Determining the Equity & Accountability of Disability Services Queensland (DSQ) Funding: A Focus on Disability Groups

A Study conducted by the University of Queensland on behalf of The Schizophrenia Fellowship of South Queensland Inc.

Ruth Crowther PhD

THE UNIVERSITY OF QUEENSLAND

CONTENTS

EXECUTIVE SUMMARY

This report provides a description of a small-scale study that was undertaken in 2004 by the University of Queensland on behalf of the Schizophrenia Fellowship of South Queensland Inc.

The original remit of this study was to identify the proportion of Disability Services Queensland (DSQ) expenditure spent on individual disability groups. The hypothesis behind this was that given that the historical basis of DSQ is embedded in intellectual disabilities, services for this client group would receive the largest proportion of monies, whilst services for people with psychiatric disabilities would receive considerably less. However, upon commencement of the project is quickly became apparent that the necessary data to answer this question was unavailable. The question was therefore reformulated to focus on identifying the information that DSQ does make publicly available and identifying where the gaps exist in demonstrating accountability of funding. In addition, the study also aimed to identify whether there was any relationship between epidemiological burden of disease estimates and resource allocation based on the available data.

Report findings

- Data on DSQ expenditure on the different disability groups is extremely limited.
- Expenditure figures on Grants and Subsidies are available and reported in DSQ annual reports. Up until 2002 figures were provided on exact amounts allocated to specific services however, this information is no longer available and is deemed 'commercial in-confidence'.
- Expenditure figures are available for the different funding programs offered by DSQ (i.e. Adult Lifestyle Support, Family Support, etc). However, whilst it was possible to identify the number of applicants for the Adult Lifestyle Support Program stratified according to disability group, data was not available on the disability groups of those applicants who were successful.
- Figures were available on the number of clients accessing Commonwealth/State-Territory Disability Agreement (CSTDA) funded services on a single snapshot day. These data showed that over two thirds of clients had intellectual disabilities (69%) with 6.7% of clients having psychiatric disabilities.
- There appears to be a negative correlation between the level of burden of intellectual and psychiatric disabilities and resource allocation to the two disability groups. In 2001/02, psychiatric disability represented an estimated 13% of disease burden and received 1.6% of DSQ grant expenditure compared to intellectual disability which represented an estimated 1.4% of disease burden and received 11.4% of DSQ grant expenditure.
- Despite acknowledgement of the importance of accountability in a number of policy documents, it appears that there are limited procedures in place for identifying expenditure according to disability group.

1. BACKGROUND

This study is the result of a collaboration between the Schizophrenia Fellowship of South Queensland Inc. and the University of Queensland.

The state organisation Disability Services Queensland (DSQ) is the gatekeeper for a number of funding programs for people with psychiatric disabilities. Given its historical background as being a service specifically for people with intellectual disabilities, the Schizophrenia Fellowship was interested in determining whether the proportion of funding allocated to services for people with intellectual disabilities outweighed that allocated to services for people with psychiatric disabilities. In addition, the Fellowship was also interested in determining whether there was any relationship between epidemiological burden of disease estimates and allocation of resources to the different disability groups.

2. DISABILITY IN AUSTRALIA

Functioning and disability are multidimensional concepts, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and the factors in their environment which affect these experiences. A person's functioning or disability is conceived as a dynamic interaction between health conditions and environmental and personal factors (World Health Organisation, 2001). Where there are limited accommodations in place in society to account for the difficulties faced by individuals with disabilities, disability policies play an important part. Many of the policies focusing on disabilities have adopted a human rights philosophy whereby people with disabilities should have equal access to the same opportunities to participate in society as those without disabilities (United Nations, 1994). One of the major policy documents that adopts this philosophy is the Disability Discrimination Act 1992, (DDA) which makes discrimination on the grounds of disability unlawful and provides a framework for the setting of standards. The definition of 'disability' used in the DDA is very broad and includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities. The Act states that any of these disabilities can be either permanent or temporary. Given that there are a number of policy documents focusing on providing equal opportunities and social inclusion for people with this range of disabilities we may assume that disability has a high prevalence in Australia. In addition, awareness is constantly increasing of the high prevalence of psychiatric disorders in Australia, which as previously mentioned comes under the umbrella of 'disability'.

2.1: INCIDENCE OF DISABILITY

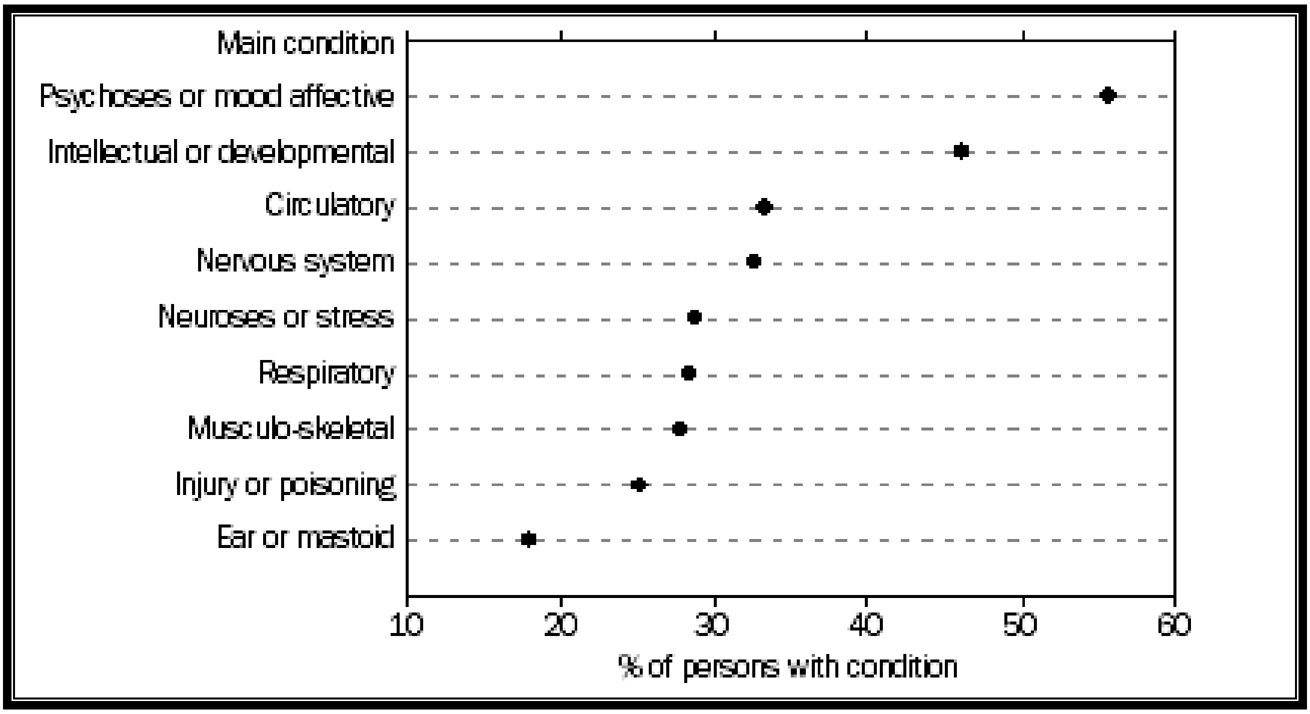
One in five people (20%) in Australia had a disability in 2003, unchanged from five years ago (after age standardising) with the rate being much the same for males (19.8%) and females (20.1%) (AIHW, 2003a). Disability was defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

The disability rate has steadily increased with age from 4% of 0-4 year olds to 41% of 65-69 years old to 92% of people 90 years and older. Just over half (51%) of people aged 60 years and over had a disability. Most of these people (59%) did not need any assistance to manage health conditions or cope with everyday activities. For those who did, the most commonly reported needs were help with property maintenance, health care and transport. The rate of profound or severe disability increased with age from 3% of 0-4 year olds to 10% of 65-69 year olds to 74% of people 90 years and over.

Physical conditions were the most common main health conditions of persons with a disability (84%). The remaining 16% had a mental or behavioural disorder as their main condition. However, those whose main condition was a mental or behavioural disorder were more likely to have a profound or severe core-activity limitation than those with a physical condition (46% compared to 29%).

Figure 1 below highlights the percentage of people in Australia with physical conditions that cause the highest rates of profound or severe core-activity limitations. Over half (56%) of those with psychoses or mood affective disorders, such as dementia and depression, had a profound or severe core-activity limitation compared to almost half of those with an intellectual disability (48%). These figures compare to 33% for those with circulatory conditions, such as stroke and heart disease, and 33% for those with diseases of the nervous system having profound or severe core-activity restrictions.

Figure 1: Persons with a disability. Profound or severe core-activity limitation rates by condition, 2003 (SDAC)



This figure illustrates that in Australia, a large proportion of those with psychoses or mood affective disorders and intellectual or developmental disorders experience profound or severe core-activity limitations. Given that these groups of disorders can be so disabling (and can therefore require a high level of support and services), it is of interest to obtain estimates of their relative prevalence in Queensland.

Disability Estimates in Queensland

It is not possible to obtain state specific data on the different disability groups in Queensland using straightforward 1998 ABS Survey of Disability and Carers data. The reason for this is that due to the relatively small sample sizes for some states and territories, such estimates would have large sampling errors. Therefore the data on prevalence estimates presented in this section were obtained using a different approach as specified in a recent AIHW publication (AIHW 2003a). The estimates at state and territory level rely on underlying assumptions that each state or territory has the same age- and sex-specific prevalence rates as those of the overall Australian population and that the estimated numbers are not affected by factors other than demographic variations. Data from the 1998 ABS Survey of Disability, Ageing and Carers are used to derive age and sex specific rates of the five main disability groups in Queensland. These rates are then applied to the age and sex distributions of the 30 June 1998 estimated resident population (from ABS population data) to calculate the estimated number of people by age and sex. The resulting numbers for each age and sex group are summed to give an estimate of the total number of people in the state within each disability group (table 1). At the time of writing, although summary data was available on the 2003 SDAC (ABS, 2004), specific data on disability prevalence by state was not.

The estimates show that the highest proportion of disabilities in Queensland was for physical / diverse disabilities which accounted for 51% of all disabilities. This was then followed by sensory or speech disabilities which accounted for 23% and psychiatric disabilities which accounted for 14%. Interestingly intellectual disabilities accounted for only 9% of disability groups with the lowest group being acquired brain injury (7%).

Table 1: Estimates of disability in Qld by sex and age, 1998 ('000) (AIHW 2003a)

	0 - 64	**65+**	**Σ**
Intellectual			
Males	46.7	8.3*	55.0
Females	23.0	13.2	36.2
Σ	**69.7**	**21.4**	**91.1 (9%)**
Psychiatric			
Males	44.7	15.3	59.9
Females	47.0	29.7	76.7
Σ	**91.6**	**45.0**	**136.6 (14%)**
Sensory / Speech			
Males	71.9	57.4	129.3
Females	39.5	61.2	100.7
Σ	**111.4**	**118.6**	**230 (23%)**
Acquired Brain Injury (ABI)			
Males	17.0	4.5*	21.5
Females	11.1	4.3*	15.4
Σ	**28.1**	**8.8***	**36.8 (7%)**
Physical / Diverse			
Males	167.3	80.6	247.9
Females	161.2	105.6	266.8
Σ	**328.6**	**186.2**	**514.8 (51%)**
All Disabilities	**629.4**	**380.0**	**1009.30**

Note: Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50%. Interpret these accordingly.

2.2: BURDEN OF DISEASE

Of interest to this study was the extent to which resources allocated to the different disability groups reflect epidemiological estimates of disease burden in Australia. Burden of disease studies provide detailed and internally consistent estimates for Australia of the incidence, prevalence, duration, mortality and disease burden for an exhaustive and mutually exclusive set of disease and injury categories. In doing so they enable the quantification of loss of health from 176 causes of disease and injury and for ten major risk factors. The two burden of disease studies done on Australian populations include one examining the burden of disease and injury in Australia (Mathers, *et al.,* 1999; 2000) and a second examining the burden of disease in Victoria (Vos & Begg, 1999; 2000). To date, there have been no burden of disease studies done in Queensland, although it is anticipated that one is due to begin in 2005.

Both these studies use a common index known as the DALY (Disability Adjusted Life Year) to assess the combined impact of both premature death and disability amongst those who are alive. The DALY takes into consideration, not only lives lost due to premature death (PYLL), but also includes equivalent years of 'healthy' life lost due to poor health or disability. DALYs are calculated for each disease and injury category as defined by ICD-10 (World Health Organisation, 1993), and are calculated as the sum of years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident causes of the health condition. The DALY is therefore calculated as YLL+YLD with one DALY representing one lost year of 'healthy life'. It is presented here as a summary measure, as it allows comparisons between diseases of a very different nature to be made.

The DALY also uses explicit preference values for different health states known as 'disability weights'. These weights are derived from the Global Burden of Disease study (Murray & Lopez, 1996) by panels of health experts using 'Person Trade-Off' (PTO) methods for 22 indicator conditions. DALY weights are expressed on a scale from zero to one with zero being full health and one being death.

Tables 2 and 3 and Figure 2 below, present Weights and DALYs for the specific disability groups/illnesses that are of relevance to this study and that data is available for. These data are taken from the Victorian Burden of Disease study (Vos & Begg, 1999, 2000; Vos, *et al.,* 2001) as in the absence of Queensland data, this is the most comparable data set available. It is important to bear in mind here that although the populations in each state are likely to be similar in terms of demography, Victoria has a denser population. As at December 2003, the population for Victoria was 4,948.0 compared to 3,840.1 for Queensland (ABS, 2003), thus it is 1.28 times (or 28%) larger.

It is difficult to present figures on disability weights for the different disability groups as they are applied according to ICD-10 diagnoses (World Health Organisation, 1993) rather than aggregated disability groupings. However the data that is available is presented (table 3). The weights given to psychiatric disabilities and intellectual disabilities vary considerably. The weight of 0.434 given for schizophrenia is a composite weight based on a weight of 0.3 for treated schizophrenia and 0.7 for untreated schizophrenia. These figures compare to a weight of 0.290 for a mild intellectual disability which increases to 0.820 for a severe intellectual disability. In terms of disability weights, age related vision disorders and adult onset hearing loss are classified as considerably less disabling with a range of 0.020 for mild cases to 0.430 for severe vision loss.

Table 2: Disease Categories and Disability Weights (Vos & Begg 2000)

DISEASE CATEGORY / SUBCATEGORY	DISABILITY WEIGHT
Schizophrenia	0.434*
Obsessive-compulsive disorder (OCD)	
Mild to Moderate OCD	0.170
Severe OCD	0.600
Bipolar Disorder	0.176
Major Depression	
Dysthymia cases	0.140
Major depressive episode – Mild	0.140
Major depressive episode – Moderate	0.350
Major depressive episode - Severe	0.760
Panic disorder	
Mild to moderate panic disorder	0.160
Severe panic disorder	0.690
Borderline Personality Disorder	0.540
Age related vision disorders	
Mild vision loss	0.020
Moderate vision loss	0.170
Severe vision loss	0.430
Adult onset hearing loss	
Mild hearing loss (23-34 dBHTL)	0.020
Mild hearing loss (35-44 dBHTL)	0.040
Moderate hearing loss	0.120
Severe hearing loss	0.370
Mental retardation (no defined aetiology)	
Mild intellectual disability	0.290
Moderate intellectual disability	0.430
Severe intellectual disability	0.820
Profound intellectual disability	0.760
Down syndrome	
Mild intellectual disability	0.290
Moderate intellectual disability	0.430
Severe intellectual disability	0.820
Profound intellectual disability	0.760

* This is a composite weight based on a weight of 0.3 for treated schizophrenia and 0.7 for untreated schizophrenia.

As indicated in Figure 2, in terms of the different psychiatric diagnoses, affective disorders are the leading cause of overall disease burden in Victoria (34% of total) after anxiety disorders (23%) and substance use disorders (also 23%). The third leading burden of mental disorders has been classified as 'other' with no further details being available (13%). The burden of schizophrenia constitutes 5% of DALYs and affective disorders constitute 34% which combined give a total of 39% of disease burden. Eating disorders represent a burden of 3% of DALYs.

Figure 2: The burden of disease in disability adjusted life years (DALYs) by psychiatric disorder, Australia 1996.

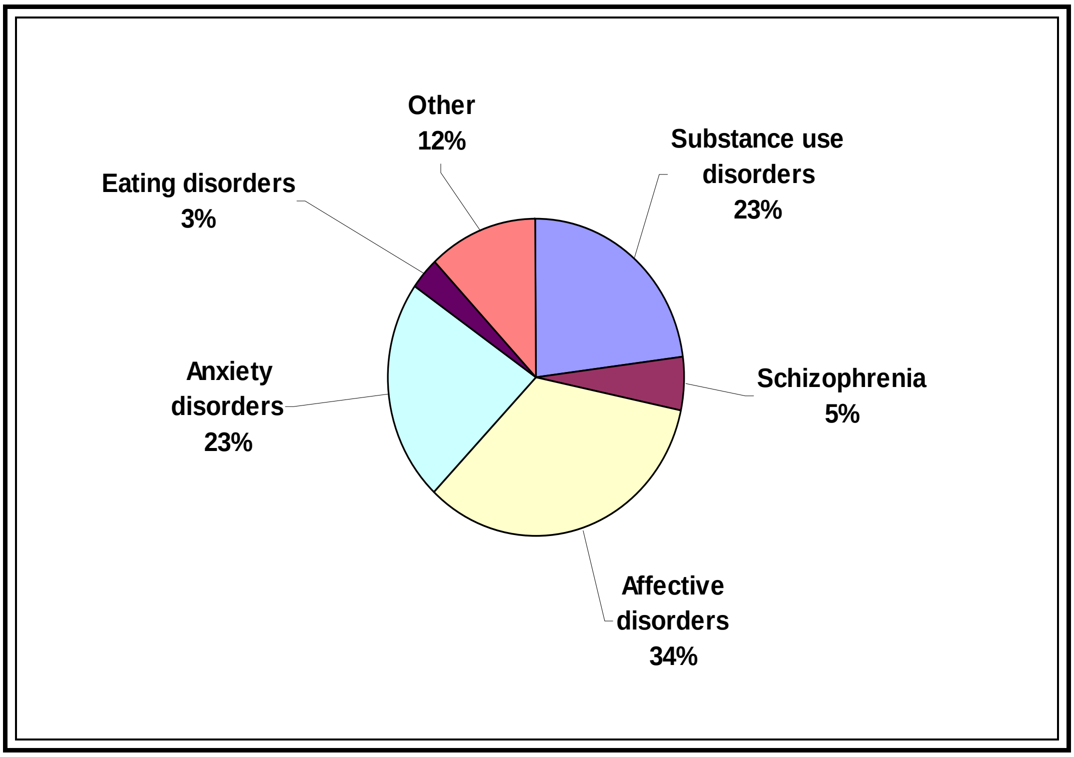


Table 3 below illustrates the DALYs according to the major groupings of Intellectual Disability and Mental Disorders. For mental disorders, the disability burden is slightly smaller for males than it is for females although this is reversed when schizophrenia only is examined. Overall, mental disorders are attributable for 13.2% of the disease burden for Victoria although only a small proportion of this is accounted for by schizophrenia (0.7% of all causes). Much of this figure is accountable for by depressive disorders. When schizophrenia is examined as a percentage of all mental disorder DALYs it accounts for 5.4% of the burden. Intellectual disabilities account for 1.4% of the disease burden in Victoria with the male burden being higher than it is for females.

Table 3: Disability Adjusted Life Years by Sex and Disability Group. Victoria 1996 & 2001.

	MALES	FEMALES	TOTAL	% OF ALL CAUSE DALYs
Mental Disorders*	40,776	41,451	82,227	13.2%
Schizophrenia	*2,236*	*2,175*	*4,412*	*0.7%*
Intellectual Disabilities**	5,795	3,488	9,283	1.4%

* Presents 1996 data extracted from Victorian Burden of Disease Study (Vos & Begg 2000). ** Presents 2001 data from updated Victorian burden of disease study (personal communication with Theo Vos).

It is important to note here that that these data are representative of different years. This is due to the inability to obtain figures for mental disorders for 2001. In addition as previously mentioned this data is for Victoria rather than Queensland as Queensland data is not available. It is not possible to extrapolate these findings to the Queensland population for a number of reasons. In addition to a lower population rate than Victoria, Queensland may have a different population structure with a higher proportion of indigenous people. Also, in order to calculate DALY percentages it is necessary to have an estimate of the total number of DALYs caused by all illnesses. To obtain such a figure would require a separate burden of disease study focusing specifically on Queensland.

3. DISABILITY SERVICES QUEENSLAND (DSQ)

Disability Services Queensland (DSQ) was established in December 1999 with the intention of providing a strong focus on disability across the Queensland Government. It replaced the former disability program that was part of Families, Youth and Community Care Queensland and that was predominantly aimed at intellectual disabilities.

DSQ is the first disability focused department in Queensland. Central to ongoing reform of disability services, DSQ aspires to working closely with communities to enhance service delivery and allow people with a disability and their families more input into the policies that affect them. Responsibilities of DSQ include:

- The provision of services and supports, both direct services (provided by the Department) and those provided through the non-government sector;
- Community infrastructure development; and
- Whole-of-Government leadership and coordination.

Whereas Queensland Health Mental Health Program is responsible for the delivery of clinical and treatment services, DSQ is responsible for the funding of non-clinical services and support for people with a disability. The definition DSQ uses as its guidelines is from the Queensland Disability Services Act 1992 (QDSA). This Act applies to people who have a disability that is permanent or likely to be permanent which may, or may not be, of a chronic episodic nature and is:-

- attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of impairments and results in:-
    - a substantial reduction of the person’s capacity for communication, social interaction, learning or mobility; and
    - the person needing support.

In terms of a psychiatric disability, the Act states that the disability must:-

- Arises from psychiatric impairment;
- Significantly reduces the person’s capacity to carry out life activities: communication, social interaction, learning or mobility;
- Is permanent or likely to be permanent; and
- May or may not be of a chronic episodic nature.

In addition to direct funding provision, DSQ also administers a number of funding programs initiatives. These initiatives include the:- Adult Lifestyle Support Program (ALSP); Family Support Program; Friendship Program; Alternative Living Service; Post-School Program; Resident Support Program; Grant Payments and Project 300 (a full description of these programs is provided in appendix one). Funding for these initiatives is usually administered to community organisations who are then responsible for overseeing the delivery of the program/s.

DSQ operates according to a number of policy documents. Within these are documents focusing specifically on disabilities and also policies focused specifically on psychiatric disabilities. The focus on psychiatric disabilities appears to be as a result of an increasing awareness of the high prevalence rates and costs of mental illness and an acknowledgement that this client group has historically missed out on funding through DSQ. A summary of the policy documents and how they relate to accountability is presented in appendix two. Those explained include: - The National Mental Health Strategy; The Ten Year Mental Health Strategy for Queensland and; The Strategic Plan for Psychiatric Disability Services and Support.

4. METHODOLOGY

4.1: AIMS

This study aimed to utilise publicly available information to address a number of questions regarding resource distribution for psychiatric services from monies allocated to Disability Services Queensland (DSQ). Within this, the specific questions to be addressed were:-

1. What is the incidence of disability across the DSQ sector?
2. How much funding is allocated to the different disability groups through DSQ?
3. What is the spread of resource allocation across the different psychiatric disabilities
4. Does the amount of funding allocated reflect that expected as indicated by Burden of Disease data?
5. Is there structural bias against cyclical disabilities?
6. What does the Commonwealth get for its dollar?

However, upon commencement of this study it became apparent that the data was not available that would enable the answering of these questions. Therefore the research questions were re-formulated as follows:-

1. What proportion of their total expenditure does DSQ allocate to services aimed specifically at assisting people with psychiatric disabilities and their families / carers?
2. What proportion of their total expenditure does DSQ allocate to programs aimed specifically at assisting people with psychiatric disabilities and their families / carers?
3. What information does DSQ make publicly available on how it distributes funding?
4. Given the emphasis on accountability within the National Mental Health Strategy, the Ten Year Mental Health Strategy for Queensland and the Strategic Plan for Psychiatric Disability Services, is DSQ able to publicly account for the disability groups to which it allocates funding.
5. Where do the gaps exist on accountability of funding allocations?

4.2: METHODS

4.2.1: Sources of Information

Annual reports provided by the following Government organisations will be scrutinized to determine income and expenditure by DSQ for the years 2000/01, 2001/2002, 2002/03 and 2003/2004 (where data is available).

a) Disability Services Queensland (DSQ)
b) Family and Community Services
c) Queensland Health
d) Health and Aged Care

In addition to scrutiny of annual reports, departments will be contacted directly to determine whether figures not reported in the documentation are available. Publications by the Australian Institute of Health and Welfare will also be scrutinized to identify any other reports containing relevant data.

Burden of disease data will also be examined to determine whether there appears to be any relationship between expenditure on individual disability groups and level of burden of intellectual and psychiatric disabilities.

4.2.2: Disability classifications used in this report

Table 4 illustrates the disability groupings used in this report. The classifications used are the same as those used in the Commonwealth State Territory Disability Agreement (see appendix three) and are taken from the National Community Services Data Dictionary (AIHW 2003b) which provides guidelines and definitions for use for the Australian national disability groupings of disability. It is worth noting here that these disability groupings should not be used to classify people. Rather, they are intended to categorise people's experience in various domains of functioning and disability.

Table 4: Disability classifications used in this report

DISABILITY CATEGORY	TYPE OF DISABILITY
Intellectual	Developmental Delay Intellectual Specific learning / ADD Autism
Psychiatric	Psychiatric
Sensory / Speech	Deafblind (dual sensory) Vision (sensory) Hearing (sensory) Speech
Physical / Diverse	Physical
Acquired Brain Injury	Neurological

5. RESULTS

The results will be presented according to the main (re-formulated) research questions. Section 5.1 will examine the proportion of funding allocated by DSQ in the form of grants and subsidies for the years 2000/01; 2001/02; 2002/03 and 2003/04 (where available) and present data on how much is allocated to psychiatric services. Section 5.2 will then further develop this funding pathway by identifying how much of this funding is spent on services that exist specifically to assist those with psychiatric disabilities and intellectual disabilities and their carers.

5.1: FUNDING ALLOCATIONS THROUGH DISABILITY SERVICES QUEENSLAND

Limited data on the amount of funding allocated to the different disability groups is available from DSQ. The main data reported in this section are on the amounts of funding allocated through grants and subsidies. This is presented in three ways: -

- Aggregate amounts
- Amounts allocated to individual services
- Amounts allocated to the different funding programs

5.1.1: Grants and Subsidies

In terms of attempting to identify how much funding is allocated to different services and client groups, DSQ presents its data in three ways. Firstly it presents an aggregate amount for grant allocation and subsidies and total expenditure (Table 5) Secondly, up until (and including) 2001/02, amounts allocated to individual services in the form of grants are presented. From this list it is possible to identify services for people with psychiatric disabilities who received grants. Thirdly, it presents total amounts allocated for the different funding programs, i.e. Adult Lifestyle Support Program, Post-School Programs, etc. Whilst this is useful in terms of comparing aggregate amounts given to different programs, the inability to determine how many clients received each funding program according to their disability group makes these figures difficult to interpret.

Table 5: DSQ total expenditure and total grants and subsidies

	2000/01 $'000	**2001/02 $'000**	**2002/2003 $'000**	**2003/04 $'000**
Grants and Subsidies	157,938*	177,923**	202,552	234,454
Total Expenditure	275,237	305,628	343,655	385,274
Cent / $ spent on grants & subsidies	***57c***	***58c***	***59c***	***61c***

*Actual total expenditure presented in the list of services in the annual report is $154,053,000. ** Actual total expenditure given in the list of services in the annual report is $168,264,000.

In 2000/01, 57 cents per dollar was spent on grants and subsidies, increasing steadily to 61 cents per dollar in 2003/04. The remainder of expenditure was spent on employee expenses, supplies and services, depreciation and amortisation and equity return expenses. It is important to bear in mind here that this figure is for all disability services - not specifically psychiatric services.

There is also a discrepancy between the total expenditure given directly to services as illustrated by the list of grants and the total grants and subsidies given in the annual report summary figures.

The discrepancy appears to lie in a difference in monies given to services directly and monies given to the funding programs and industry contributions (see table 8 below). For 2000/01 this difference is $3,885, however for 2001/02 this difference increases to almost $10,000 dollars ($9,659).

Prior to 2001/02, DSQ also presented exact figures for recurrent and non-recurrent grant amounts allocated to each service. Although successfully funded individual services were identified, they were not categorised according to which disability groups they serve. Personal communication with DSQ has reinforced that this data by disability group is not available. Table 6 below shows the amounts allocated to services that serve people with psychiatric disabilities and the amounts allocated to services for people with intellectual disabilities (and specifically the Endeavour Foundation).

Table 6: DSQ Grants and Subsidies*

SERVICE NAME	2000/01	2001/02	2002/03***	2003/04***
SERVICES FOR PSYCHIATRIC DISABILITIES				
ARAFMI	642,291	473,722**	Na	Na
Mental Health Association (Qld)	73,979	77,691	Na	Na
National Employment & Psychological Services Centre	2,780	-	Na	Na
Queensland Association for Mental Health	57,027	-	Na	Na
Schizophrenia Fellowship South Qld	11,184	18,880	Na	Na
Schizophrenia Fellowship	-	29,000	Na	Na
Service for children whose parents have a psychiatric disability	14,140	-	Na	Na
Children whose Parents have a Mental Illness	206,518	209,617	Na	Na
Stepping Stone Clubhouse	26,358	53,655	Na	Na
Caboolture Psychiatric Disability Project – Connections	197,417	245,831	Na Na	Na Na
The Toowoomba Clubhouse Association	28,914	22,326	Na	Na
Toowoomba Clubhouse Association	22,776	_	Na	Na
The Richmond Fellowship	492,048	1,674,820		
TOTAL GRANTS ALLOCATED TO PSYCHIATRIC DISABILITIES	**1,775,432**	**2,805,542**	**NA**	**NA**
SERVICES FOR INTELLECTUAL DISABILITIES				
Endeavour Foundation	18,155,796	20,242,329	Na	Na
Redcliffe Opportunities for Peoples Enhancement Inc (ROPE)	7,981	40,083	Na	Na
TOTAL GRANTS ALLOCATED TO INTELLECTUAL DISABILITY SERVICES	**18,163,777**	**20,282,412**	NA	NA
TOTAL GRANTS ALLOCATED TO ALL DISABILITIES	157,938,000	177,923,000	202.552,000	234,454,000

* This data is extracted from DSQ annual reports. ** This is an aggregate amount for ARAFMI as grants were allocated to two separate services ($123,972 & $349,750). ***Separate figures for these years are unavailable for amounts allocated to services. DSQ states that "this information is deemed commercial-in-confidence and, in order to avoid any advantage or disadvantage to non-government service providers is listed as an aggregate amount only".

It appears from the data that only a minority of funding allocated through the grants and subsidies pathway actually reaches services aimed at people with psychiatric disabilities. 1.1% and 1.6% of total grants and subsidies was allocated respectively in 2000/01 and 2001/02 to services for people with psychiatric disabilities (table 7). Data is not available for the years 2002/03 and 2003/04. This figure decreases further when the proportion allocated to disability services is examined in relation to total expenditure. In 2000/01 this figure reduces to 0.65% and in 2001/02 it reduces to 0.92%. Examined another way these figures represent 0.65 cents per dollar spent on people with psychiatric disabilities in 2000/01 and 0.92 cents per dollar in 2001/02.

In terms of funding given to services aimed at intellectual disabilities the figures are considerably higher than those for psychiatric disabilities. In 2000/2001, almost all of the $18.2 million given to intellectual disability services was allocated to The Endeavour Foundation. This figure rose to $20.3 million in 2001/02. The 2002 figures however, present a decrease in the amount of funding allocated to intellectual disabilities with 11.4% of all grant allocations going to intellectual disability services compared to 11.5% in 2000/01.

Table 7: Range and percent of amounts allocated to psychiatric and intellectual disability services through grants and subsidies

	2000/01	**2001/02**
Psychiatric Disabilities (Total)	$1,775,432	$2,805,542
Psychiatric Disabilities (Range)	$2,780 → $642,291	$18,880 → $1,674,820
PSYCHIATRIC DISABILITIES (% OF ALL GRANTS)	**1.1%**	**1.6%**
Intellectual Disabilities (Total)	$18,163,777	$20,282,412
Intellectual Disabilities (Range)	$2,906 → $4,999,612	$6,028 → $6,694,426
INTELLECTUAL DISABILITIES (% OF ALL GRANTS)	**11.5%**	**11.4%**

The amounts allocated to the two disability groups also varied considerably in range. Overall for the two year period, the smallest amount allocated to psychiatric disabilities was $2,780 (National Employment & Psychological Services Centre) and the largest amount was $1.6 million (allocated to the Richmond Fellowship).

In terms of services for people with intellectual disabilities, both the smallest amount of $2,906 and the largest amount of $6.7 million were allocated to the Endeavour Foundation. Both the larger sums of $5 million and $6.7 million were given to the Endeavour Foundation Clinic/Administration.

It is important to bear in mind here that up to approximately 600 services may have received funding during a year and, due to constraints of the project, it was not possible to contact each service directly to determine which client groups they serve. It is therefore possible that a limited number of services for both psychiatric and intellectual disabilities may not have been included in the table. In addition a number of the services omitted may be generic. Caution therefore needs to be exercised when interpreting this data as it is likely that the figures may be an under-representation of the actual amount spent.

DSQ annual reports also present data according to the different programs they fund. The funding for these programs comes directly from the grants and subsidies allocation. DSQ have reported that they do not record data on the disability groups of the clients that receive this funding, although in terms of the Adult Lifestyle Support Program, data is available for clients who completed a registration of need for this service in 1999 (see table 9 below).

Table 8 illustrates the proportions allocated to the different funding programs DSQ offer. The figures provided are cumulative over the years. With the exception of the specialist disability services general funding program, the largest proportion of funding is allocated to the Adult Lifestyle Support Program.

Table 8: Amount spent on different funding programs within DSQ

	2000/01* $'000	**2001/02**** $'000	**2002/2003** $'000	**2003/04** $'000
Specialist Disability Services General Funding Program	NA	77,836	81,681	97,081
Adult Lifestyle Support Program	NA	27,029	34,273	43,317
Institutional Reform Program	NA	19,310	22,568	22,185
Post School Services	NA	12,690	16,033	17,165
Service Development Program	NA	4,139	6,457	13,784
Family Support Program	NA	7,871	8,620	11,478
Respite	NA	3,569	4,245	9,526
Project 300	NA	8,073	7,880	8,707
Services to Adults Programs	NA	5,120	5,637	5,277
Attendant Care Program	NA	2,423	2,351	2,261
Emergent Support	NA	1,617	3,120	397
Industry Contributions	NA	195	217	101
Other	NA	8,051	9,470	3,175
Total Grants and Subsidies	**157,938**	**177,923**	**202,552**	**234,454**
Total Expenditure	**275,237**	**305,628**	**343,655**	**385,274**

* Individual funding program allocations not available for 2000/01. ** These are the figures reported in the 2002/2003 annual report. The 2001/2002 annual report presents slightly different figures for certain funding programs. In both reports the total grants expenditure figure is the same.

5.2: OTHER AVAILABLE INFORMATION FROM DISABILITY SERVICES QUEENSLAND

Given the lack of available information on expenditure according to disability groups, this section presents information on other publicly available information through DSQ that does not provide specific funding allocations. The two main indicators of resource usage by disability group are presented in two sections, namely:-

- Registrants of Need for DSQ Programs.
- Disability groups of people receiving CSTDA funded services.

5.2.1: Registrants of Need for DSQ Programs

This section contains information collected through the registration of need process for Adult Lifestyle Support Program funding during 1999. As at 22 October 1999, there were 4,229 individuals who had registered a need for Adult Lifestyle Support (table 9).

Registrants were able to nominate multiple disability groups therefore the total number exceeds the actual number who registered a need. In total 4,429 people registered a need for Adult Lifestyle Support. Of these, almost two-thirds (64.8%) indicated they had an intellectual disability. Sensory disabilities (including vision, hearing, deaf-blind and speech) were also frequent, accounting for 54.5% of all registrants, whilst 44.8% indicated a physical disability. Other disabilities included neurological (23.5%), psychiatric (19.3%), and cognitive (18.7%).

Table 9: Registrants for Adult Lifestyle Support Program in Queensland, 22 October 1999

DISABILITY GROUP	MALE	FEMALE	TOTAL
Intellectual[1]	1,760	1,321	3,081
Physical	1,008	885	1,893
Acquired brain injury[2]	801	650	1,451
Sensory			
(Deafblind)	*(22)*	*(17)*	*(39)*
(Vision)	*(371)*	*(281)*	*(652)*
(Hearing)	*(174)*	*(142)*	*(316)*
(Speech)	*(730)*	*(567)*	*(1,297)*
All sensory	1,297	1,007	2,304
Psychiatric	**449**	**368**	**817**
Other	20	14	34
Total	5,335	4,245	9,580

[1] Intellectual disability includes specific learning disabilities, autistic spectrum disorders and developmental delay. Figures are available for these separately. [2] Acquired Brain Injury includes neurological disabilities.

When multiple disability groups were taken into consideration, the smallest proportion of 8.8% stated they had a psychiatric disability as either a primary disability or another significant disability. The second smallest group was for acquired brain injury, which was specified as a primary or other significant disability by 15.1% of the nominated groups. 19.8% stated a physical disability was their primary or other significant disability followed by 24.1% of those with sensory disabilities. The most specified disability group was intellectual disabilities which accounted for 32% of all disability groups.

Although this data on the number of people applying for the ALSP was readily available, DSQ reports that it is not possible to identify the disability groups of successful applicants for the program. The reason given was that:-

> *"People may receive more than one ALSP package. If this is the case, their disability would be counted more than once. For example: a person receives an original package. A few years later they might get a 'top up' package due to inflationary pressures/cost of services/changing needs etc. This means the person now has 2 packages. They may then receive an emergency package due to an unforeseen incident. In this instance the person would now be receiving 3 packages. Because our database captures data based on packages rather than the person, our database would have three entries for a disability rather than just the*

> *one. In order to get the data, somebody would have to go through all funded clients, and ensure people are counted only once"* (personal communication with DSQ).

Data were also available for the total number of clients registering a need for programs at June 2001 and June 2002. Unlike the 1999 data, this data is not available according to disability groups. Data is only available for a limited number of programs.

As at 30 June 2001, there were a total of 5,960 people who had registered with DSQ for individual funding since the program began. At this time, the total number of applications for Adult Lifestyle Support was 5,404 with 789 individuals funded recurrently. (Data relating to the Family Support Program (FSP) and Post School Services (PSS) – formerly known as Moving Ahead Program and Options Plus Programs was not captured on the Registration Application and Funding database in 2000-01).

As at 30 June 2002, there were 9,472 people who had registered with DSQ for individual funding (The large increase in registrations was due to the inclusion of FSP and PSS on the database). Of these, 6,314 people had applied for an Adult Lifestyle Support Package, with nearly 1,000 of these people being successfully funded under the program. The total funding allocated at this time was $27.48m. In addition, 1741 people had applied for a Family Support Package with 396 individuals being successfully funded with a total funding allocation of $8.7m.

Whilst the 1999 data is valuable in providing an indication of how many people applied for funding under the Adult Lifestyle Support Program in 1999, the lack of information on how many of these were successful is a considerable oversight in terms of accountability. Similarly, the lack of specific data for recent years suggests that DSQ need to re-examine their data collection systems in order to identify the disability groups of those successfully funded.

5.2.2: Commonwealth/State-Territory Disability Agreement (CSTDA) Funded Services Administered through Disability Services Queensland

In the absence of data quantifying funding allocations to services aimed specifically at people with psychiatric disabilities, the best data available to give an indication of how many people with psychiatric disabilities receive services is through the CSTDA National Minimum Data Set. DSQ administers funds provided by both the State and the Commonwealth under the CSTDA and all funds distributed by the Department are subject to public money accountability requirements. Specialist disability services funded by the Department relating to the CSTDA are:

- Accommodation Support;
- Community Support;
- Community Access;
- Respite;
- Advocacy, Information and Print Disability; and
- Other support services (such as Research and Evaluation, and Training and Development).

A description of the CSTDA, the CSTDA Minimum Data Set and the service classifications that come under the CSTDA are attached as Appendix 3.

Service types

Data in this section is extracted from the 2002 Commonwealth/State-Territory Disability Agreement National Minimum Data Set which reports on disability service providers in Queensland that received funding under the CSTDA during 2001-2002. It details the types of services provided and the characteristics of people with a disability who received services on the snapshot day, 22 May 2002 (DSQ 2003b).

Table 10 presents the number of service outlets funded through the CSTDA in Queensland, categorised according to the type of service offered and whether they were Government or Non-Government organisations. A total of 1,123 outlets provided services through 300 organisations through CSTDA funding. Of these, 69% were non-government organisations. The total number of service users accessing these services on the snapshot day was 7,603, of which 77% were accessing non-government organisations.

The service types funded under the CSTDA were: 44.2% (n=496) Accommodation Support; 16.6% (n=186) Community Support; 19.1% (n=214) Community Access; 11.9% Respite (n=134) and 3.6% (n=40) Advocacy, Information and Print Disability.

Table 10: Services and service users funded by the Commonwealth/State-Territory Disability Agreement, 2001/2002

	SERVICE TYPE						
Characteristic	**Accomm. Support**	**Comm Support**	**Comm Access**	**Respite**	**Advocacy, information & print disability**	**Other**	**Total**
Number of service outlets for 2001-2002	496	186	214	134	40	53	1,123
Government	189	104	5	40	-	6	344
Non-Government	307	82	209	94	40	47	779
Number of service users receiving a service on 22 May 2002	3,350	1,449	2,281	523	-	-	7,603
Government	766	863	38	74	-	-	1,741
Non-Government	2,584	586	2,243	449	-	-	5,862
Estimated number of service users for 2001-2002	5,890	16,946	7,739	6,580	-	-	37,155
Government	960	5,543	115	722	-	-	7,340
Non-Government	4,930	11,403	7,624	5,858	-	-	29,815

Extracted from 2002 CSTDA NMDS DSQ report (DSQ 2003b)

Disability Groups

This section of the report presents information about the characteristics of the people with a disability who utilised these services on a snapshot day (DSQ 2003b).

The data presented in table 11 shows that of the 7,603 service users, the highest number of clients accessing CSTDA services had intellectual disabilities with 69% receiving a service on the snapshot day. The second highest group was for clients with physical disabilities (14.3%) with the third highest group perhaps surprisingly being those with Acquired Brain Injury (8.3%). A possible explanation for this could be the inclusion of neurological disorders under this grouping. Clients with psychiatric disabilities represented 6.7% of the population which although low, is not as under-represented as those clients with sensory disabilities who constituted 1.7% of the population.

It is important to note here that care should be taken when interpreting data as more than one service may be accessed by individual service users on the snapshot day. There were also a number of services where consumer information was not collected. These service types were: - advocacy, information, print disability and other. In addition, as the number relates to service utilisation on a set day only, it cannot be directly related to service users during the year. By dividing the funding amongst service users on a set day, the figure obtained will not reflect the true cost across all service users. Again it is important to bear in mind that this data represents a snapshot day and not all service users during a year.

Table 11: Service users' primary disability group by service type accessed, Queensland, 22 May 2002 (preliminary)

	SERVICE TYPE				
Primary disability group	**Accomm. support**	**Comm. support**	**Comm. Access**	**Respite**	**Total**
Intellectual[1]	2,309 (68.9)	882 (60.9)	1,753 (76.9)	301 (57.6)	5,245 (69)
Physical	541 (16.1)	247 (17)	175 (7.7)	128 (24.5)	1,091 (14.3)
Acquired brain injury [2]	197 (5.9)	207 (14.3)	162 (7.1)	68 (13)	634 (8.3)
Sensory	34 (1)	46 (3.2)	40 (1.8)	7 (1.4)	127 (1.7)
Deafblind	*4 (0.12)*	*4 (0.3)*	*8 (0.4)*	*1 (0.2)*	*17 (0.2)*
Vision	*9 (0.27)*	*30 (2.1)*	*18 (0.79)*	*2 (0.4)*	*59 (0.8)*
Hearing	*18 (0.54)*	*5 (0.3)*	*3 (0.13)*	*3 (0.6)*	*29 (0.4)*
Speech	*3 (0.09)*	*7 (0.5)*	*11 (0.5)*	*1 (0.2)*	*22 (0.3)*
Psychiatric	**269 (8)**	**67 (4.6)**	**151 (6.6)**	**19 (3.6)**	**506 (6.7)**
Total	**3,350 (44)**	**1,449**	**2,281**	**523**	**7,603**

[1] Intellectual disability includes specific learning disabilities; autism and developmental delay. Figures are available for these separately. [2] Acquired Brain Injury includes neurological disabilities. Percentages may be different than those presented in source document due to the combining of disorders.

6. DISCUSSION

The discussion section of this report will consider a number of issues including providing explanations as to why the original research questions were unanswerable. In the majority of cases the answer is simply that DSQ does not collect and record the data required to answer them. However where there are more thorough explanations these are presented below.

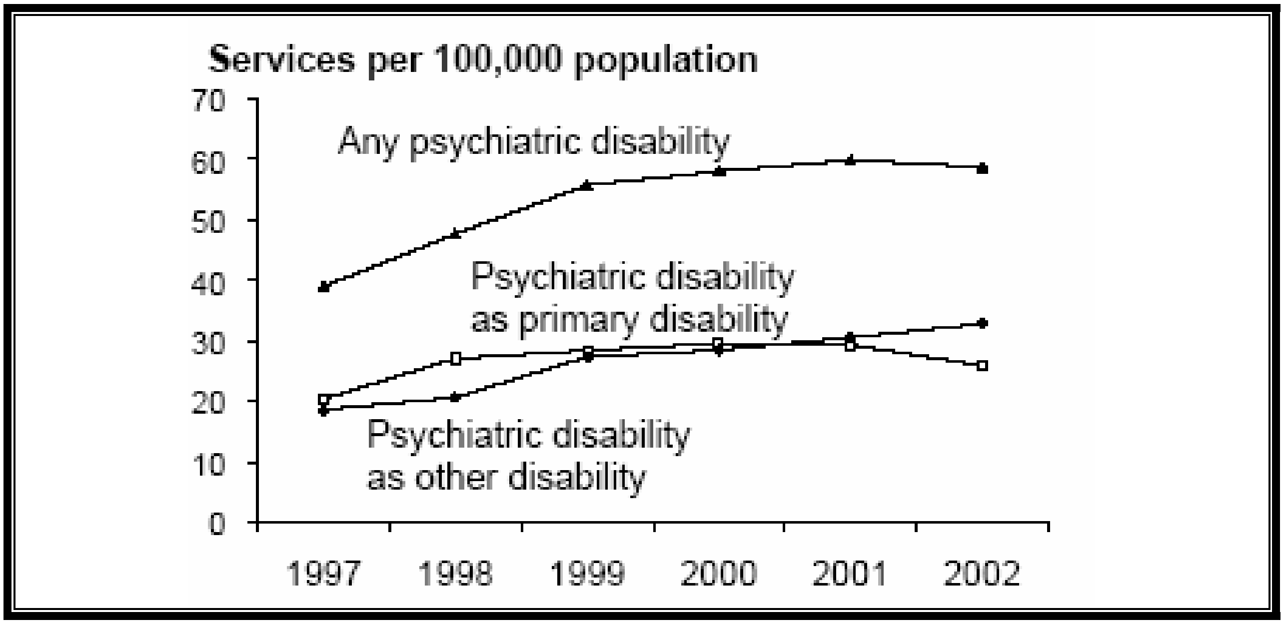
In addition, this section will also discuss the issues that have arisen in the area of accountability throughout the course of the study and will strive to identify where the gaps exist in terms of obtaining information on the proportion of people with psychiatric disabilities receiving funding through DSQ funded programs.

What is the incidence of disability across the DSQ sector?

It was not possible to obtain exact figures on how many clients from the different disability groups access services provided through DSQ. The only means of identifying the clients who utilise services is by examining data provided under the CSTDA Minimum Data Set which provides information on the number of clients accessing services on a snapshot day.

Although Figure 3 below shows that the number of clients with a psychiatric disability accessing CSTDA funded services has increased since 1997, the data presented in this report suggests that people with psychiatric disabilities accessing CSTDA services in Queensland are significantly under-represented. The rate for clients with a psychiatric disability that was not their primary disability has continued to increase compared with the recent decline for whom it was their primary disability. The figures presented below are representative of all CSTDA funded services Australia-wide, therefore include employment support services which are likely to be accessed by a higher number of clients with a psychiatric disability than other services provided (i.e. residential care, etc).

Figure 3: CSTDA-funded disability support services received by people with a psychiatric disability per 100,000 population, 1997 to 2002



In summary, it is not possible to ascertain exact figures for the numbers of people representative of the different disability groups receiving services through the DSQ sector.

How much funding is allocated to the different disability groups through DSQ?

It was not possible to identify exactly how much funding DSQ allocated to the different disability groups for any of the years examined. The only means whereby an estimate could be obtained was by examining the lists of services provided with grants and subsidies in DSQ annual reports. This however was problematic for a number of reasons. Firstly, the data presented was obtained by identifying services in the list that were known to be specifically for people with psychiatric disabilities. In a list of approximately 600 services however, it is likely that there are a number of generic services who serve all disability groups. A number of those services suspected to be generic were contacted directly to determine the number of clients with psychiatric disabilities they provide a service for and, in almost all cases, the response was either a minimal number or none at all. A number of services did not respond. A larger scale study could survey each of these services individually to determine their client groups although as of 2002/2003, DSQ ceased to present the lists of services in their annual reports stating that the information 'was deemed commercial-in-confidence'.

This explanation also applies to the question of 'what is the spread of resource allocation across the different psychiatric disabilities?'

Does the amount of funding allocated reflect that expected as indicated by Burden of Disease data?

In terms of the relationship between epidemiological estimates of disease burden and actual allocations of resources through DSQ, the lack of figures available has made this question difficult to answer. Table 12 however illustrates the relationship according to the available data.

Table 12: Expenditure and disability burden

	DALY	Dollars allocated 2001/02	% of total grant expenditure	No accessing CSTDA funded services
Psychiatric Disability	13.2%	$2,805,542	1.6%	506 (6.7%)
Intellectual Disability	1.4%	$20,282,412	11.4%	5,245 (69%)

The table illustrates that there appears to be no correlation between the burden of psychiatric disability and intellectual disability, and the amount of expenditure on these groups by DSQ. Indeed psychiatric disability, which is responsible for a significantly higher burden of disease than intellectual disability, received considerably less funding through grant allocations. Additionally, when examining figures on actual CSTDA funded service utilisation by primary disability group, there were considerably less people with a psychiatric disability than there were intellectual disabilities. Indeed people with intellectual disabilities constituted the largest proportion of service users.

When examining data on resource allocation or service allocation in comparison to burden of disease data it is important to do so with caution. There has been much debate around whether the determination of resource allocation priorities within health care should be based on burden of disease. It has been argued that burden of disease estimates do play a role in highlighting the overall burden associated with mental disorders and the same can be said for other disorder groups. Whilst the estimates may provide a useful tool for determining research and development priorities and be useful in measuring the effectiveness of outcomes at a macro-level, it is a commonly held view that issues of health service resource allocation, particularly short term allocation, should be informed primarily by considerations of efficiency and equity (Neil, Lewin & Carr, 2003).

Is there structural bias against cyclical disabilities?

Again, given the lack of information on funding allocation by disability groups it is impossible to determine whether or not there is any structural bias against cyclical disabilities such as those classified under psychiatric disabilities. The continual references to inequity of funding in DSQ publications does however suggest that DSQ are aware that psychiatric disabilities are not receiving an equal proportion of funding. That this is due to a bias against cyclical disabilities cannot however be presumed.

A possible explanation for the apparent lack of funding for psychiatric disabilities maybe to do with problems with definition. It is possible that the under-funding of clients with psychiatric disabilities may in part, be due to the difficulties in using this terminology within a disability framework. As discussed earlier, DSQ operates according to the definition of disability stated in The Disability Services Act (1992). A number of the funding models provided by DSQ have been tailored in keeping with this definition, for example the Adult Lifestyle Support Packages. Queensland Alliance have recently reported on this issue in a recent Newsletter (Queensland Alliance, September 2004) and express concern that in an area of service provision where recovery may well be possible, a direct conflict of interest may arise between the viability needs of services and the recovery needs of their clients. DSQ have acknowledged that these concerns have not gone unnoticed and have stated that, ‘unlike other disabilities where the permanence of the condition is apparent, a more complex judgement must be made in the case of a psychiatric disability’. Whilst this indicates an awareness of the problem, it does not however eliminate the impact that definition has on funding – namely that a client cannot obtain funding if they do not fit the criteria.

What does the Commonwealth get for its dollar?

The only means whereby this question is answerable is by examining the proportion of total expenditure by DSQ spent on grants and subsidies as specified within DSQ annual reports. Table 5 in the results section illustrates a steady increase in total expenditure through the financial years 2000 up to and including 2004. Consequently there has also been a steady increase in expenditure on grants and expenditure. In 2000/2001 a total of 57 cents per dollar was spent directly on funding programs through the grants and subsidies allocation. This has increased to 61 cents per dollar in 2004. When the amount of funding received specifically by psychiatric services is taken into consideration, the cents per dollar dramatically reduces to 0.65 cents for 2000/2001 and 0.92 cents for 2001/02. Data is not available for later than 2002.

Again, for the reasons outlined above, these figures should be interpreted with caution as it is likely they are under-representative of the actual proportion spent on psychiatric disabilities.

Accountability

Accountability is generally interpreted as the process whereby service providers make available information on how funds have been spent. Although there is a responsibility upon DSQ to explain and justify where funds have been allocated, the recipients of these monies should, as part of the funding agreement, report back on how these funds have been administered. It is likely that this process occurs as it is stipulated as a requirement of being granted funding, however it is beyond the remit of this study to contact all services who have received funding through DSQ to determine whether they are able to account for the clients who receive their services. In addition, given the lack of information on which services have received grants and subsidies from 2002 onwards, this would no longer be possible. This also raises the question of whether DSQ are meeting their accountability requirements in withholding this information.

A document published by DSQ entitled “Business Model Future Directions: the Way Forward” (DSQ 2000) indicates that the lack of accountability for public funds is an issue that DSQ is aware of and addressing. DSQ acknowledges the need to ensure funding and services are distributed in a more coordinated and consistent manner, therefore under a new business model, it is in the process of separating the roles of developing policy, purchasing services and providing services. Although this may not initially have a bearing on the actual amounts of funding allocated to the different disability groups, it should provide us with the data necessary to determine the extent to which inequitability of funding distribution is an issue. It is worthy of note however, that the timeline for implementation of these improved systems is from July 2004 onwards and, at the time of writing, there still appears to be limited accountability in terms of the amounts allocated to the different disability groups.

7. CONCLUSION

In conclusion, despite efforts to identify the funding allocations through DSQ for people with psychiatric disabilities, it has not been possible to answer the original research question this study was designed for. Indeed, as is often the case with research, during the course of the study the question has evolved from, ‘how much funding is allocated to psychiatric disabilities through DSQ?’ to ‘what is the available information on how much funding DSQ allocate to psychiatric disabilities?’ In answering this question, the study has highlighted exactly what information is available and where the gaps are in identifying accountability of funds. Although we know that a little over half of total expenditure makes its way directly through to disability services in the form of grants and subsidies, it is of concern that it is not possible to identify how much of this goes to services for people with psychiatric disabilities and their carers. Given the emphasis within national and state mental health policy documents on accountability of funds, it appears that DSQ is not yet meeting these standards.

Table 13: Summary of findings

	DALY	% of total grant expenditure (01/02)	% accessing CSTDA funded services (01/02)
Psychiatric Disability	13.2%	1.6%	6.7%
Intellectual Disability	1.4%	11.4%	69%

In terms of examining resource allocation within DSQ according to burden of disease estimates, it appears that there appears to be a negative correlation between the level of burden of the two disability groups and the amount of expenditure. Although psychiatric disability represents an estimated 13% of the disease burden it only received 1.6% of grant expenditure in 2001/02. Conversely, intellectual disability represents an estimated 1.4% of the disease burden yet received 11.4% of grant expenditure (it is important to remember here that these burden of disease figures are for Victoria, which although 28% larger than Queensland, is likely to have a similar representation of burden estimates). Although this suggests that resource allocation decisions may be made based on historical tradition rather than need, the finding that almost two-thirds of people with intellectual disabilities applied for Adult Lifestyle Support funding compared to only 19.3% with psychiatric disabilities suggests that people with psychiatric disabilities and their families perhaps need to be made aware that DSQ is a source of support and funding for them.

REFERENCES

ABS (Australian Bureau of Statistics) 1999. Disability, Ageing and Carers Australia: Summary of Findings. Canberra: cat. no. 4430.0.

ABS (Australian Bureau of Statistics) 2003. Australian Demographic Statistics. Canberra: cat no. 3101.0.

ABS (Australian Bureau of Statistics) 2004. Disability, Ageing and Carers Australia: Summary of Findings. Canberra: cat no. 4430.0.

AIHW, 2000. National Community Services Data Dictionary. Version 2. Cat. No. HWI27. Canberra: AIHW. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/9995

AIHW July 2002. *Unmet need for disability services. Effectiveness of funding and remaining shortfalls.* Canberra: AIHW cat. no. DIS 26. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/7741

AIHW (2003a). Disability Prevalence and Trends. Canberra: AIHW cat. no. DIS34. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/9671

AIHW July 2003b. Commonwealth-State/Territory Disability Agreement National Minimum Data Set Collection. Data Guide: Data items and definitions 2003-04. Canberra: AIHW. Available online at:- http://www.disability.qld.gov.au/cstda/documentation.cfm

AIHW September 2003c. Health Expenditure Australia: 2001-2002. Canberra: AIHW. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/9307

AIHW 2004a. Health Expenditure Australia: 2002-2003. Canberra: AIHW. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/9307

AIHW 2004b. Health system expenditure on disease and injury in Australia, 2000-01. Canberra: AIHW. Available online at:- http://www.aihw.gov.au/publications/index.cfm/subject/9

AIHW 2004c. CSTDA NMDS tables prepared for the CSTDA Annual Public Report 2002–03. AIHW cat. no. DIS 36. Canberra: AIHW (Disability Series). Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/10093

DSQ 2000. Business plan 2000–2002. Brisbane: DSQ.

DSQ 2001. Annual Report 2000-2001. Brisbane DSQ. Available online at:- http://www.disability.qld.gov.au/publications/index.cfm

DSQ 2002. Annual Report 2001-2002. Brisbane DSQ. Available online at:- http://www.disability.qld.gov.au/publications/index.cfm

DSQ 2003a. Annual Report 2002-2003. Brisbane DSQ. Available online at:- http://www.disability.qld.gov.au/publications/index.cfm

DSQ 2003b. Commonwealth/State-Territory Disability Agreement National Minimum Data Set. Available online at:- http://www.disability.qld.gov.au/cstda/documentation.cfm

DSQ 2004. Annual Report 2003-2004. Brisbane DSQ. Available online at:- http://www.disability.qld.gov.au/publications/index.cfm

Mathers, C. Vos, T. Stevenson, C. (1999). The burden of disease and injury in Australia. Australian Institute of Health and Welfare, Canberra. Available online at:- http://www.aihw.gov.au/publications/index.cfm/title/5181

Mathers, C. Vos, T. Stevenson, C.E. & Begg, S.J. (2000). The Australian burden of disease study: measuring the loss of health form diseases, injuries and risk factors. Medical Journal of Australia 172: 592-596.

Murray, C.J. & Lopez, A.D. (1996). The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Global Burden of Disease and Injury Series, Volume I. Harvard School of Public Health, Cambridge, Mass.

National Disability Administrators (NDA) 2004. Commonwealth State/Territory Disability Agreement Annual Public Report 2002-03 (prepared by Australian Healthcare Associates). Canberra: Australian Government Department of Family and Community Services.

Neil AL, Lewin TJ, Carr VJ. Allocation of resources and psychosis. *Australian and New Zealand Journal of Psychiatry* 2003; 37: 15-23.

Queensland Alliance September 2004. Newsletter of the Queensland Alliance.

Steering Committee for the Review of Commonwealth/State Service Provision (SCRSCCP) 2001, *Report on Government Service Provision,* AusInfo, Canberra.

United Nations (UN) 1994. *Standard rules for the equalization of opportunities for persons with disabilities*. New York: United Nations.

Vos, T & Begg, S. (1999). The Victorian Burden of Disease Study: Mortality. Public Health and Development Division, Department of Human Services, Melbourne. Available online at:- http://www.health.vic.gov.au/healthstatus/bod/mortality.htm

Vos, T & Begg, S. (2000). The Victorian Burden of Disease Study: Morbidity. Public Health and Development Division, Department of Human Services, Melbourne. Available online at:- http://www.health.vic.gov.au/healthstatus/bod/mortality.htm

Vos, T, Begg, S. Y. Chen & Magnus A. (2001). Socio-economic differentials in life expectancy and years of life lost in Victoria, 1992–1996. New South Wales Public Health Bulletin 12:126–130

World Health Organisation (1993). The ICD-10 Classification of Mental and Behavioural Disorders – Diagnostic Criteria for Research. WHO, Geneva.

World Health Organisation (2001) The International Classification of Functioning, Disability and Health (ICF). WHO, Geneva.

APPENDICES

APPENDIX ONE
PROGRAMS FUNDED UNDER DSQ

PROGRAM	AIM	ELIGIBILITY CRITERIA
Adult Lifestyle Support	To enable the provision of support in flexible ways to meet the need and goals of people with disabilities. Assists adults to maintain the living arrangements of their choice and participate in their community. Examples of how funds provided through Adult Lifestyle Support can be used by adults with a disability are:- Support at home and managing the household; taking part in recreation and leisure activities; strengthening personal and family relationships and networks and; purchasing necessary aids and equipment. A DSQ Support Facilitator works with individuals and their families to ensure they have the opportunity to plan for their future, investigate opportunities within their community and secure appropriate funded assistance.	Adults with a disability between the ages of 18 and 65 years as defined under the Disability Services Act 1992.
Friendship Program	To encourage friendships between people with a disability and other community members.	There appears to be no eligibility criteria for this program
Post School Program *Constitutes Moving Ahead and Options Plus*	To assist young people to make the transition from school to adult life and support them to develop skills that enable them to participate in the life of their local community and take on adult roles within their families. It also supports families to plan for the young person's future and identify informal and formal networks needed to help them achieve their goals.	Be 18 by 31 January in the year that they enter the Program; be exiting or have exited special school or special education programs and/or services; have a level of disability that results in high and complex support needs; be eligible for assistance under the Queensland Disability Services Act 1992 and; not have access to tertiary education, vocational training or employment options.
Resident Support Program	To improve the quality of life for people with a disability living in private residential services such as hostels or boarding houses.	Live in a private residential service such as a hostel or boarding house and; are eligible to receive Home and Community Care (HACC) or disability services.
Project 300	The aim of Project 300 is to: - improve the quality of life for 300 people returning to their community; progress the reform of the three psychiatric hospitals in Queensland by promoting community treatment options for people with mental illness and; develop infrastructures in the community for the provision of clinical and disability support services and housing solutions for people with	To be eligible for this program the person must:- choose to leave the hospital and agree to participate in the project; be assessed as being able to leave hospital as they no longer require a 24 hour extended treatment or rehabilitation program; have ongoing clinical needs that can be met by a community mental health team including conditions of leave under the mental health Act; have disability support needs that can be met within the parameters of the project and; have housing need that can be met within the

	psychiatric disability.	parameters stipulated in the Memorandum of Understanding between Queensland health and the Department of Public Works and Housing.
Family Support	To strengthen the capacity of families to care for their family member with a disability; to assist families to build formal and informal supports; to assist families to increase their knowledge, skills and confidence; to support the inclusion of family members with a disability in community life; to reduce family crises.	**Eligibility criteria for Family Support Program for Children is as follows:** the family member(s) have a disability as defined under the *Queensland Disability Services Act 1992** ; the family member(s) with a disability are under 18 years of age; the family member(s) with a disability must be living with their birth or adoptive family. Priority will be given to families who have high and complex support needs which are not being met within the existing service system. **Eligibility criteria for the Family Support Program for Adults is as follows:** the person has a disability as defined under the *Queensland Disability Services Act;* the person/s with a disability is between 18 and 65 years of age; the person/s with a disability is seeking supports to remain living in the family home. **Priority in 2004-2005 will be given to:** families who currently have little or no support; families with more than one person with a disability living within the family home; and families where adult members with a disability are living with ageing carers. * *The Queensland Disability Services Act 1992* defines a disability as being attributable to an intellectual, cognitive, neurological, sensory, psychiatric or physical impairment, or a combination of these impairments. The child will need support due to a substantive reduction of their capacity for communication, social interaction, learning or mobility. The disability is likely to be permanent and may be of a chronic episodic nature. Eligibility does not automatically mean a family will receive support. The number of families able to be supported through the Family Support Program is dependent upon funding availability.

APPENDIX TWO
KEY MENTAL HEALTH POLICIES

An increasing awareness of the high prevalence rates and costs of mental illness has led to a number of significant changes in government policy at both national and local levels, relating to mental health services. Similar to the mental health movement in other parts of the world, a fundamental part of these changes has been the reorientation of mental health services away from predominantly institutional settings into community settings. In response to this shift, a number of policy documents have evolved, of which the key ones of relevance to this study are presented below. These are:- The National Mental health Strategy; The Ten Year Mental Health Strategy for Queensland and; The Strategic Plan for Psychiatric Disability Services and Support.

THE NATIONAL MENTAL HEALTH STRATEGY (NMHS)

In response to the shift towards community based care for people with psychiatric disabilities, a national policy and planning framework has evolved leading to the adoption of the first National Mental Health Policy and National Mental Health Plan in 1992. The aim of the policy and planning framework is to maximise outcomes for both consumers and carers and has been continually revised and updated with the current National Mental Health Plan spanning 2003 – 2008. The aims of this current strategy are:-

- to promote the mental health of the Australian community;
- to, where possible, prevent the development of mental disorder;
- to reduce the impact of mental disorder on individuals, families and the community;
- to assure the rights of people with mental disorder.

Within the Plan, four priority themes have been identified as significant. These are:-

- Promoting mental health and preventing mental health problems and mental illness;
- Increasing service responsiveness;
- Strengthening quality;
- Fostering research, innovation and sustainability.

Within these priority areas are a number of outcomes and key directions, the majority of which are beyond the scope of this report. Those however, that refer to funding issues, and are therefore pertinent to this study, include outcomes 30 and 31 identified under the priority theme of ‘Strengthening Quality’. -

- **Outcome 30:** Reform of public sector funding models to better reflect need:-
    - ***Key direction 30.1:*** Continue the development of casemix classifications through the Australian Mental Health Outcomes and Classification Network;
    - ***Key direction 30.2***: Develop funding formulae based on population needs, weighted for Aboriginal and Torres Strait Islander populations, rural and remote locations and other relevant variables;
    - ***Key direction 30.3***: Develop funding formulae taking into account provision of programs which will lessen the adverse impacts of mental health problems and mental illness.

- **Outcome 31:** Improved ability of the private sector to meet need through funding models and related reform:-
    - ➢ ***Key direction 31.1:*** Explore ways in which the private health sector can deliver a wider range of services;
    - ➢ *Key direction 31.2:* Explore the potential for private health funds to offer a wider range of service products;
    - ➢ ***Key direction 31.3:*** Explore models of funding that support involvement of allied health professionals in private mental health service provision;
    - ➢ ***Key direction 31.4:*** Review impediments and other barriers to innovative service delivery that is appropriate and effective.

TEN YEAR MENTAL HEALTH STRATEGY FOR QUEENSLAND (QUEENSLAND HEALTH)

The Queensland Government has begun to address the historic problems that exist within Queensland's mental health system by developing a Ten Year Mental Health Strategy for the state. As the strategy advances the directions identified in the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994), it is the only strategic document for mental health in Queensland presented in this report. For those interested in reading more about these, the references are supplied in the bibliography. Queensland also operates under the legislation of the Mental Health Act 2000 which is also not included here as it deals with the involuntary assessment and treatment, and protection of people with mental illness rather than service provision and development.

The Ten Year Mental Health Strategy outlines the key directions and framework for the implementation of reforms which aim to make quality mental health care more accessible and less stigmatised. The key directions for these reforms include enhancement of community mental health services, the reorganisation of the service delivery system (especially psychiatric hospitals), the review of mental health legislation, and the improvement of intersectoral links particularly with housing and disability support agencies. There are also a number of immediate priorities that have been established for Queensland. These are:-

1. Establishing mainstreamed integrated services to promote continuity of care across service components;
2. Providing locally available care through the more equitable distribution of mental health resources;
3. Involving consumers and carers in the planning, operation and evaluation of services;
4. Prioritising services to those most in need and ensuring services respond appropriately to the needs of priority groups;
5. Progressing the reform of psychiatric hospitals;
6. Establishing and maintaining links with the primary health care services;
7. Implementing quality management systems, including the National Services Standards;
8. Improving intersectoral links, particularly with housing and disability support agencies.

Most pertinent to this report is number two of these priorities: *'providing locally available care through the more equitable distribution of mental health resources'*. Although this is not directly concerned with identifying whether adequate funding is being allocated to mental health, it is of relevance to the additional objective of identifying whether funding is equitably distributed amongst the different psychiatric disability groups.

STRATEGIC PLAN FOR PSYCHIATRIC DISABILITY SERVICES AND SUPPORT 2000-2005 (DISABILITY SERVICES QUEENSLAND)

Perhaps most pertinent to this report is the policy framework utilised by Disability Services Queensland, given that they are the focus of the study. Disability Services Queensland is the key organisation within the State that controls the distribution of funding to services for people with disabilities primarily through the Commonwealth State/ Territory Disability Agreement. At present DSQ operates according to the Strategic Framework and Plan for Disability Services.

The Strategic Plan for Psychiatric Disability Services and Support 2000-2005 addresses Strategic Direction two of the Framework and the Strategic Plan by aiming to improve access to services and support for people with a psychiatric disability and their families, across both the government and the community. It contains seven strategic directions which are regarded as the key priority areas to be addressed by DSQ in delivering services for people with psychiatric services.

The first of these aims to strengthen individuals, families and communities by focusing on enhancing the lives of people with a psychiatric disability, their families and communities by supporting natural networks and relationships.

The second strategic direction is particularly pertinent to this report as it focuses on improving access for people with a psychiatric disability to services provided by government and NGO service providers. One of the outcomes of this strategic direction is that it aims to ensure that people with psychiatric disabilities have ‘equitable access to Disability Services Queensland funding initiatives”.

The third strategic direction focuses on the developing and reforming of services for people with psychiatric disabilities and their families whereas the fourth focuses on ensuring the provision of high quality services for people with a psychiatric disability and their families.

The fifth direction can be seen as being closely aligned with the second as it aims to increase the numbers of people with a psychiatric disability in Queensland receiving the services and support they require. DSQ aims to achieve this priority by implementing a number of strategies. These include ensuring that the DSQ Business Plan addresses the unmet need of people with psychiatric disabilities and their families; identifying future priorities for funding at a local level to ensure that those with a psychiatric disability and their families receive services and supports according to their needs; provide advice to the Minister in regard to the Commonwealth State Disability Agreement negotiations to achieve increased service provision for people with a psychiatric disability; and of particular relevance to this report, DSQ will develop and implement specific access and equity initiatives for people with a psychiatric disability and their families to overcome historical funding inequities. The sixth strategic direction within this policy document focuses on the development of respectful working relationships with people with a psychiatric disability, their families, and government, community and service sectors. The seventh and final strategic direction focuses on ensuring the provision of appropriate safeguards and advocacy mechanisms for people with a psychiatric disability.

The emphasis within DSQ documentation on improving service provision for people with disabilities and their families, suggests that there is an awareness of the historical inequity of funding distribution to this client group. The aim of this study is to determine the extent to which this is true.

APPENDIX THREE:

COMMONWEALTH / STATE TERRITORY DISABILITY AGREEMENT (CSTDA)

The Commonwealth State Territory Disability Agreement (CSTDA) provides the national framework for the delivery, funding and development of specialist disability services for people with disabilities. Under the three agreements signed so far (the first in 1991) all parties are responsible for funding specialist services for people with disabilities:

- The Australian Government has responsibility for the planning, policy setting and management of specialised employment assistance;

- State and territory governments have similar responsibilities for accommodation support, community support, community access and respite; and

- Support for advocacy and print disability is a shared responsibility.

Through the Agreement, the Australian, State and Territory Governments strive to enhance the quality of life experienced by people with disabilities through assisting them to live as valued and participating members of the community.

The Multilateral Agreement

Under the current agreement, all Ministers with responsibility for disability services agreed to pursue five strategic policy priorities through the Agreement. These are to:

- strengthen access to mainstream and generic services for people with disabilities;
- strengthen across government linkages;
- strengthen individuals and families;
- improve long-term strategies to respond to, and manage demand for, specialist disability Services and;
- improve accountability, performance reporting and quality of specialist disability services.

All governments, and especially the Australian Government, placed a particular emphasis on the fifth priority – ‘improve accountability’. The aim of this is to ensure that information that must be reported to the public is reported in ways that are understandable and transparent.

Bilateral Agreements

The Australian Government has signed individual agreements with each state and territory under the umbrella of the Multilateral Agreement. These agreements commit the parties to work together to address key issues for people with a disability including:

- flexibility between service provision by different levels of government;

- the situation of young people living in Australian Government funded residential aged care facilities; and

- issues facing people with a disability who are ageing.

Each state or territory within Australia has an organisation that is responsible for the distribution of CSTDA funding and the collection of data from the CSTDA MDS (see below).

In Queensland, Disability Services Queensland (DSQ) is the CSTDA funding agency although that is not responsible for providing employment assistance under the CSTDA. This is provided under the auspice of CRS Australia. Services provided under the Commonwealth–State Disability Agreement and administered by the State and Territory governments include:-

- Accommodation support services which provide people with a disability with accommodation (group homes, hostels and large institutions) and support to maintain accommodation (attendant care and in-home support).
- Community access services to help people with a disability to develop or maintain the personal skills and self confidence necessary to enhance their independence and self reliance in the community.
- Community support helps people with a disability to integrate and participate in the community. It includes information/referral services, recreation and holiday programs, case management, brokerage, counselling, early intervention therapy, print disability services, mutual support/self help groups and other therapy services.
- Respite care services to relieve or support (for limited periods) people with a disability living in the community and their families and carers.

As previously mentioned, there are a number of services provided under the CSTDA that are administered by the Commonwealth Government. These include:-

- Open employment services which provide employment assistance to people with a disability in obtaining and/or retaining paid employment in another organisation.
- Supported employment services which support or employ people with a disability within the same organisation.
- Open and supported employment services which provide both open and supported employment assistance.

Total government expenditure on the disability support services specified above in 2001/2002 was $2.75 billion. Of this expenditure, accommodation support services accounted for over half ($1,412 million) with around one-tenth of funding being spent on both community access services ($304 million) and community support services ($299 million). Expenditure on respite services accounted for 6% of funds ($156 million) whilst employment services also received around one-tenth ($261 million). A further $221 million was spent on administration (AIHW 2003c).

The areas in which the Commonwealth and States/Territories share administration include advocacy services, which enable people with a disability to increase their control over their lives by representing their interests and views in the community and research and development. The CSTDA does not apply to the provision of disability services and activities provided under the *Veteran's Entitlements Act 1986* or services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive other services under the CSDA.

In practice, CSTDA funded services are generally directed at people under the age of 65 however there are no criteria that state that services are not available to people over this age. The latest CSTDA does however stipulate that any disability must manifest before the age of 65 years.

Unmet Need Funding

During negotiation of the third Agreement, the Australian Government offered $125 million in growth funding to the states and territories to assist them to meet unmet need in state and territory services. This is in addition to the unmet need funding provided to states and territories under the second agreement which has been continued to the third agreement and amounts to nearly $551 million over the five years of this Agreement.

In relation to disability employment services, the Australian Government has already taken steps to address the identified unmet demand by allocating an extra $750 million to address unmet need in employment services with the increased employment funding announced in the last two Federal Budgets.

The Australian Institute of Health and Welfare has completed a major study into the unmet need issue (AIHW 2002) and found that despite the additional funding being added to disability services via the CSTDA, there were still over 12,000 people in 2001 in need of accommodation and respite services, and over 5000 people needing employment support. This suggests there is still an inadequacy in funding provision through this pathway.

Commonwealth/State Territory Disability Agreement Minimum Data Set

Information on disability support services provided or funded under the CSDA is collected in the framework of the CSTDA Minimum Data Set (MDS), developed in 1993 and jointly maintained by the AIHW and the Commonwealth, states and territories, under the auspices of the National Disability Administrators.

The CSTDA NMDS is a set of nationally significant data items that are collected in all Australian jurisdictions that have an agreed method of collection and transmission. As part of the funding agreement, consumers and service providers have to provide data on a 'snapshot' day to funding departments in each jurisdiction which is then collated nationally.

The purpose of the CSTDA NMDS is to facilitate the annual collection of nationally comparable data about CSTDA funded services, and to obtain reliable, consistent data with minimal loads on the disability services field. Until recently the CSTDA MDS has collected data on 'snapshot' days which have provided funding bodies, funded agencies, service users and other stakeholders with information about the services being delivered, and those utilising them, at a set point in time (AIHW, July 2003b).

In recognition of the changing information need in the disability services field the CSTDA MDS collection has recently been redeveloped. The most significant change in the redeveloped collection is that funded agencies are now required to provide information about all service users during the year rather than on a single snapshot day. This means that funded agencies are obligated to collect and store data on an ongoing basis, for transmission to their funding department at specified points in time (quarterly in some jurisdictions and annually in others).This redeveloped collection was implemented in 2002 with the first data collection period ending on the 30th June 2003. At the time of writing this data was not yet available.

Funding allocations through CSTDA

Funding allocated through this pathway is administered by Disability Services Queensland (see above). The financial commitments under the CSTDA from 2002 until 2007 are presented in tables 4 and 5 below.

The Australian Government has stated that it will make a total of $543,124,832 available during this period to Queensland to enable them meet their responsibilities under the Agreement. This is 19.2% of the total funds committed Australia wide.

Commonwealth funding commitment

	2002-03	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**TOTAL**
NSW	176,167,536	181,727,222	187,409,221	193,028,814	198,766,419	937,099,212
VIC	120,200,973	124,074,395	128,033,031	131,950,725	135,950,690	640,209,813
QLD	***102,221,729***	***105,386,107***	***108,620,101***	***111,816,623***	***115,080,272***	***543,124,832***
SA	59,567,535	61,282,520	63,035,236	64,763,476	66,528,009	315,176,775
WA	42,442,219	43,866,448	45,322,010	46,764,272	48,236,822	226,631,773
TAS	18,543,358	19,082,812	19,634,134	20,177,950	20,733,187	98,171,441
NT	5,513,748	5,695,550	5,881,352	6,065,360	6,253,233	29,409,243
ACT	7,376,246	7,623,024	7,875,230	8,125,110	8,380,238	39,379,849
TOTAL	**532,033,344**	**548,738,078**	**565,810,315**	**582,692,331**	**599,928,871**	**2,829,202,938**

This includes unmet need funding separately identified under CSTDA 2 which is built into base.

The commitments made by the states and territories are indicated below with Queensland making a commitment of $1,447.510 over the five year period.

State and Territory funding commitments

	2002-03	2003-04	2004-05	2005-06	2006-07	TOTAL
NSW	702.128	694.700	710.400	736.600	812.100	3,655.928
VIC	719.372	748.200	757.374	774.036	791.065	3,790.047
QLD	***234.185***	***276.125***	***293.900***	***313.000***	***330.300***	***1,447.510***
SA	124.422	130.401	137.105	144.152	151.56	687.640
WA	195.461	207.253	218.897	231.169	243.764	1,096.544
TAS	58.300	56.642	67.808	70.046	72.357	334.153
NT	13.767	14.524	15.323	16.137	16.863	76.614
ACT	38.500	36.858	37.813	38.599	39.692	191.462
TOTAL	**2,086.135**	**2,173.703**	**2,238.620**	**2,323.739**	**2,457.701**	**11,279.898**

This data excludes funding provided for research and development.

CSTDA FUNDED PROGRAM DEFINITIONS	
Service Type	**Remarks / Definition**
Accommodation Support: Services that provide accommodation to people with a disability and services that provide support needed to enable a person with a disability to remain in their existing accommodation or to move to more suitable or appropriate accommodation.	
Large Residential / Institution	Large residential / institutions usually located on large parcels of land and provide 24 hour residential support in a collective setting of more than 20 beds.
Small Residential / Institution	Small residential / institutions usually located on large parcels of land and provide 24 hour residential support in a collection or cluster setting of 7 to 20 beds.
Hostels	Hostels provide residential support in a collective setting of usually less than 20 beds, and may or may not provide 24 hour residential support. Generally situated in an institutional setting and also have respite beds included on the premises.
Group Homes	Group homes have combined accommodation and community based support to people in a residential setting. Usually no more than 6 service users are located in any one house, although this can vary. Group homes are generally serviced 24 hours a day.
Attendant Care / Personal Care	An attendant care program provides for an attendant(s) to assist people with daily activities that they are unable to complete for themselves because of their physical, intellectual or any other disability.
In-Home Accommodation Support	Support involves in-home living support and/or development programming services for people with a disability, supplied independently of accommodation.
Alternative Family Placement	Placements of a person with a disability with an alternative family who will provide care and support. Includes shared-care arrangements and host family placements.
Other Accommodation Support	Other support services that provide short term, one-off instances of accommodation such as: • Accommodation provided so that Individuals or families can access specialist services, or further education; • Emergency or crisis accommodation support - eg. following the death of a parent or carer; and

	- Houses or flats for holiday accommodation.
Community Support: Services that provide the support needed for a person with a disability to live in a non-institutional setting.	
Therapy Services for Individuals	Specialised, therapeutic care services including occupational therapy, physiotherapy, and speech pathology. These services are intended to improve, maintain and slow deterioration of a person's functional performance and / or assist in the assessment and recommendation of equipment to enable people to perform as independently as possible in their environment.
Early Childhood Intervention	Support service to assist children up to (but not including) six years of age with a developmental delay to integrate with peers into pre-schools and the wider community.
Behaviour / Specialist Intervention	These include the range of services relating to the management of challenging behaviours, including dangerous antisocial behaviour. Services include intensive intervention support, training and education in behaviour management, and consultancy services for other professionals.
Counselling	Services that provide counselling to individuals, families and groups.
Regional Resource and Support Teams	Regional resource and support teams are generally inter-disciplinary teams that provide a combination of services that cannot be broken down into parts. Regional resource and support teams may also assist service users to access mainstream services and/or support mainstream funded agencies.
Case Management, Local Coordination and Development	This is a broad service type category, including elements of individual or family focussed case management and brokerage as well as coordination and development activity within a specified geographical area. Services assist people to maximise their independence and participation in the community through working with the individual, family and / or carers in care planning and / or facilitating access to appropriate services.
Other Community Support	
Community Access: Services designed to provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence. People who do not attend school, or who are not employed full-time mainly use these services.	
Learning and Life Skills Development	These programs provide on-going day-to- day support for service users to gain greater access and participate in community-based

	activities. Programs may focus on continuing education to develop skills and independence in a variety of life areas (eg. self-help, social skills and literacy and numeracy) or enjoyment, leisure and social interaction.
Recreation / Holiday Programs	Recreation services and holiday programs aim to facilitate the integration and participation of people with disabilities in recreation and leisure activities available in the general community.
Other Community Access	
Respite: Respite services provide a short term and time limited break for families and other voluntary care givers of people with disabilities, to assist in supporting and maintaining the primary care giving relationship, while providing a positive experience for the person with a disability.	
Own Home Respite	Respite care provided in the individual's own home location.
Centre- Based Respite / Respite Homes	Respite care provided in the community setting similar to a 'group home' structure and respite care provided in other centre-based settings.
Host Family Respite / Peer Support Respite	Host family respite provides a network of 'host families' matched to the age, interests and background of the individual and their carer.
Flexible Combination Respite	Respite services that offer any combination of my own home, centre-based, host family, peer support respite and respite homes.
Other Respite	Includes: • Crisis respite; and • Holidays for the person with a disability where the primary intention of the support is to provide respite support.
Employment	
Open Employment	Services that provide employment assistance to people with a disability in obtaining and / or retaining paid employment in another organisation.
Supported Employment	Services that support or employ people within the same organisation.
Open and Supported Employment	Services that provide both open and supported employment

	assistance.
Advocacy, Information and Print Disability	
Advocacy	Services designed to enable people with a disability to increase the control they have over their lives through the representation of their interests and views in the community.
Information / Referral	Information services provide accessible information to people with disabilities, their carers, families and related professionals. This service type provides specific information about disability specific and generic services, equipment and promotes the development of community awareness.
Combined Information / Advocacy	Services that offer both information and advocacy services to individuals where these two components cannot reasonably be separated.
Mutual Support / Self Help Groups	Focus or special interest groups to provide support and assistance for people with disabilities, their families and carers. These groups promote self-advocacy through the provision of information, support and assistance.
Print Disability	Includes alternative formats of communication for people who by reason of their disabilities are unable to access information provided in a print medium.
Other Support	
Research and Evaluation	Research and evaluation with respect to the provision and services funded under the CSTDA for people with disabilities. This includes the investigation of the need for new services or enhancement of existing services and the measurement of outcomes for people with disabilities using these services.
Training and Development	Training and development services may be funded for example, to train disability funded agencies to deliver higher quality or, more appropriate services to people with disabilities or develop materials or methods that promote service improvements.
Peak Bodies	Peak bodies are generally funded to support non-government disability funded agencies in achieving positive outcomes for people with disabilities.
Other	Services that are completely outside any of the defined service types detailed above.

Source: CSTDA National Minimum Data Set – Data Guide: Data Items and Definitions 2002-03