IDSC places emphasis on joint projects with non-government organisations. Grants totalling $4.0 million were given to NGOs in 1984-85 by IDSC. The bulk of this sum was given to provide supported accommodation and employment services. Of this total, $3.4 million was given to Minda Incorporated for the provision of one large institution, and for group homes and activity

therapy centres. The large institution - Minda Brighton - has 500 beds and another 100 beds are located in Mincom group homes and hostel. The hostel has 18 beds; the fourteen group homes have between 4 and 8 beds each. Orana Incorporated is another large supplier of accommodation which is partially funded by IDSC. It has eight hostels with a total of 209 beds. It also runs some workshops and activity therapy centres.

Other projects funded with grants from IDSC in 1984-85 included family-based respite care, group homes, sheltered workshops, day activities, holiday camp programs for independent living and social skills training. One innovative residential project for adults is a mobile training team to train young adults in their own homes, thus enabling them to move out into a rented home in the community in groups of three or four.

5.2 The South Australian Health Commission

5.2.1 People with Psychiatric Disabilities

Mental health services in South Australia are administered by the Mental Health Division of the South Australian Health Commission. In recent years, policy initiatives have emanated from the Mental Health Advisory Committee which is a composite body of Health Commission, psychiatric institutions, general hospital, community and non-government representatives. Three discussion papers, entitled 'General Policy Guidelines' and covering adult inpatient services, country services and crisis intervention services have been produced in the last few years.

The paper on acute inpatient services discusses an appropriate organisation of services with an area basis, integration with the private and non-government sectors, and co-ordination among all sectors to prevent duplication and overlap. The proposed network of services comprising crisis and assessment teams, inpatient accommodation, outpatient services, psychiatric support services, residential accommodation (halfway houses, group homes, hostels, boarding houses), day hospitals, day centres (living skills, day activity, sheltered employment) is virtually identical to the network defined in the New South Wales Forward Plan. However, the discussion paper, despite its title, does not address broad policy issues. Rather, it

focuses on administrative issues such as financing (hospital budgets, patient benefits) and staffing/management problems.

In terms of service provision, there is some discussion about maintaining the present acute bed to population ratio, retaining acute admissions at both psychiatric and general hospitals (despite the recommendations of the 1983 Bright Enquiry). Such discussion also covers the establishing of a working party to address 'the services available to the chronically mentally ill in both hospitals and the community, the deficiencies in these services and make recommendations for future development' (South Australian Mental Health Advisory Committee, 1985a:21). Some caveats are made about deinstitutionalisation, and the Committee appears to support the principle only if there are adequate community facilities, which they suggest may be just as costly as the institutional services. In fact there has been a major reduction in the daily bed use rate at one of the two main psychiatric institutions, Hillcrest (a 64 percent drop between 1960 and 1980, and a further decrease of 30 percent between 1980 and 1983). The discussion paper states that it would seem appropriate that the other hospital, Glenside, should aim for a similar reduction over the next five years, 'provided there is adequate continuing support for these people' (South Australian Mental Health Advisory Committee 1985a:21).

The problem is that there is a gap between these general policy principles and a detailed program for implementation stating how these community services will be established. It is possible that the proposed working paper on services to the chronic mentally ill will discuss the mechanisms for implementation. The theme of community services is taken up again in the third discussion paper, 'General Policy Guidelines and Community and Crisis Intervention Services.' Here it is proposed that community psychiatric services should have firm links to hospital services and recommends that the two main psychiatric hospitals, Hillcrest and Glenside, prepare detailed models for development of hospital based community and crisis intervention teams to service their metropolitan areas of responsibility (South Australian Mental Health Advisory Committee (1985c).

Institutional services

There are two major psychiatric hospitals in South Australia, both situated in Adelaide. In 1984-85, Glenside Hospital had a total of 546 beds while Hillcrest Hospital had 414 beds (Table 5.2). In addition, there were four acute inpatient units in general hospitals. If the psycho-geriatric beds and the drug and alcohol and other special beds are excluded, there was a total of 790 acute and long stay beds, or 0.58 beds per 1000 population.

Both psychiatric hospitals have a major responsibility for the continuing care of chronic psychiatric patients. As noted earlier, there has been a major reduction in bed usage rate at Hillcrest hospital, so that in 1984-85 there were only about sixty beds dedicated to chronic patients under the age of 65. There were over 200 chronic mentally ill patients in Glenside. The aim over the next five years is for a similar reduction in these patients from Glenside so that overall the number of chronic mentally ill patients resident in psychiatric hospitals in South Australia should be less than 120.

Sheltered employment in 1984-85 was offered by Invicta Sheltered Workshops Ltd at three workshops located at Hillcrest and Glenside Hospitals and at Norwood Centre. As is the case for the workshops for people with intellectual disabilities, the buildings and staff for the workshops for people with psychiatric disabilities are provided by the hospitals, while Invicta negotiates the contracts for work. In the financial year 1985-86 there were major changes in this area. The composition of Invicta's board of management was altered and a project officer was appointed to examine options for alternative forms of sheltered employment such as work enclaves and work preparation centres.

An example of a new initiative is the Special Training Employment Programme (STEP) funded co-operatively by the Commonwealth and South Australia governments. STEP is a work preparation program catering for people who have suffered a mental illness and wish to gain employment. It provides individualised programs which include assessment of work skills, vocational guidance, job try-outs, job seeking and keeping skills training, employment counselling and support, and employment placement assistance. Although recurrent funding is provided by the Commonwealth Department of Employment

TABLE 5.2: SOUTH AUSTRALIA MENTAL HEALTH SERVICES - SOUTH AUSTRALIAN HEALTH COMMISSION

Institutional services	Number of hospitals /units	Type of psychiatric bed: Acute beds	Long stay beds	Psycho-geriatric beds	Other beds	Total	Operating costs 1984-85 ($'000)
Psychiatric hospitals	2	166	540	359	145	960	41,636
General hospitals	4	84	-	-	-	-	(a)
Total	6	250	540	359	145	960	41,636

Community services	Number of client places	
Hostels	618	346(b) 451(c)
Community Mental Health Clinics	3	1,582
Day programs		(d)
Sheltered workshops	3	(d)
Total		2,379
Grants to NGOs		-
TOTAL		44,015

Source: South Australian Health Commission, Information supporting the 1985-86 Estimates.

Notes: (a) It is not possible to estimate costs of psychiatric units in general hospitals.
(b) Subsidies provided by the S.A. Health Commission to the hostel owners.
(c) The cost of operating the Mental Health Accommodation Program which is the support service provided for the hostels.
(d) These costs were included in the hospital budgets.

and Industrial Relations, the South Australian Health Commission provides the capital funding in the form of premises within the grounds of Hillcrest hospital.

Community services

In 1984-85 the main form of supported community accommodation was a system of hostels, a unique co-operative effort between government and private enterprise. There were 21 hostels (18 in the metropolitan area) and they had an average of 27 persons per hostel. Provision existed for a total of 618 residents. The State government paid the hostel manager a per capita subsidy for pensioners or low income residents. In addition, each resident paid his/her pension to the hostel management. The hostels must be licensed, the conditions for which are contained within the Mental Health Act 1976-79. The hostel system in 1984-85 was co-ordinated by a staff of 9.5 (full time equivalent) persons (including six social workers) from the Health Commission under the Mental Health Accommodation Program. All admissions to hostels were assessed for placement by the staff of this Unit. The social work staff were allocated specific hostels and were responsible for providing support to the manager and for the case work management of all allocated residents.

This hostel program was criticised because it catered for an older psychiatric population (average age 57.5 years) and the hostels rarely offered constructive day programs or provided training in basic living and household skills (Barber, 1985:85). In 1983, the Community Mental Health Division of the South Australia Health Commission estimated that an additional 200 beds were needed in the community for people currently living in inadequate boarding houses or inappropriately located in psychiatric hospitals.

Some of these concerns were echoed in the 1985 Review of Psychiatric Rehabilitation Centres (as the hostels are formally known) undertaken by the South Australian Health Commission. Despite its name, the Review commented that the hostels lacked a comprehensive rehabilitation program. Individual needs vary, so the Review recommended adequate provision of a range of rehabilitation programs. Other problems with the hostel system noted by the Review included (South Australian Health Commission, 1985a:24):

- the provision of only one model of accommodation for one particular group of clients (middle aged to elderly people with chronic mental illness);

- lack of access to hostel accommodation by country residents;

- absence of clearly differentiated levels of supervision and associated services;

- perpetuation of a dependency model rather than a developmental or educative approach;

- the positive aspects of small group living (privacy, individuality) could not be promoted because of the size of the hostels;

- the number of professional support staff available to residents is minimal and does not allow for the development of individual management procedures or appropriate programs.

Recommendations were made for the establishment of small special purpose hostels for identified groups with special needs such as young persons with chronic schizophrenia, the confused elderly, disturbed women, and disturbed adolescents. Some concern was expressed about the physical standards of care in hostels and the considerable variation in these standards which existed. Recommendations were made for the development of regulations to uphold a new set of standards. It was also proposed that a two-tier personal care subsidy be introduced to reflect the difference between supervision of residents and assistance with residents' activities of daily living, including the additional resources required to cope with cases of difficult, destructive or disturbed behaviour.

To encourage non-government organisations to provide special purpose accommodation, it was recommended that the Mental Health Accommodation Program provide resources as required 'to assist the voluntary sector establish and maintain a network of community based accommodation' (South Australian Health Commission, 1985a:38). There are also a number of recommendations regarding legal considerations, administrative arrangements,

subsidy and financial arrangements. Finally, the Review discussed future development, in particular the need for a broader approach to the provision of community accommodation and care services including hostel care, small group homes (supportive but independent living on either a long or short term basis) and individual flats or units (independent living with access to supervision or support services).

Since the release of this report in July 1985, some changes have been implemented. Three hostels have been closed and alternative accommodation established. Three smaller community houses, and five additional units have been set up. There are immediate plans for twelve more houses, each accommodating three residents, three twelve bed hostels for special needs groups, a community house for behaviourally disordered women, and assistance in the provision of accommodation for the young psychiatrically disabled. More generally, there is a broad objective which involves the development of 'a range of models for consideration in planning the provision of long and short term accommodation, involving various groups from the public and private sectors' (South Australian Health Commission, 1986b:2).

On the administrative side, a new assessment and referral process has been established within the Mental Health Accommodation Program. There has been an improvement in the social work service to hostel residents through an increased level of staffing, definition of case management role, regular staff supervision and staff development. A Mental Health Resource Centre has been established which provides office accommodation for seven non-government organisations, as well as being a drop-in centre for schizophrenics. The Health Commission is encouraging these non-government organisations to acquire housing stock, for which they will provide the necessary support staff.

Other community health services include outpatient clinics attached to psychiatric hospitals and general hospital units and three community mental health centres - Beaufort, Carramar and St. Corantyn. All three centres are located within metropolitan Adelaide and provide outpatient and day patient services (group therapy such as social skills, living skills, behaviour therapy, occupational therapy, counselling, and crisis intervention). Attached to Carramar is a halfway house for outpatients and day patients

waiting for emergency housing. One of the recommendations of the Bright Inquiry (1973) was that those three clinics should be amalgamated with general community health centres. This proposal has been resisted to date. A number of community outreach workers are employed at Hillcrest Hospital and the Flinders Medical Centre. They follow up discharged patients and maintain a caseload of patients never admitted. Four community health nurses work in country areas. Day programs are only available at the two psychiatric hospitals, three of the general hospital units and the three specialist mental health clinics (Table 5.2). More day programs are currently being investigated, and the hospitals have already begun to re-locate their day programs into the community.

Grants to Non-Government Organisations

In 1984-85 grants to non-government organistions were primarily for support groups for individuals or families of the mentally ill. No funds were given for the development of accommodation and/or employment services. However the 1985-86 financial year saw a change in the orientation of funding to NGOs with the establishment of the Mental Health Resource Centre (described earlier). This is a grouping of seven NGOs who aim to acquire housing stock for community residential accommodation for people with psychiatric disabilities. The Health Commission plan to provide support staff for these community houses.

5.2.2 People with Physical Disabilities

Policies

In South Australia, policies and services for the physically disabled are not clearly identifiable, for reasons similar to those described for New South Wales. Recent discussion papers on policies for the physically disabled have originated from The Ageing Project within the South Australian Health Commission. In the absence of a specific administrative and service structure for people with physical disabilities under 65, it is quite common for this association with aged persons' services, even though it may not be the most appropriate mode of service delivery. The two most relevant of these discussion papers for the younger physically disabled group are General

Medical Rehabilitation Policy and Head Injury Service. The others are concerned with services which focus primarily on the elderly population.[1]

In the General Medical Rehabilitation discussion paper, the term rehabilitation describes 'the range of attitudes, knowledge and skills which are, or should be, applied to people of all ages in a number of settings when their disease or injury causes disablement, especially if handicap or dependency seems a possible or is an actual outcome' (South Australian Health Commission, 1985c:1). The paper describes the components of services that should exist at both regional and State levels. However, the regional network appears far from satisfactory because it does not distinguish services on the basis of age or disability, nor does it discuss accommodation options which are a necessary concomitant to rehabilitation services. Statewide services refer to the facilities which actually exist and does not include a statement of the service types which should exist.

The Head Injury Service discussion paper proposes the development of a comprehensive, co-ordinated statewide service for post-acute care of people with acquired brain damage. It describes fourteen components for a total service including inpatient care with fast and slow stream rehabilitation, inpatient long term care, respite care, day activity centres, vocational training, group living, foster family care, consulting clinics, transport, administrative support for self help and lobby groups, education, central care registry, and co-ordination mechanisms. According to the discussion paper, the components not available currently are day activity centres, group living, foster family care, consulting clinics, transport, administrative support, education, central care registry, and co-ordinating mechanisms. Interestingly, the recommendations to acquire both the day activity centres and the group living centres suggest that the State government should assist identified non-government organisations to prepare submissions to obtain

1. The other discussion papers are:
South Australia Health Commission, Hospice Care Policy, The Ageing Project, Adelaide, South Australia Health Commission, June 1985.
South Australia Health Commission, Service Provision Guidelines for South Australian Regional Domiciliary Care Services, The Ageing Project, Adelaide, South Adelaide Health Commission, February 1986.
South Australia Health Commission, Discussion Paper on Psychogeriatric Services for South Australia, The Ageing Project, Adelaide, S.A. Health Commission, August 1985.

funding from the Commonwealth Department of Community Services. This attempt to co-ordinate State and Commonwealth programs in the delivery of a comprehensive service is a common approach in South Australia. Joint planning of this nature was also seen in relation to intellectually disabled persons services and probably partially explains the relatively higher per capita expenditure by the Federal government in this State (see Chapter 3). Such a high degree of co-operation between the Commonwealth and State government does not exist in either New South Wales or Victoria.

Services

It is extremely difficult to determine the specific services for people with physical disabilities under 65. As in other States, a proportion of the physically disabled population live in nursing homes which are privately owned and run. However, there are two State nursing homes which cater, in part, to the physically disabled under 65 - the Julia Farr Centre for the multiply physically disabled and Morris Wards Hampstead Centre for those with acquired brain damage and spinal injuries.

Community services include outpatient clinics attached to many of the acute departments of hospitals - neurosurgery, neurology, orthopedics, medical etc.. Many services are also available at the general community health centres or through the Domiciliary Care Service. However it is impossible to determine the relative utilisation of these services by those over 65 and those under 65.

Grants to Non-Government Organisations

Grants are given to a number of non-government organisations providing services to people with physical disabilities. The largest recipient is the Royal Society for the Blind which received a grant of $2.8 million in 1984-85, and which provides some accommodation and vocational services. The Crippled Children's Association received $260,000 in 1984-85. It has a residential section which accommodates up to sixty children. The Association also provides independent living training to assist the transition from living in the family home to living independently in the community. It also run the Handicapped Employment Training Assistance (HETA) program, which

provides training for up to 60 physically disabled school leavers and other young adults entering or re-entering the workforce. A much smaller grant is given to the Royal South Australian Deaf Society. The Society provides a range of services including a hostel with eleven beds and a House project which provides independence training for teenagers and adults, vocational services, aids to daily living. The total amount of grants to non-government organisations providing accommodation and vocational services for the physically disabled in 1984-85 was $3.1 million.

5.3 South Australian Housing Trust

The South Australian Housing Trust has a long history of assisting people with disabling conditions to live independently within the community. Originally, this was done by modifying existing rental properties through installation of ramps, grab rails, and sliding doors. In 1966, twenty six home units (ten villa flats and sixteen family houses) were purpose-built for disabled people providing wheelchair access, special equipment, and large interior spaces. Although the Trust no longer builds estates of this nature (following debate about the social consequences of housing so many disabled people together) it is still very active in its provision of disabled persons housing.

By June 1985, 2682 dwellings, or five percent out of a total rental stock of 53,281 had been specially constructed or modified to suit the needs of disabled people (South Australian Housing Trust, 1985). The majority of these houses had been either allocated through the normal allocations procedure or through the priority housing assistance scheme. In the case of normal allocations, the Trust commences its assessment from the time of application. Priority housing assistance, however, is granted to people with a genuine accommodation crisis. These people can be referred by social workers in other government departments or voluntary welfare agencies, or they are culled from the regular review of current applications which seek to identify people experiencing particularly adverse circumstances. Decisions on individual referrals are reviewed monthly by a Committee comprising representatives from South Australia Council of Social Service, Mental Health Services, Women's Shelters, Department for Community Welfare, and the Commonwealth Department of Social Security.

Seventy three of the 2682 dwellings available for disabled people were provided to community-based non-government organisations for use as accommodation for the physically and intellectually disabled through the Community Tenancy Scheme which has been operating since 1979. In addition, to providing the houses, the Trust also undertakes the necessary alterations and modifications to make them suitable for the prospective occupants. Like New South Wales, South Australia is not just involved in the building and construction of its housing stock. It has a purchased housing program which enables the Trust to buy houses on the open market, thereby increasing the choice available to applicants. This is especially relevant to disabled persons where proximity to services and facilities is critical. This program has been operating in South Australia since 1972-73. In addition, specially designed units for disabled people are now included in all new housing development. Specific design features, identified in a survey of housing for disabled people conducted by the Trust, are now incorporated wherever possible in houses for disabled people.

During 1984-85, an innovative modification to the garden of a paraplegic tenant was carried out by Trust staff in their own time. They constructed raised garden beds for wheelchair access and a complicated pulley system to enable the person to tend hanging baskets from a shade covered pergola. Like New South Wales, the South Australian Housing Trust has a number of specific housing programs for which disabled persons would be eligible. These include Youth Housing, Aged Persons Housing, Rent Relief Schemes, Joint Ventures, and Housing Co-operatives. Most of these programs came into operation in South Australia well before they were introduced in New South Wales. Unfortunately, there is no means of estimating the overall level of expenditure on disabled persons housing provided by the South Australian Housing Trust.

5.4 South Australian Department for Community Welfare

This department plays a small role in the provision of services for disabled people. It runs three residential homes for intellectually disabled children. The largest, has sixteen short-term beds, another has six long term/permanent beds, while the third has four beds. The total operating cost of these homes in 1984-85 was just over $1.2 million.

Through the department's Community Welfare Grants, subsidies are given to non-government organisations for the provision of specific services. In 1985, seventeen approvals were given to projects assisting people with disabilities. However the sum of these grants was only $43,000, most of which was for information and support services.

Probably the most important function of the Department for Community Welfare in relation to disability services provision is the nomination, in early 1987, of the Deputy Director-General to the position of Disability Services Coordinator. This person will work closely with a senior advisory group, consisting of a representative from IDSC, the Adviser to the Premier and a representative from the Children's Services Office, to establish mechanisms 'to improve the planning and provision of services to the disabled, and the co-ordination of these services between government and non-government agencies and between the State and the Commonwealth' (Office of the Deputy Director, Department for Community Welfare, 1987).

5.5 Summary of Issues

Current policies in South Australia for people with intellectual and psychiatric disabilities are not focused on deinstitutionalisation per se, as they are in New South Wales. Rather, the emphasis has been on the development of community services for people not living in institutions. This is reflected in the relative expenditure on institutional and community services. In New South Wales, 94 percent of expenditure was on institutional services compared to 81 percent in South Australia (Table 5.3). South Australia gives more than New South Wales as grants to non-government organisations: $7 million compared to $2 million.

A significant feature of service provision in South Australia is the fact that the South Australian Housing Trust has been providing accommodation for people with mainly physical disabilities for a much longer period than either New South Wales or Victoria. This is reflected in the Australian Bureau of Statistics' data in Chapter 2, specifically Table 2.3, which show a significantly higher proportion of severely handicapped people living in public housing accommodation - nineteen percent compared with twelve percent New South Wales, and an insignificant proportion in Victoria.

TABLE 5.3: SUMMARY OF EXPENDITURE ON SERVICES FOR PEOPLE WITH DISABILITIES - SOUTH AUSTRALIA - 1984-85

Services	Institutional services	Community services	Grants to NGOs	Total
	$'000			
Intellectual disability	20,188	3,327	3,998	27,513
Psychiatric disability	41,636	2,379	-	44,015
Physical disability	(a)	(a)	3,126	3,126
Unallocated[b]		1,226		1,226
Total[c]	61,824	6,932	7,124	75,880

Source: Tables 5.1, 5.2

Notes:
(a) Expenditure on institutional and community services for people with physical disabilities could not be obtained

(b) Unallocated to a particular disability group. Comprises expenditure by the South Australia Department for Community Welfare

(c) Excludes expenditure by South Australia Housing Trust

Another interesting comparison between South Australia and New South Wales is the difference in the degree of Commonwealth - State co-ordination in the planning and funding of non-government organisations to provide services to both intellectually and physically disabled people. In South Australia this co-ordination is fundamental to an integrated service structure, while in New South Wales it is virtually non-existent. Despite policy concerns in South Australia about groups such as women, children, Aborigines and people living in isolated rural areas, there is very little evidence, like New South Wales, that their special needs have been addressed. On balance, it appears that there is a higher level of overall provision of services to all groups of people with disabilities in South Australia compared to New South Wales.

CHAPTER 6: SERVICES PROVIDED BY THE VICTORIAN GOVERNMENT

In Victoria, the pattern of service delivery for people with disabilities is similar to that in South Australia and New South Wales, in that the Health Department traditionally has been a key provider of services. However, in 1985 there was an important development in the provision of services to people with intellectual disabilities. The administration of services for this group was moved from the Department of Health to the Department of Community Services, thereby signifying the government's recognition of the fact that intellectual disability is not a health or illness problem, but rather a problem of delayed development among otherwise healthy people. Services to people with physical disabilities are provided largely by non-government organisations. However, unlike New South Wales and South Australia, the Victorian government is very generous in its support of these organisations, providing grants which, in 1984-85 totalled $27 million, of which $10 million was for accommodation services. For comparative purposes, the data have been structured in a similar way to the data for New South Wales and South Australia, with a breakdown of information by State government department for each main disability group in terms of institutional services and community services.

6.1 Community Services Department Victoria

6.1.1 People with Intellectual Disabilities

Policies

No less than four reports on services for intellectually disabled persons have been produced in Victoria in the last 10 years[1]. A recurring theme throughout these reports has been the proposal to create an administrative

1. These reports are:
Evans, J.L. Report of the Victorian Committee on Mental Retardation. Melbourne, Victorian Government Printer, 1977.
Cocks, E. Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons. Melbourne, Health Commission of Victoria, 1982.
Rimmer, J. Report of the Committee on Legislative Framework for Services to Intellectually Disabled Persons. Melbourne, Victorian Government Printer, 1984.
Roper, T. Services to Assist Intellectually Disabled Victorians. Melbourne, Victorian Government Printer, 1984.

structure, separate from health or mental health administrations. Both Evans (1977) and Rimmer (1984) went so far as to recommended the establishment of a separate statutory authority. Cocks (1984) identifies a number of reasons for this latter recommendation. There is the overriding issue that intellectual disability is not primarily a health problem and service development has suffered from application of the 'medical' model. Services are fragmented and lack co-ordination and a single administrative structure is required to co-ordinate services over the life time of the individual. Intellectual disability is the 'Cinderella' of health services and receives low levels of funding because it is lost within large health bureaucracies.

In 1981, four years after the completion of the Evans Report, the Mental Retardation Division was established within the Health Commission of Victoria. This was separate from the newly created Mental Health Division, and though it was not a separate statutory authority it was able to achieve a great deal. The creation of this separate administrative structure coincided with the election of the Cain Labor Government in March 1982 and in its first two years of office, the budget allocation for mental retardation increased by over 42 per cent between 1981-82 and 1983-84, when the total increase for State spending on health was only 27 percent (Roper 1984:2). A major thrust of the program was the expansion of the community residential program from twelve community residential units in April 1982 to forty four in April 1984, with a further twenty one houses purchased and negotiations underway for another eleven. Regional teams providing local support had 42 staff in 1982: by 1984 this number had almost quadrupled to 160.

As of October 1 1985, the Mental Retardation Division was transferred from the Health Department Victoria to the Community Services Department Victoria and renamed the Office of Intellectual Disability Services (OIDS). Although not a statutory authority, this organisational change represented an important breakthrough for intellectual disability services because it formalised the government's recognition that persons with an intellectual disability do not have a health problem.[2] Furthermore, it provided those

2. Premier Cain acknowledges this in his News Release on 20 June 1985. He said: 'It (the transfer) acknowledges the growing recognition that intellectual disability is primarily a problem of delayed development and the individuals therefore require appropriate development opportunities and training if they are to achieve their maximum independence.'

services with a higher profile because the new Office represented half of the total size of the newly created Community Services Department: no longer would the intellectual disability service be lost in a large health bureaucracy.

The most recent government report on services for intellectually disabled persons was prepared by the Minister of Health, Tom Roper in 1984. Like the Richmond report in New South Wales, this report emphasised the principles or ideological base from which services could be developed. These principles include normalisation, a move to deinstitutionalisation, control by clients over choice of service, community involvement in provision and planning of services, a move toward generic service provision, the development of a wide range of service models to meet diverse needs, the establishment of qualitative standards and continuous evaluation of services, and the development of staffing structures and training to meet the needs of new services. The report goes on to establish a series of specific initiatives as an expression of the broader principles. These include more detailed proposals for the establishment of a planning network, regional services, generic service provision, planning a ten year deinstitutionalisation programme, residential options, institutional management reform, vocational services, and individual development programs. This document serves as a policy framework from which service development has occurred. This has been facilitated by the passage of the Intellectually Disabled Persons Act in 1986.

Institutional services

There are eleven institutions for intellectually disabled persons in Victoria, known as residential training centres. At the end of 1984-85 they had a total of 3137 beds and 2738 residents. This is a bed to population ratio of 0.77 per 1000 population, almost double the New South Wales ratio. These institutions vary significantly in size from 35 beds to over 800. Despite this high institutional population, these are not necessarily traditional institutions. One centre, Janefield, for example, began a program in 1980 to 'normalise' its dormitory style units. Staff houses on the premises of the institution, left vacant for some years, were renovated to accommodate the younger residents in these three-bedroom, suburban style houses. It could be argued that this was an insufficient attempt at

'normalisation' because clients are still located in the grounds of an institution and not integrated into the community. Nevertheless it showed an awareness of the problems of institutionalisation. It should be made clear that these training institutions are quite separate from mental institutions. A large proportion of the residents are occupied during the day, with approximately 60 percent attending day programs offered within or outside the centres.[3] The total cost of operating these institutions in 1984-85 was $56.4 million (Table 6.1).

Community services

The Roper report (1984) committed the government to a broad range of community based accommodation services. This includes:

- community support teams to help clients stay with their families, live independently, or live in foster or other situations;
- community residential unit program;
- respite and holiday care arrangements;
- family board;
- co-residency arrangements;
- programs such as Interchange (family-based respite care through NGOs);
- foster care;
- cluster apartments.

In financial terms, the most important of these programs is the community residential unit (CRU) program. It involves the purchase by OIDS of ordinary houses in the community and the provision of staffing subsidies to non-government organisations, known as residential associations. These residential associations manage and staff the houses. The type of housing

3. This estimate was made in the article, 'Costs of Services', Options 2(5), 1983, p.9.

TABLE 6.1: INTELLECTUAL DISABILITY SERVICES - VICTORIA - DEPARTMENT OF COMMUNITY SERVICES

	Number of units	Number of beds/places	Operating Costs 1984-85 ($'000)
Institutional services			
Residential training centres	11	3137	56,425
Community services			
St Nicholas project CRU's	23	101	1,517
Regional teams	12		6,475
Total			7,992
Grants to NGOs			
CRU program	63	352	7,310
Day training centres	69	2,600	18,900
Other			230
Total			26,440
TOTAL			90,857

Source: Office of Intellectual Disability Services, data provided on request.

varies depending on the needs of individuals requiring accommodation. There are basically three levels of staffing, related to the severity of disability. The maximum number of residents per house is six. Detailed guidelines exist which spell out policies and procedures.[4]

This program began in 1975 on a pilot basis in the Lodden/Campaspe region of Victoria. After surveying the need for residential care in the area, funds were allocated in 1978 to purchase and operate six community residential units in the region. This had only increased to twelve CRUs by April 1982. As mentioned earlier, the election of the Cain Labor Government to office in March 1982 meant a dramatic acceleration of this program so that by the end of the 1984-85 financial year, 52 houses were operating with a total of 293 places. In addition there were eight more houses (48 places) providing respite care and three independent living units with eleven places. The total grant to the residential associations for operation of this program in 1984-85 was $7.3 million (Table 6.1).

In addition to the houses described above, there are twenty three houses operated directly by the OIDS. They are not managed by voluntary residential associations like those under the CRU program. They house 101 ex-residents of St. Nicholas Hospital, which was closed during 1984-85. St Nicholas Hospital has provided care for twenty years for up to 150 people with intellectual disabilities, many of whom have multiple handicaps. Its closure symbolises the dynamic change from institutional to community care. However, it does not mean a reduction in the provision of care. In fact the resident to staff ratio is at least 2.5:1, except during sleeping hours. This represents a much higher ratio than can be readily achieved in an institutional setting. Although the population of St. Nicholas represents only a small proportion of all 2800 residents in State run institutions, it is seen as a major step in the direction of deinstitutionalisation. The cost of operating these twenty three houses in 1984-85 was over $1.5 million (Table 6.1). This relatively low cost is explained by the fact that the whole process of relocation took place during the 1984-85 financial year, with the last of the houses becoming available in March 1985. A more

4. The relevant manual is called the Community Residential Unit Program, Policy and Procedure Manual.

realistic operating budget for the twenty three houses is provided by the allocation for 1986-87 of $4.8 million.

One innovative approach towards the provision of group homes currently being explored by the OIDS is the home ownership proposal. In cases where intellectually disabled people have inherited the family home after their parents die, OIDS is looking at the feasibility of entering into funding and service agreements with the new owners. At the same time, they would provide a subsidy to run the home for the owner and other clients and to employ support staff if necessary.

In 1984-85, OIDS had twelve regional teams. They fulfil a number of functions including individual assessment of clients, development of general service plans, the improvement of access to services, provision of information and education about intellectually disabled service needs and options, planning, developing and providing services, and support of non-government organisations. These teams provide two kinds of support to the community residential houses: administrative or managerial support to the house management committees, and professional services (by social workers, psychologists, and occupational therapists) to the residents of the houses. The total operating cost of these teams for 1984-85 was almost $6.5 million (Table 6.1).

In addition to the day programs provided by the residential training centres, in 1984-85 there were another 69 adult units (including four sheltered workshop sections and some special school sections) providing day programs in the community. These are mainly activity therapy centres offering independent skill development, some recreational activity and some employment-focused activity. There were places for 2600 clients in 1984-85. These units were operated by voluntary committees of management just like the community residential units. The OIDS funds those voluntary organisations to run the day programs. In 1985-86, the total funds made available for these programs was $18.9 million (Table 6.1)

Other Grants to Non-Government Organisations

Finally, and in addition to grants to voluntary organisations for the establishment and operation of group homes and training centres, OIDS gives

subsidies to other non-government organisations. In 1984-85, the total amount given was $230,000 (Table 6.1). Some of this money was for information and support groups for intellectually disabled people. A substantial amount went to the Interchange program (matching a child with a host family for relief care) and foster care.

New initiatives

It is important to comment on a new program started in 1985 by the OIDS. It is called the Open Employment Training Program and its aim is basically to provide competitive employment opportunities to intellectually disabled Victorians[5]. Under the program, clients receive intensive, ongoing support

throughout the length of their employment, including placement, job-site training, ongoing monitoring and follow-up. Unlike work enclaves which assume the continued presence of a professional, this program assumes that on-site supervision can be phased out over time. This venture into competitive employment is a unique step, not yet tried by either of the administrations of services for people with intellectual disabilities in New South Wales or South Australia, and probably not even possible while their administrations remain situated within health bureaucracies.

It is not possible to conclude without making some comments on the comparison between intellectual disability services in Victoria and New South Wales. Victoria provided more community residential units in 1984-85, with roughly 85 houses and some 450 places, compared to 25 houses and roughly 100 places in New South Wales. In terms of deinstitutionalisation, Victoria has set a precedent with the St Nicholas project, achieving goals similar to those proposed by Richmond, namely using the resources of an institution to set up staffed houses in the community. The administration of services in Victoria has been separated from the health bureaucracy, recognising that intellectual disability is not an illness but delayed development. Even the institutional services in Victoria are separate from mental health institutions and for some reason they appear to cost $30 million less to operate for a similar number of clients (2738 clients in Victoria compared with 2616 clients in New

5. This new program is described in a recent edition of Options, the newsletter of OIDS. The article is 'Open Employment Training Program', Options 5 (1), April/May 1986, p.1.

South Wales). Finally, there is a virtual absence of community-based day training centres in New South Wales, compared to 69 centres with 2600 places in Victoria. The prospect of a competitive employment training program similar to the one Victoria offers, seems a remote prospect in New South Wales.

6.1.2 People with Physical Disabilities

The Victorian government does not fund any direct services for people with physical and sensory disabilities apart from an information bureau. However, it does provide a rather substantial amount of money in the form of grants to non-government organisations. In 1984-85, the Victorian Health Department funded a total of fifty one non-government organisations providing services to people with physical and sensory disabilities. The total cost of these grants was $27 million (Table 6.2). Of these fifty one NGOs, nine provided accommodation services. Grants to these nine NGOs totalled $10 million. The remaining forty two organisations provide a range of services including paramedical services, transport services (some of the big NGOs have a fleet of over 100 vehicles), rehabilitation, and recreation services. From October 1 1985, funding of these organisations was transferred from the Health Department Victoria to the Community Services Department Victoria.

TABLE 6.2 GRANTS TO NGO'S PROVIDING SERVICES TO PEOPLE WITH PHYSICAL AND SENSORY DISABILITIES - VICTORIA

Organisation providing -	Number of Organisations	Expenditure 1984-85 ($'000)
Accommodation services -	9	10,072
Other services	42	16,900
TOTAL	51	27,000

Source: Community Services Department Victoria, data provided on request.

These grants are very significant and far exceed the level of provision in either of the other States. In fact this very generous allocation of funds to NGOs applies across the board. A national survey of NGOs showed that organisations in Victoria received on average, more money from the State government than similar organisations in any other State (Milligan, Hardwick, and Graycar, 1984).

6.2 Health Department Victoria

6.2.1. People with Psychiatric Disabilities

Policies

There are currently no policy statements on services for the mentally ill in Victoria, as there are in New South Wales and South Australia. In October 1986, a discussion paper was circulated and after a series of consultations a revised policy has been drafted. It is expected that this will be launched by the Minister later in 1987.

Institutional Services

Institutional services are provided through two types of hospitals: psychiatric and mental. Psychiatric hospitals provide short term diagnosis and treatment of acute psychiatric illness. Mental hospitals provide for longer term treatment or indefinite hospitalisation. There are seventeen psychiatric hospitals throughout Victoria with a total of 942 acute beds, and ten mental hospitals (excluding one Commonwealth rehabilitation hospital) with a total of 1429 long term beds (excluding the Commonwealth beds). In addition, there are six psychiatric units in general hospitals with a total of 100 additional acute beds. Excluding psycho-geriatric beds and drug and alcohol and other special beds, the total number of acute and long stay beds is 2471 beds which represents a bed to population ratio of 0.60 beds per 1000 population. Total operating costs for the psychiatric institutions in 1984-85 was $139.2 million (Table 6.3).

Like the other States, Victoria has seen a dramatic decline in inpatient bed days over the last twenty years and a shift to outpatient care (Krupinski, Alexander and Carson, 1982). The process of deinstitutionalisation is still occurring, if at a diminished rate, and the period from 1981 to 1985 has seen

TABLE 6.3: MENTAL HEALTH SERVICES - VICTORIA

Institutional services	Number of hospitals units	Type of psychiatric bed					Operating costs 1984-85 ($'000)
		Acute	Long stay	Psycho-geriatric	Other	Total	
Psychiatric and Mental Hospitals	17	942	1429	1039	124	3534	139,150
General hospital psychiatric units	6	100					N/A
Total	23	1042	1429	1039	124	3534	139,150
Community Services				No. of places			
Halfway Houses	2						
Group Homes	74			281			
Community Mental Health Clinics	24						
Total							12,154
Grants to NGOs							840
TOTAL							152,144

a twenty two percent decrease in long term mental hospital beds. The provision of acute psychiatric beds remained stable over this period at just over 1000 beds. Thirty six day programs were available at eleven of the psychiatric and mental hospitals in 1984-85. Despite their location within hospitals, a large proportion of attendances were by outpatients. At some hospitals, outpatients outnumbered inpatients. The cost of the day programs were subsumed within the overall operating costs of the hospital. Day programs were also run by the community clinics.

Community services

Supported accommodation in 1984-85 included two halfway houses, four hostels, three on Larundel hospital grounds and one at Willsmere hospital, and 74 group homes with a total of 281 client places. The two halfway houses were transitional accommodation programs based in the community. The length of stay for the first house was anywhere from six weeks to two years. For the second house, length of stay varied from three to six months. The hostels were transitional accommodation programs based in hospital grounds. All supported accommodation (halfway houses, hostels and group homes) were supervised and co-ordinated by both Mental Health Division hospitals and clinics. A total of six group homes were run jointly with community based mental health non-government organisations. As in the other States, non-government organisations also managed group homes without direct Mental Health Division service involvement.

In 1984-85, Victoria had twenty four community mental health clinics which provided a range of follow-up services including occupational and activity programs, behaviour modification programs, crisis intervention services, community nursing services, and, as noted already, the supervision and administration of group homes. Unlike programs in other States, the Victorian Community Mental Health Program was developed separately from the Community Health Program which was a Federal Labor Government initiative in 1975. The Community Mental Health Program began in early 1973, but in all States except Victoria, was subsumed under the Community Health Program from 1975 in recognition of the congruence of organisational and philosophical principles underlying both programs. The Victorian Community Mental Health Program has always been administered directly by the Victorian Mental Health

Authority, later the Mental Health Division, now the Office of Psychiatrically Disabled Services (OPDS).

In addition to the community mental health clinics, the Mental Health Division funded a pilot community program, known as the continuing care team. This team has broad responsibility for the development and co-ordination of community-based services at regional and sub-regional level. The team members are professionals with community development experience and skills. They do not provide any direct services, but rather they operate as consultants to the other service providers. Since the piloting of this scheme, recommendations have been made for the funding of three more continuing care teams. The total cost of operating community services specifically for the psychiatrically ill in 1984-85 was $12.2 million (Table 6.3).

Grants to Non-Government Organisations

Victoria funds a number of non-government organisations to provide a range of mental health services. The total budget for grants to NGOs in 1984-85 was $1.46 million, of which roughly $0.84 million was given to organisations providing accommodation, sheltered workshops and day program activity (Table 6.3). The remaining organisations tend to be mostly support and self help groups.

6.3 Ministry of Housing Victoria

Policies

Victoria is like New South Wales in that up until the late 1970s, government housing activity largely involved providing rental accommodation to families and aged pensioners. In 1984, a report entitled Assistance for the Disabled - Draft Guidelines indicated that there was no overall policy regarding housing for the disabled within the Ministry of Housing. However, a number of programs do exist in which accommodation assistance is provided to people with disabilities.

Regular Housing Scheme

Disabled people are eligible for public housing under the regular housing scheme, and the Ministry pays for any modifications made to the home as the result of the person's disability. The costs of amending housing tended to range between $5,000 to $15,000 in 1984-85. There are no data recording the numbers of disabled persons assisted under the regular scheme, although it has been estimated that the proportion of public housing clients who are disabled could be greater than 15 percent (Ministry of Housing, 1984:5).

Disabled persons receiving invalid pensions are theoretically eligible to apply to the Ministry for single rental accommodation. However, they are not actively encouraged to apply because preference is given to elderly people and to families. Eligibility is income assessed, and accommodation is built by the Ministry on land supplied by councils and church organisations. No statistics are available concerning the number of disabled persons assisted under this scheme.

The granny flats scheme commenced in 1975 and enables a disabled person to live 'with the family' in a self-contained unit in the back garden of a home owner. A home owner may apply for a granny flat so long as the proposed occupier is eligible for the Age or Invalid Pension, or War Services Pension. A private home renter can also apply for a granny flat, with the permission of the owner. Another aspect of the scheme is that home owners can buy a unit from the Ministry, have it erected by an approved builder, and when the unit is no longer required, sell it back to the Ministry.

The home renovation service commenced in April 1981, and provides assistance to pensioners, low income earners, and the disabled in carrying out necessary repairs or modifications to their homes. To be eligible for the service, all persons must be home owner-occupiers or persons purchasing homes from the Ministry and have a gross weekly income not exceeding a level set by the Ministry. Assistance provided by the Ministry includes:

- Advice - ranging from verbal discussions to a Building Inspector's report. This service is provided free of charge.

- Technical Assistance - concerned with arranging repair works, e.g. preparation of specifications, employment of tradesmen and supervision of works. A surcharge of up to eight percent of the total cost of the works may be charged for this assistance.

- Financial Assistance - Renovation loans up to a maximum of $10,000 over fifteen years are available to eligible applicants.

Disabled persons are also eligible to apply for extensions to a home if they can demonstrate the need for the extension, supported by a doctor's certificate.

In 1984-85, 383 households (aged and/or disabled) were given technical assistance, 183 loans were provided to disadvantaged persons including the disabled, at a cost of $0.62 million, and two households with disabled persons received money from the Ministry for extensions to their homes.

Group Housing Program

This program, established in 1984-85, caters primarily for aged and disabled people and is designed to increase the availability of residential accommodation for special needs groups. Non-government organisations apply to the Ministry to establish housing for disadvantaged persons. The Ministry pays for the accommodation and its maintenance, but the group manages the home, including the selection of tenants, staffing and the rent payment. The only stipulation by the Ministry is that all tenants not require live-in support. In 1984-85, thirty three homes operated, thirty one of which accommodated mainly psychiatrically ill and/or intellectually disabled tenants. At this time, there were between forty and fifty one persons housed through the scheme, including tenants with drug and alcohol problems. In 1985-86 the Ministry's budget for this program was $2.1 million, having increased from $650,000 in 1984-85 when the scheme was in its pilot stage.

Rooming House Program

This program commenced in 1981 and was established to diversify the available housing stock and to provide adequate standard rooming house accommodation.

The target group for this program is non-specific, although many rooming houses accommodate persons who are psychiatrically ill. The program is open to community groups, who make submissions to the Housing Ministry for the management of the properties. Rooming houses tend to be single room accommodation with shared facilities.

At June 1984, 250 rooms were being tenanted and a further 247 updated. The plan is to purchase an additional ten new properties a year, accommodating approximately 600 persons per year. The Housing Ministry has purchased twenty six rooming houses, seven of which have been upgraded and nineteen are awaiting or undergoing renovation. Of the seven currently operating, only one has been designed specifically to allow ground floor wheelchair access for the physically disabled. The Ministry's budget for this program for 1984-85 was $5.2 million, and for 1985-86 was $6.6 million.

Rental Housing Co-operative Scheme

This scheme is one in which community groups apply to lease housing through the Ministry. Capital costs and initial renovation costs are paid for by the Ministry, after which the co-operative is responsible for maintenance and rent. The co-operative must also select its own tenants, so long as they are eligible for Ministry of Housing assistance and the selection system used is primarily needs based. In 1984-85, one rental housing co-operative managing seven houses operated for people with disabilities. Another nine were in the process of being purchased or renovated, and the scheme aimed to purchase an additional nine houses in 1985-86. The total budget for this scheme (including the additional nine houses) for 1985-86 was approximately $2 million.

Shared Housing Program

This program is one in which low income earners can apply to share accommodation as a group (two to five members). The group is placed on a waiting list until housing is available, after which they become tenants of the Housing Ministry. Disabled persons are eligible to apply for this scheme. No budget is available for the program.

There is quite a striking difference between Victoria and the other two States in relation to Housing Department policies for people with disabilities. In Victoria, most of the policies are aimed at home owners, through the home modifications scheme, home renovations schemes, and granny flats, with less emphasis on the provision of public housing stock per se. This is reflected in the statistical information provided in Chapter 2, where the proportion of severely disabled people living in public housing accommodation is insignificant compared with twelve percent in New South Wales and nineteen percent in South Australia (Table 2.3). Despite these differences, there are some similarities between the three States. All States offer a program whereby they provide houses to non-government organisations, who in turn manage these houses as group homes for people with intellectual or psychiatric disabilities.

6.4 Summary of Issues

Victoria stands out from the other two States in its provision of services for people with disabilities, in particular its provision to people with intellectual disabilities and to people with physical disabilities (Table 6.4). Services for people with intellectual disabilities in Victoria are more extensive overall than in New South Wales or South Australia especially in terms of community residential places. This better provision of community-based services to people with intellectual disabilities is reflected in higher expenditures per severely intellectually disabled person. Both Victoria and South Australia spend more than double the expenditure of New South Wales on community-based supported accommodation and employment services.

As in the other States, people with physical disabilities are heavily reliant upon the non-government sector to provide supported accommodation and employment services. However, unlike the other States, the Victorian government provides much more substantial grants to these non-government organisations. In 1984-85, a total of $27 million was given to these non-government organisations, of which $10.1 million was specifically for supported accommodation services. This compared with $0.3 million to these organisations in New South Wales and $3.1 million in South Australia. South Australia, on the other hand, has at least developed some discussion papers

TABLE 6.4: SUMMARY OF EXPENDITURE ON SERVICES FOR PEOPLE WITH DISABILITIES - VICTORIA - 1984-85

Services	Institutional services	Community services	Grants to NGOs	Total
	$'000			
Intellectual disability	56,425	7,992	26,440	90,857
Psychiatric disability	139,150	12,154	840	152,144
Physical disability	(a)	(a)	10,072	10,072
Total[b]	195,575	20,146	37,352	253,073

Source: Tables 6.1, 6.2, 6.3

Notes: (a) Expenditure on institutional and community services for people with physical disabilities could not be obtained
(b) Excludes expenditure by Victorian Ministry of Housing

on policies for people with physical disabilities which separate the younger physically disabled population from the elderly population and also identify the needs of specific groups.

Another significant feature of services provided by the Victorian government is the focus by the Ministry of Housing on schemes to assist persons with disabilities who are owner occupiers. This is quite different to directions taken by South Australia where the emphasis is more on the actual provision of public housing. New South Wales, although a little slower of the mark, appears to be following the South Australia lead. Victoria, like the other two States, has not specifically addressed the special needs of women, children Aborigines and people living in isolated areas.

CHAPTER 7: COMPARISONS AND CONCLUSIONS

The previous four chapters provide a detailed description of supported accommodation and employment services and programs for people with disabilities offered by the Commonwealth government and three State governments - New South Wales, South Australia and Victoria. Estimates have been made of State government expenditure on institutional and community services for three groups of people with disabilities - people with intellectual disabilities, people with psychiatric disabilities, people with physical disabilities.

In this chapter, the role of the Commonwealth government and the State governments are summarised. Comparisons are made between the States in terms of the balance between institutional and community services for each disability group. Expenditure per disabled person is estimated to give some idea of the relative differences in the level of State provision. Other issues addressed in this chapter include: administrative structures, deinstitutionalisation, Commonwealth-State co-ordination, and the role of non-government organisations.

Role of the Commonwealth Government

The Commonwealth government, through the new Disability Services Act, funds non-government organisations to provide a range of services. These include supported employment, accommodation support, respite care, competitive employment, training and placement, independent living training, advocacy and information, recreation, and services for people with a print disability. Subsidies are given to non-government organisations in the form of capital or recurrent grants to provide these services. This program has been operating in a more limited form and under a different name since 1963.

The new Act was passed in November 1986 and one of its key features is its client-oriented focus. The new legislation actually incorporates statements on the rights of people with disabilities. Under the previous program, funds were only available to non-government organisations providing services to people with physical or sensory disabilities and to people with intellectual

disabilities. Under the new Act, provision is made for the inclusion of organisations providing services to people with psychiatric disabilities.

The Role of the State Governments

The three States reviewed here provide supported accommodation and employment programs primarily for people with intellectual disabilities and psychiatric disabilities. Services for people with physical disabilities are more difficult to identify and this is related to the diverse needs of each physical disability group, and also to the fact that the Commonwealth government has always had a major involvement in both the direct provision and funding of non-government organisations to provide services for people with physical and sensory disabilities.

Despite the widespread support in all three States for the principles of normalisation, deinstitutionalisation, a focus on community-based services, client participation in planning and management, service systems integrated and co-ordinated at a local level, and human rights and equity, there is great variation in the extent to which the States have embraced these principles, or even defined them. The following discussion compares the services for each disability group.

7.1 People with Intellectual Disabilities

Expenditure

The level of service provision varies enormously between the States. This is most clearly emphasised in Table 7.1 which shows the expenditure on services for people with intellectual disabilities by State and also gives an expenditure estimate per severely handicapped person by State. This per capita figure has been calculated by dividing total expenditure by the number of severely intellectually handicapped persons in each State[1]. The

1. The number of severely intellectually handicapped persons in each State was taken from the ABS Handicapped Persons 1981 Survey. Expenditure data on the other hand, relate to 1984-85. However assuming that the numbers of disabled people have changed slightly between 1981 and 1984-85, the relative proportions of disabled people in each State have probably not changed significantly. As we are primarily interested in the relative differences between States, rather than absolute amounts, these discrepancies between the numerator and denominator should not affect these relative differences.

TABLE 7.1: EXPENDITURE ON SERVICES TO PEOPLE WITH INTELLECTUAL DISABILITIES BY STATE 1984-85

	Institutional services		Community services		Grants to NGOs		Total	
	Total	Per severely intellectually handicapped person	Total	Per severely intellectually handicapped person	Total	Per severely intellectually handicapped person	Total	Per severely intellectually handicapped person
	$'000	$	$'000	$	$'000	$	$'000	$
New South Wales	83,884	3848	4,303	197	668	31	88,855	4076
South Australia	20,188	2765	3,327	456	3,998	548	27,513	3769
Victora	56,425	3135	7,992	444	26,440	1469	90,857	5048

Source: Tables 2.1, 4.8, 5.3, 6.4

Notes:

(a) Population figures, used as the denominator to obtain expenditure per severely intellectually handicapped person, were taken from the ABS 1981 Handicapped Persons Survey. See Table 2.1.

(b) Only includes expenditure by Departments of Health in New South Wales and South Australia and Department of Community Welfare, Victoria. In New South Wales and South Australia some expenditure is made by the respective departments of Youth and Community Services and Community Welfare but it is not possible to break it down according to the three disabled groups. Excludes expenditure by Housing Departments in all three states.

importance of this per capita figure is not its absolute value but rather its measure of the relative differences in expenditure between the States.

Table 7.1 shows that Victoria spends more per capita on services for people with intellectual disabilities than either South Australia or New South Wales. The total per capita figure for Victoria is $5048, of which $3135 or 62 percent is spent on institutional services, $444 (9 percent) is for community services and $1469 (29 percent) is grants to non-government organisations. In contrast, New South Wales spends an average of $4076 per severely intellectually handicapped person, of which $3848 (94 percent) is for institutional services, $197 (5 percent) is for community services, $31 (1 percent) is for grants to non-government organisations. South Australia spends a total of $3769 per handicapped person, of which $2765 (73 percent) is for institutional services; $456 (12 percent) is for community services; $548 (15 percent) is for grants to non-government organisations.

These expenditure estimates reveal that the focus in New South Wales in 1984-85 was much more on institutional services than community-based services. This is reinforced by the data provided in Table 7.2 which show there were 0.48 beds per 1000 population in New South Wales compared with only 0.03 community residential places. By comparison, both Victoria and South Australia have more institutional beds per 1000 population (0.77 and 0.55, respectively) and more than three times as many community residential places per 1000 population (0.11 and 0.09 respectively) than New South Wales. Thus total overall provision is higher in both South Australia and Victoria.

Deinstitutionalisation

The focus of current policies in New South Wales is very much on deinstitutionalisation. The Richmond program aims to reduce the 2616 beds in 1984-85 to 1091 beds by 1990, so the bed to population ratio in New South Wales will fall much further over the next three years. This focus on deinstitutionalisation is not so pronounced in South Australia and Victoria. Rather, they have concentrated much more on the development of community residential services and day training programs. Nevertheless, deinstitutionalisation remains an important consideration. In Victoria, the Office of intellectually Disabled Services has successfully transferred all 101 residents of St. Nicholas Hospital to twenty three community homes,

TABLE 7.2: SERVICES FOR PEOPLE WITH INTELLECTUAL DISABILITIES BED TO POPULATION RATIOS BY STATE, 1984-85

	Institutions		Community Residential Units	
	Total beds	Beds per 1000 population(a)	Total places	Places per 1000 population(a)
New South Wales	2616	0.48	160	0.03
South Australia	745	0.55	119	0.09
Victoria	3137	0.77	453	0.11

Source: Tables 4.2, 5.1, 6.1

Notes: (a) Population figures used to derive bed to population ratios are the total State resident populations at June 30 1985, from ABS Monthly Summary of Statistics Australia, Cat.No. 1304.0, June 1986.

achieving total closure of an institution - a goal still to be achieved by the Richmond program in New South Wales.

One of the major criticisms of the Richmond program has been its limited scope. The thrust of implementation to date has been the movement of patients out of institutions into community houses with associated support services. Money saved from the provision of institutional services has been used for the provision of community services. However, the focus is on providing community services only for those currently in particular institutions. Parents or guardians who have struggled to keep their intellectually disabled child out of an institution are not eligible for any of the new community services. It would be a truly ironic situation if they had to go into an institution before they were eligible for services. The original recommendations of the Richmond report were much broader proposals for the development of a comprehensive range of community services for all people in need. However the implementation to date has been more narrowly focused on those currently residing in specific institutions. It remains to be seen whether the program is broadened to provide community services to

those inappropriately located in nursing homes or the family home, or to those who need additional support to allow them to continue living as independently as possible in their own home.

Administrative structures

An overriding concern of providers of services for people with intellectual disabilities has been the creation of a separate administrative structure that would ensure separation from mental health services or even removal from within health bureaucracies. This has been a concern because intellectual disability, unlike psychiatric disability is not a health problem. It is a problem of delayed development and is not an acquired illness like psychiatric illness. According to Cocks (1984) this notion of a separate administrative structure has been the theme of seven out of ten reports on services for people with intellectual disabilities written in Australia since 1977. This has occurred to a greater or lesser extent in the three States under review. In New South Wales, a separate administrative structure for intellectually disabled services was established within the Department of Health in 1985, when a decision was made to implement the proposals of the Richmond Report. An implementation unit was established within the Central office of the Health Department specifically to undertake the task of transferring over half the residents of Fifth Schedule (psychiatric) hospitals to community residential units. In addition, administrative structures and advisory committees were established in the eleven regions to implement the Richmond proposals and to develop detailed programs for a comprehensive network of services.

Separation from mental health services occurred much earlier in the other States with the establishment of the Intellectually Disabled Services Council as part of the South Australia Health Commission in 1982, and the Mental Retardation Division within the Health Commission in Victoria in 1981. In both South Australia and Victoria, institutions for the intellectually disabled are quite separate from the psychiatric institutions. In New South Wales, although there are separate administrative structures, people with intellectual disabilities and psychiatric disabilities still co-reside in the same institutions.

The transfer of the Mental Retardation Division from the Health Department of Victoria to the Department of Community Services in 1985 represents an important step in the struggle by providers and consumers to achieve recognition of the fact that intellectual disability is not a health (or illness) problem. This transfer means that services which Cocks has described as the 'Cinderella' of health services are now no longer lost within a large health bureaucracy. Furthermore, one of the arguments for a transfer of this nature was the belief that when these services are removed from a health administration they are no longer constrained by the pervasive 'medical' model. Evidence of this effect is given by the development of a new program, a competitive employment program, within the new Office of Intellectual Disability Services that is located within the Department of Community Services. Such a program would be difficult to accommodate within a Health department.

Co-ordination

A critical feature of an integrated, comprehensive service for people with intellectual disabilities is good co-ordination with the Commonwealth government. The Commonwealth government, through the Disability Services Program, funds non-government organisations to provide both supported accommodation and employment programs for these people. However, in New South Wales there is very little evidence of the State government, in particular the Department of Health, working with the Commonwealth to jointly decide which non-government organisations should be funded and how they will be integrated into a total service.

South Australia is exceptional in having developed good co-ordination mechanisms with the Commonwealth government. The Intellectually Disabled Services Council in South Australia has regular meetings with the State Office of the Commonwealth Department of Community Services to jointly plan the funding of non-government organisations. They are even working towards establishing the same criteria for the funding of non-government organisations.

The Role of Non-government Organisations

Despite similar rhetoric from all three States about the need to involve the non-government (voluntary) sector in the provision of service to people with intellectual disabilities, there are large variations between the States in terms of this involvement. One measure of the extent of this involvement is the degree of co-ordination with the Commonwealth government, who are, after all, the main funding body for non-government organisations. Another measure of the extent of this involvement is the amount of funds the States provide to the non-government sector. In 1984-85, New South Wales gave $0.7 million to NGOs providing supported accommodation and employment services to people with intellectual disabilities. In South Australia, these same grants totalled $3.9 million and in Victoria, $26.4 million (Table 7.1). In Victoria, the funding of these organisations also means the formal integration of NGOs into the intellectually disabled service delivery network in the form of residential associations for the management of community residential units and similar associations for the day training centres.

7.2 People with Psychiatric Disabilities

Expenditure

Table 7.3 is similar in format to Table 7.1, giving the total expenditure on services for people with psychiatric disabilities by State as well as expenditure per severely psychiatrically disabled person by State. Once again the importance of this per capita figure is not its absolute value but rather its measure of relative differences between the States. The pattern of total expenditure by State on services for people with psychiatric disabilities is similar to the pattern of total expenditure on services for people with intellectual disabilities. In 1984-85, Victoria spent more per capita than either South Australia or New South Wales. However, differences did occur in the proportion of expenditure on institutional services and community services. The total per capita figure for Victoria in 1984-85 was $4988, of which $4563 (91 percent) was for institutional services, $398 (8 percent) for community services and $27 (1 percent) for grants to non-government organisations. This imbalance between institutional and community services and the lack of substantial grants to non-government organisations was similar for both South Australia and New South Wales.

TABLE 7.3: EXPENDITURE ON SERVICES TO PEOPLE WITH PSYCHIATRIC DISABILITIES BY STATE 1984-85

	Institutional services		Community services		Grants to NGOs		Total	
	Total $'000	Per severely psychiatrically handicapped person $	Total $'000	Per severely psychiatrically handicapped person $	Total $'000	Per severely psychiatrically handicapped person $	Total $'000	Per severely psychiatrically handicapped person $
New South Wales	98,052	2573	4,306	112	586	15	102,944	2702
South Australia	41,636	4042	2,379	230	-	-	44,015	4273
Victoria	139,150	4563	12,154	398	840	27	152,144	4988

Source: Tables 2.1, 4.8, 5.3, 6.4

Notes: (a) Population figures used as the denominator to obtain expenditure per severely psychiatrically handicapped person, were taken from the ABS 1981 Handicapped Persons Survey. See Table 2.1

(b) Only includes expenditure by the Departments of Health in all three States.

Table 7.4 further reflects this imbalance between institutional and community services in all three States. In 1984-85, Victoria had the highest bed to population ratio for institutional services (0.60 beds per 1000 population, compared to 0.58 in South Australia and 0.41 in New South Wales). It also had a greater number of community residential places than either South Australia or New South Wales.

TABLE 7.4: SERVICES FOR PEOPLE WITH PSYCHIATRIC DISABILITIES BED TO POPULATION RATIOS BY STATE, 1984-85

	Institutions		Community Residential Units	
	Total beds	Beds per 1000 population	Total places	Places per 1000 population
New South Wales	2207	0.41	200	0.04
South Australia	790	0.58	618(b)	0.45
Victoria	2471	0.60	281	0.07

Source: Tables 4.3, 5.2, 6.3

Notes: (a) Population figures used to derive bed to population ratios are the total State resident populations at June 30 1985, from ABS Monthly Summary of Statistics Australia, Cat No. 1304.0, June 1986.

(b) These refer to 618 hostel beds provided co-operatively by government and private enterprise. As most hostels average 27 persons each, they are larger than group homes and are therefore not really comparable to the numbers of community residential places given for the other two States.

Deinstitutionalisation

Deinstitutionalisation is also a key issue in the delivery of services for people with psychiatric disabilities. In all three States, this process has been occurring for over twenty years. In New South Wales, in-patients in psychiatric hospitals have dropped from 13,192 in 1965 to 5,039 in 1984. Similar reductions can be seen in the other States. However, as the figures in Table 7.4 show, despite the emptying of the psychiatric hospitals, there

is little evidence of an attempt to substitute in-patient accommodation for community residential accommodation.

The process of deinstitutionalisation has been occurring in response to a number of factors: an international anti-psychiatry movement, described by such writers as Szasz (1961) and Laing (1960); the notion that hospitalisation, especially for prolonged periods is positively detrimental towards the rehabilitation of the patient (Goffman, 1961); the development of effective drug treatment in the stabilisation of patients; and concern with the cost effectiveness of large institutions and the notion that community care was a cheaper alternative.

Scull (1976), writing on deinstitutionalisation in the United States, claims that the explanation for deinstitutionalisation is very complex. He observes that deinstitutionalisation took place at different rates throughout the world, and even within the same country. He spells out why the traditional explanations for deinstitutionalisation, namely improved drug therapy and the demonstration by liberal social scientists that mental hospitals were fundamentally detrimental to patients, are implausible arguments. He claims that the primary factor behind the adoption of a policy of deinstitutionalisation is a drive to control the rising costs associated with institutionalisation. This, in turn, is related to the relatively recent (postwar) change in the role of the State, and the expansion of social welfare programs. In effect, he is arguing that the growth of social welfare payments such as pensions and benefits have been substituted for expenditure on institutional care. This process has been ameliorated or even legitimated by the drug therapy argument and the humanitarian aspects of the argument that describes the bad effects of institutions.

Scull's explanation for deinstitutionalisation is quite plausible in the Australian context where, in times of fiscal constraint, this substitution of expenditure on institutions for direct cash welfare payments can be seen as a way of shifting the burden of responsibility from the State governments, who operate psychiatric institutions, to the Commonwealth government who administers pensions and benefits. Over the same period that deinstitutionalisation has been taking place, Saunders (1987) has shown that expenditure on invalid pensions (many of which are received by psychiatric

patients) have grown at an average annual rate in excess of fifteen percent between 1959-60 and 1985-86. After adjusting for inflation, real expenditure on invalid pensions grew by eight percent per annum over this period. This growth was related equally to the increase in the level of the pension and to demographic factors, i.e. an increase in numbers eligible to receive pension.

The absence of adequate community services indicates that deinstitutionalisation, for the most part, has been a cost cutting exercise rather than a humanitarian approach to the care of the psychiatrically ill. Deinstitutionalisation of psychiatric patients has come under increasing scrutiny and criticism in Australia and many other countries. A major part of this criticism is related to the fact that appropriate community care was rarely made available as a substitute for institutional care. Responsibility for care of discharged patients has fallen largely on to families, especially women. Alternatively, these people have been inappropriately housed in private boarding houses, nursing homes, or prisons. With harsher economic conditions and rental shortages, many are left homeless. More often, it is being argued that community care is at least as costly as institutional care if it is to be more than a cheap form of custodial care (Mills and Cummins, 1982; Lennie and Owen, 1983).

Last year and earlier this year there was renewed focus on the plight of the mentally ill in New South Wales.[1] This is probably a direct response to the Richmond program and misunderstandings about its possible achievements. Despite recommendations of the Richmond program to provide a comprehensive mental health system, the implementation so far has focused on transferring the people who are currently in the institutions into community houses with appropriate support services. These people, however, represent a small proportion of the total number of people who have been deinstitutionalised over the last twenty years. Criticisms of the Richmond programs are related to confusion over who are the actual targets of services. Moreover, the New South Wales government is unwilling to clarify the situation, presumably because it would have to admit that many people are not eligible for the program. It remains to be seen whether the program will be broadened to embrace a wider target population.

1. See articles in the Sydney Morning Herald, August 25, 26, 27, 28, 1985; February 23, 1987; March 23, 1987. Also a two-part series on the ABC 7:30 Report, March 1987.

Co-ordination

There has been no co-ordination between the States and the Commonwealth government in the provision of services for people with psychiatric disabilities because the Commonwealth government has not traditionally provided services to these people. However the new Commonwealth legislation include this group, so in future there will have to be some communication between the States and the Commonwealth.

The Role of Non-government Organisations

It may be that the absence of Commonwealth government involvement in the funding of non-government organisations to provide supported accommodation and employment services to people with psychiatric disabilities has meant that there is a dearth of such organisations. Table 7.3 shows that State grants to NGOs to provide services to people with psychiatric disabilities are insignificant in all three States, representing a very small percentage of total State expenditure.

7.3 People with Physical Disabilities

In all three States under review, it is difficult to identify both policies and services for people with physical disabilities, and often, when they do exist, they are lumped inappropriately with policies and services for elderly people. One reason for the difficulty in identifying these services is the vast range of physical disabilities and the specialised needs of each group. Another reason is, quite simply, the lack of provision by the States, related to the fact that the Commonwealth government has always had a major involvement, either in the direct provision - nursing home subsidies, Home and Community Care (HACC), Program of Aids to Disabled People (PADP), Commonwealth Rehabilitation Service (CRS) - or in the funding of non-government organisations (Disability Services Program) for people with physical and sensory disabilities.

Unable to get a total picture of direct State government provision, this review has focused on the grants provided by State departments of Health to non-government organisations providing services for people with physical disabilities. Table 7.5 shows the variation that occurs between the these States. New South Wales gives only $260,000 to NGOs to provide accommodation

and employment services for people with physical disabilities; South Australia gives $3.1 million, while Victoria gives $10.1 million. Relatively speaking, this is equivalent to about $2 per severely physically handicapped person in New South Wales, $68 in South Australia and $86 in Victoria. This disparity is even more dramatic given that the Victorian government gives a total of $27 million to organisations providing services for people with physical or sensory disabilities, of which the $10.1 million for accommodation and employment services is a part.

TABLE 7.5: GRANTS TO NGOs PROVIDING ACCOMMODATION AND EMPLOYMENT SERVICES TO PEOPLE WITH PHYSICAL DISABILITIES, 1984-85.

State	Grants to NGOs	
	Total ($'000)	Per severely physically handicapped person $
New South Wales	260	2
South Australia	3126	68
Victoria	10,100	86

Source: Tables 4.8, 5.3, 6.4.

7.4 All People with Disabilities

Table 7.6 shows the total expenditure on institutional services, community services and grants to NGOs for all people with disabilities by State. It sums the expenditure data in Tables 7.1 and 7.3 as well as including expenditure on grants to NGOs for people with physical disabilities (Table 7.5) and other State expenditure that could not be allocated across the different disability groups (see Tables 4.8, 5.3 and 6.4).

In total, Victoria spends almost double the amount spent by New South Wales, per severely disabled person - $1945 compared with $1109. South Australia is mid-way between the two. However in all three States, the largest proportion of total State expenditure goes on institutional services. This represents 94 percent of total expenditure in New South Wales, 81 percent in South Australia and 77 percent in Victoria. In Chapter 2 it was shown that only

TABLE 7.6: EXPENDITURE ON SERVICES TO PEOPLE WITH INTELLECTUAL, PSYCHIATRIC AND PHYSICAL DISABILITIES BY STATE 1984-85

	Institutional services		Community services		Grants to NGOs		Total	
	Total $'000	Per severely handicapped person $	Total $'000	Per severely handicapped person $	Total $'000	Per severely handicapped person $	Total $'000	Per severely handicapped person $
New South Wales	185,978	1038	10,323	58	2,245	13	198,546	1109
South Australia	61,824	1210	6,932	136	7,124	139	75,880	1485
Victoria	195,575	1503	20,146	155	37,352	287	253,073	1945

Source: Tables 2.1, 4.8, 5.3, 6.4

Notes: (a) Population figures used as the denominator to obtain expenditure per severely handicapped person were taken from the ABS 1981 Handicapped Persons Survey. See Table 2.1

(b) Includes expenditure by Departments of Health and Community Services/Welfare. Excludes expenditure by Housing Departments in all three states because a breakdown of expenditures on services for people with disabilities was not available.

about 2 percent of the total severely disabled population live in the institutions for which these costs refer. Thus the current distribution of services and expenditure is focused on a very small proportion of disabled people. This imbalance between expenditure on institutional and community services will have to be redressed if the goals of normalisation, deinstitutionalisation and equity are to be achieved.

Most of these expenditure data relate to expenditure by the Department of Health and in the final table, the State Departments of Community Services or Welfare. However, it is important at this stage to comment on the provision by Housing Departments in the three States.

Unfortunately, it was not possible to get a breakdown of expenditure on services for people with disabilities by Housing Departments. However their contribution is quite significant. For example, in 1985-86 the New South Wales Department allocated about $3.7 million to non-government organisation to provide about 45 group homes for people with intellectual disabilities, physical and psychiatric disabilities. This amount is greater than the total grants to NGOs provided by the New South Wales Department of Health. Furthermore, the New South Wales Department of Housing has developed a comprehensive and far reaching policy for people with disabilities. It systematically addresses the problems confronting people with disabilities in all three forms of housing tenure, public rental housing, private rental housing, and home ownership. Furthermore, the Minister for Housing has a commitment to implementing the policy, as indicated by the establishment of the Disability Housing Unit in March 1986 with a staff of seven.

The South Australia and Victoria Housing Departments also provide services to people with disabilities. However, they do not have such a clear and comprehensive policy statement as New South Wales, nor do they have a special administrative unit to co-ordinate implementation. South Australia has the distinction of making a conscious decision to provide services to people with disabilities much earlier than the other two States, with the construction of twenty six purpose-built housing units (ten flats, sixteen houses) as early as 1966. Since that time they have ensured that a certain proportion of their houses are available to disabled people. Victoria, on the other hand, provides services to people with disabilities but unlike New South Wales and

South Australia, the thrust of the assistance in Victoria has been to home owners through the home modifications and home renovations schemes, granny flats, and not in the provision of public housing per se.

In conclusion, the foregoing discussion shows that in general New South Wales is behind the other States in the provision of services for people with disabilities, especially in regard to community services and support to non-government organisations. The new Commonwealth Disability Services legislation is broad and comprehensive and will ensure that the Commonwealth support to the non-government sector develops and expands. Funding for the Disability Services Program has in fact nearly trebled between 1974-75 and 1986-87.

However if the new legislation is to maximise its potential, there must be co-ordination with the States and the non-government sector to ensure a comprehensive, integrated service. This means that the respective roles of the Commonwealth and the States must be clarified and planning must be needs-based not submission-based. Co-ordination must occur within the various disability programs of the Commonwealth government itself, the Disability Services Program, the Commonwealth Rehabilitation Service, the Program of Aids for Disabled People, Home and Community Care, as well as within various departments, Community Services, Employment and Industrial Relations, and Education. Co-ordination must also occur within the State governments and, in addition, between the Commonwealth and the States. Hopefully, some of the newly established co-ordinating bodies such as the Commonwealth Office of Disability will help to achieve such a goal. Finally, it must be remembered that the non-government sector is an important partner in this venture, having originally been the only provider of services for people with disabilities. Without their involvement a comprehensive service is not possible.

APPENDIX A: LABOUR FORCE PROGRAMS OFFERED BY THE DEPARTMENT OF EMPLOYMENT AND INDUSTRIAL RELATIONS

Specific Training Programs for the Disabled

An outcome of the Inquiry into Labour Market Programs (Kirby Report) tabled in 1985 was the establishment of a new integrated Community-based Labour Market Program (CLMP), encompassing three existing programs and introducing two new schemes. The primary focus of the new program introduced on 1 January 1986, is personal development, training and work experience for disadvantaged groups only. One of the existing schemes integrated into the program includes the Work Preparation Program.

The Work Preparation Program assists individuals with disabilities to gain open employment by offering services such as individual assessment, vocational evaluation, training, job search, placement and follow-up. Projects are conducted by community agencies who are funded by the Commonwealth on a fee-for-service basis. Training allowances are paid to participants at General Training Assistance (GTA) rates (i.e., the unemployment benefit entitlement plus a training component). In 1984-85, 482 people with disabilities were approved for assistance through work preparation projects and approximately 500 new approvals are estimated for 1985-86.

A further amendment to labour market programs resulting from Kirby Committee findings was the introduction on 1 January 1986 of the Adult Training and Retraining Program. This provides assistance to adults to attend existing courses or specially designed courses at training/educational institutions. Again this new program involves the integration of several existing schemes, one of which includes Formal Training/Retraining Allowances for disabled persons.

Formal Training/Retraining Allowances are available to disabled persons who undertake formal training for an occupation in which they are likely to gain employment on completion of training. Formal training is conducted through tertiary institutions, e.g. TAFE, whereas retraining tends to be on-the-job. The allowance is equivalent to that paid to the non-disabled under GTA and is

designed to cover the costs associated with doing a course, e.g. books, fares, union fees.

Employment Subsidies are provided to employers who employ or apprentice a disabled job-seeker. The subsidy is paid for the duration of the apprenticeship which can be a minimum of 20 weeks to a maximum of 52 weeks. This program may in the future be run under a Youth and/or Adult Trainee Package.

Employers are also eligible under the Employer Subsidies scheme to receive up to $2000 for the purchase of special equipment and to make modifications to the workplace to assist the disabled employee.

Job Creation and Employment Assistance Programs for the Disabled

In line with the recommendations of the Kirby Committee, the range of wage subsidy programs currently operating to assist disadvantaged persons, were integrated into a single wage subsidy program (Integrated Wage Subsidy Program) from 1 January 1986.

One program integrated included the Disabled-On-The-Job scheme. This program is one that basically provides subsidies to employers who are unable to fill vacancies by the skill required, so are offered subsidies by the Government to employ or train disabled persons in the position. Subsidies can be of two types; wage (if the person is skilled) or training (for unskilled workers), both of which act as incentives for the employment of disabled persons.

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