Flexible Funding as an Underpinning to Community Resiliency: Early Reflections on the Introduction of Local Area Co-ordination in Queensland

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THE POLICY CONTEXT — FLEXIBLE FUNDING AND THE “CONSUMER”

The past decade and a half of human service policy initiatives and national health strategies in Australia have changed the nature of service delivery and practice. Most particularly, the focus has turned from an institutional model of care to a “self help” approach, based on a family and community support system with the person positioned as “consumer”. In no aspect of human service delivery is this shift more evident than in policies for services for people with disabilities.

This change was consolidated in the decade from 1981 — the year designated by the United Nations as the International Year of Disabled Persons (IYDP) — until 1992 when the Commonwealth and State governments in Australia signed the Commonwealth/State Disability Service Agreements (CSDA), thus allowing the transition of services and monies from Federal to State governments. The Disability Services Act 1986, operationalised the strategies outlined in the Handicapped Persons Review process conducted during 1983–84. As a broad direction, the Disability Services Act 1986 encouraged the development and funding of alternative services for “consumers” and the legislation particularly realigned the relationship between the Commonwealth, State and non-government sectors in the disability field.

In her analysis of the “needs discourses” which inform social policy, Sophie Watson finds that the discourse of “needs” clashes with that of “consumer” as the “... state attempts to regulate and intervene in the aspects of the everyday life of selected members of a social community via discourses of need: and needs discourses are used to legitimate claims for the distribution of resources and benefits”. As the expenditure in human services and welfare in Australia grows, so does an increasing demand by the funding bodies for a “targeting of services to meet peoples’ needs”. Translated, this rhetoric means that more and more stringent policies are being implemented to attempt to ensure that the expenditure is delimited as much as possible. Market efficiency criteria have risen in prominence over equality and social justice criteria in the distribution of the nation’s public sector resources. This can be observed not only in where the resources are being allocated and how, but in the language associated with them. We now speak of “the bottom line”, “the level playing field”; we discuss “cost/benefits” in regard to people’s needs, and develop “strategic plans” to determine people’s lives. We are able to observe the corporatisation of services to people with
intellectual disability by the increasing privatisation and marketisation of community care as there are now “purchasers” of care, both agencies and individuals. The market ethos “affects how people as workers, as agents of the state, and as citizens relate to themselves, to one another, and to the major public institutions around them”. From the British experience, Peter Taylor-Gooby suggests that:

Despite the emphasis on consumerism, expressed in such devices as the promulgation of “citizens’ charters” ... and the widespread use of terms such as customers to refer to individuals who were previously clients, in many respects government has rationalised and standardised provision.

Jim Ife (1997) points out such an approach has far-reaching consequences for the way in which services are structured and delivered as have a tendency to be “unlikely to seek genuine client involvement in planning service delivery, or to value the practice wisdom of those at the front line”.

LOCAL AREA CO-ORDINATION: RESPONDING TO COMPLEXITY

The concept of a “co-ordinator of care” (also known as service brokerage or case management) emerged towards the end of the 1980s, as a direct response to the increasingly complex human services sector and the push to “consumerise” the market. The model had already existed in a variety of forms within the allied health sector — for example, in rehabilitation, where co-ordinators worked with a variety of service providers to offer clients a wholistic service. Social casework had a long history of co-ordination of resources to meet the needs of individual clients. However, the model of case management grew to a position of primacy as the major form of client co-ordination from the early 1990s in mental health, aged care and disability services.

Local area co-ordination (a modified form of service brokerage) began in Australia in 1987 following the allocation of funds by the Authority for Intellectually Handicapped Persons (AIH) based in Bunbury, and servicing the Great Southern Division. Prior to this appointment, services to people with intellectual disabilities were largely offered in Perth, with country visits by human service professionals only beginning in the early 1970s. As Greg Lewis (1992) comments

… for families living in the country, there existed a one in three chance that they would have to either send their child away [to Perth] or leave their community and move to the city [Perth].

The discretionary monies made available in the Great Southern resulted in about 22 families “utilising varying proportions of those funds to maintain their child within the family home”. Funds were utilised for “respite, attendant care, domestic help, transport assistance, holiday support and behaviour management”. By 1989, the “country wait list” (for metropolitan accommodation places under the centralised model of care) was closed.

The availability of service brokerage at this level, in communities that had previously been very isolated from the human service centres in metropolitan Perth, began to build up a momentum for demand from other families for similar supports. By 1990, when a comprehensive review of the Great Southern service was undertaken, the results
supported an increase in the service. Families reported that “local area co-ordination was more user friendly and responsive than the traditional visiting team approach”. The review found two areas of concern — the first, was a question of accessibility. Families often had to wait their turn, contact was sometimes slower than they wished. Second, the services to people with disabilities in that region were slower in their response to the potential of the service brokerage model. The review recommended that “agencies needed to collaborate more closely to offer consumers the widest choice and the facility to utilise a mix of services”\textsuperscript{13}. A second review, involving over 60 families, was conduction in June 1991. Again, accessibility and availability of the local area co-ordinator emerged as key issues in the review. Another important positive finding was that families were now appreciative of the long-term viability of the service brokerage model. Finally, the evaluation noted that many families agreed that their “quality of life” had improved since connecting with the local area co-ordination approach.

The Local Area Co-ordination project was extended to metropolitan centres of Western Australia in the early 1990s. The impact on country families in terms of meeting their needs was evident in that by 1992 the “flow” of people to the metropolitan accommodation services provided by AIH had “been significantly reversed” and fewer people from the country were living in metropolitan settings. Instead, they were being “supported to remain at home or within their own communities through the provision of tied funding”\textsuperscript{14}. The cost savings of this approach were also quantified at this time. Costs associated with local area co-ordination were significantly less than those associated with providing hostel beds — a ratio of around 1:8.\textsuperscript{15} By 1994–85, the Western Australian model of Local Area Co-ordination became the State standard of care and following the creation of the Disability Services Commission in 1994, was extended to support all people with disabilities, not just intellectual disabilities.

### INTRODUCING LOCAL AREA CO-ORDINATION IN QUEENSLAND — “DOING WHAT IT TAKES”

With the introduction of the Commonwealth State Disability Agreement in 1992, Queensland passed its own \textit{Disability Services Act 1992} and expanded its division of disability services within the major family services department. Queensland had a very poor record for the provision of disability services and despite the transfer of Commonwealth funding, it remained the lowest per capita funded State for disability expenditure. Through the mid 1990s consumers, parents and allies actively lobbied the then opposition for better funding of supports people with disabilities and families. The Unmet Needs Campaign, an extremely well co-ordinated State-wide effort, mounted a series of lobbying strategies to argue for more disability dollars for the thousands of people and families with no funded services or supports and for a separate agency for disability issues. This became an election promise of the Labor opposition that was then delivered in 1999 when a separate department — Disability Services Queensland (DSQ) was created. A \textit{Draft 5 Year Strategic Plan (1999)} and \textit{Strategic Framework for Disability (2000)}\textsuperscript{16} were later launched.
The Strategic Framework for Disability document identifies the challenge of providing equitable services across the State. It states:

Queensland is the most decentralised state in Australia. Providing services for people with disabilities in rural and remote areas where the population and service infrastructure is sparse, presents particular challenges for both government and community sectors. These include additional costs, lack of service infrastructure and service options, transport difficulties and difficulties in recruitment and support of staff in government and community organisations.

One response to this challenge was the development of a pilot project to introduce a model of Local Area Co-ordination (based on the Western Australian approach) into rural and remote Queensland. Planning for this project began in 1999 with a series of community forums. The pilot commenced in late 1999, with the appointments of Local Area Co-ordinators (LACs) in Hervey Bay, Gympie, North and South Burnett, Mount Isa and Cooktown. These sites were chosen both for their high need (expressed through the Needs campaign discussed above) and their isolation and lack of support services.

One significant difference between the Western Australian and Queensland models of Local Area Co-ordination (LAC), is the strong emphasis placed in Queensland on community development as a central activity for the LAC. The relationship between an inclusive community and the quality of life of people with disabilities and their family members is recognised in the specific objectives of Queensland LAC. Participation in community life, leading valued and quality lives within their local communities, and increasing the levels of inclusion are all key principles of the LAC model. In addition, LAC performance measures include: Individual and Family Needs; Advocacy; Informal Support; Community Development; Formal Services; Funding; Monitoring of Services and Supports and Budget Management and Accountability. The spirit of the LAC model is encapsulated in the concept that the co-ordinator “does what it takes” to make a positive and sustained difference in the lives of people with disabilities and their families within the local community.

An important component of “doing what it takes” includes accessing and resourcing clients through a flexible funding arrangement. This funding operates at several levels. The first, at the level of the client, provides funding packages for specific costs associated with identified needs. These are called Adult Lifestyle Support Packages and are currently provided to those in most critical need. This funding provides for accommodation support (e.g., for personal care) and/or community access. The second set of flexible funding schemes occurs at the level of the family, providing funding support to enable family members to continue to provide in-home care for their family member. This is currently through two specific schemes:

- Intensive Family Support, co-ordinated through DSQ offices for families with children with complex and critical needs; and

- Flexible Family Support, co-ordinated through non-government organisations for families where smaller amounts of funding are available but are very flexibly used for anything from purchasing additional home help hours, special equipment or minor home modifications.
The third is at the level of the community, where small amounts of funding are found to enable integration activities or strategies to develop. This may involve for example, providing a local authority with funding to make the local pool accessible or funding community arts projects which include disabled and non-disabled people.

**LOCAL AREA CO-ORDINATION AND COMMUNITY SUSTAINABILITY: MOVING TOGETHER ACROSS THE MAP OF CARE**

The shift to a public “self-help” model of care for people with disabilities also serves to enable a regulation process within families assessed as having “needs” while at the same time arguing that the “family” is outside the public sphere. As Sophie Watson suggests, the family “… is supposed to satisfy its own needs internally yet, at the same time, it is the site of regulatory practice”\(^{19}\). The concept of “consumerism” as a principle within “community care” is now a fundamental within all the human services. As Baldock and Ungerson (1994) point out it “may not just be the services that will have to adapt but also those who use and ‘consume’ them”\(^{20}\). This “[m]ovement across the ‘map of care’ requires that people learn new ‘scripts’ which describe and legitimise the choices they must make”\(^{21}\).

Local Area Co-ordination provides a model for human services support that takes up the challenge of “consumerism” and “self-help”. At the same time, it also provides a potential model for community sustainability in its underlying principle of community development as well as service support. The formative evaluation project being conducted by the authors enables a reflection on the strengths of this alternative model of “care”. Our early reflections suggest that the LAC model as being developed in Queensland has the potential to empower people with disabilities, their families and their communities. In its pilot project format, with the flexibility of a “new form of service” LAC appears to be providing the kind of “value adding” to families and people with disabilities that enables them to become more adept in “managing” the complexities of the human service system. This positive impact is primarily so because of the personal relationship between the Local Area Co-ordinator and the family or person with a disability — what we might consider the “human face” of human services. In addition, as a key driver of change in rural and remote communities, the Local Area Co-ordinator has also the potential to become what we have termed elsewhere as “interpreters” of policy complexity and service delivery demands\(^{22}\). In other words, the linkage role between the LAC, the client and the wider support system begins to develop a concept of resiliency in that community that is broader and has more potential for long-term sustainability than is presently well understood.

Thus in response to Baldock & Ungerson’s (1994) notion of the “map of care” we would suggest that the Local Area Co-ordinator can be see as a “co-driver” in the journey, perhaps, to extend the metaphor, the person holding the map, while assisting and supporting the client to move forward themselves. The barriers, road blocks, potholes etc. that are constantly in the way are therefore potentially smoothed by this partnership — thus enabling the journey to be taken by others as well.
However, we are also expressing some caution here. It is “early days” in the formative evaluation process. It is also early days for the pilot project and all the LACs in Queensland are still establishing themselves within their communities. In the past, service brokerage models have often collapsed under the weight of the bureaucracy that established them to be “flexible” and then denied them that flexibility by demanding structure, process, reporting back, outputs and so on. The potential within the LAC model of human service support for people with disabilities needs to be enabled, not stifled. The formative evaluation process will provide us with the time for reflection, thinking through dilemmas and issues as they arise and then feeding into the implementation process as it is rolled out over the State. There are already plans for additional LAC sites across the State. We are not suggesting that LAC model can be applied like a template across diverse communities; however, using a formative evaluation in the early pilots will perhaps allow for smoother introduction of new co-ordinators in new communities.

REFERENCES


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Lesley teaches in social work, rural practice, disability and leadership. She has a keen interest in flexible learning as a means of increasing access to study for people in regional and rural communities. She has published widely on violence and disability, disability policy and practice and rural human services. She is a regular invited speaker at conferences both in Australia and overseas.