A COMPARISON OF THE AUSTRALIAN FEDERAL VOCATIONAL REHABILITATION SYSTEM TO THE AMERICAN STATE-FEDERAL VOCATIONAL REHABILITATION SYSTEM

By

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Abstract

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An extended review of the literature was taken to compare and contrast the differences between the Australian federal vocational rehabilitation system to the American state-federal system. In addition, additional information was gathered through interviews and the author's experience working as a rehabilitation counselor for CRS Australia. Several differences were found between the two systems and the implications of these are discussed along with recommendations for future practice. Also, this paper explores that the differences in the two systems in the following areas: history, legislation, roles of the two systems, and current philosophic direction.

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Chapter I

Topic

A comparison of the Australian federal vocational rehabilitation system to the American state-federal vocational rehabilitation system.

INTRODUCTION

The Australian vocational rehabilitation system had its origins in the early 20th Century. With the growing affluence and independence of the Australian colonies towards the end of the century there came pressure to improve the situation of the ordinary citizen (Tipping, 1992). First efforts in establishing any kind of vocational rehabilitation services in Australia came from the Commonwealth Government which efforts were made for the war-injured, after the First World War (Tipping, 1992). In November 1941, E. J. Holloway, the Minister for Social Services, introduced legislation to Parliament to amend the Invalid and Old Age Pensions Act to include, among other amendments, a Vocational Training Scheme for Invalid Pensioners (Tipping, 1992).

In 1948 the Federal Government of Australia accepted the principle of providing a comprehensive rehabilitation service to all members of the community (Tipping, 1975). In 1952 it established the Commonwealth Rehabilitation Service (Tipping, 1992). In the beginning, due to absence of trained staff, the Service was limited to invalid pensioners and unemployment and sickness beneficiaries who were judged capable of returning to work (Tipping, 1992).

From 1948 to 1954 vocational rehabilitation in Australia started to develop programs for its civilians. In the years for 1955-1969 vocational rehabilitation in Australia focused on the consolidation of its services and rehabilitation centers (Tipping, 1992). In the late 1960's and early 1970's vocational rehabilitation in Australia switched from providing both medical

rehabilitation and vocational rehabilitation to mainly providing vocational services (Tipping, 1992). The 1970's also brought about formal training programs and courses in rehabilitation counseling. The 1980's brought about strategies to convert the resources of the rehabilitation centers to community-based rehabilitation programs. This time period also brought about drastic changes in the delivery of services to minority rehabilitation clients, such as the native Aboriginals and Torres Strait Islanders (Tipping, 1992).

Today, in Australia, vocational rehabilitation/habilitation services are provided through several different systems. Besides the Commonwealth Rehabilitation Service (CRS), vocational rehabilitation/habilitation services are provided by the Job Network Providers (private agencies delivering case management to the unemployed receiving assistance from the government), the Department of Education, Private, Non-Profit, Voluntary Organizations, and Private industry (Brolin, 1987).

Similar to the Australian vocational rehabilitation system the American vocational rehabilitation system had its origins in originally helping those injured in World War I. In fact, the first United States federal program for vocationally rehabilitating individuals compensated disabled veterans of all earlier United States wars dating back to the Revolution (Roessler & Rubin, 1995). In 1918 the Soldier's Rehabilitation Act was passed which authorized vocational rehabilitation services for all veterans with a disability resulting from military service that presented a handicap to employment (Roessler & Rubin, 1995). In 1920 the Smith-Fess Act was passed, launching America's first civilian vocational rehabilitation program (Roessler & Rubin, 1995).

In 1935 the Federal Social Security Act was passed in the United States

establishing the state-federal vocational rehabilitation program as a permanent program (Roessler & Rubin, 1995). In 1943 the Barden-LaFollette Act extended rehabilitation services to the mentally ill and mentally retarded (Roessler & Rubin, 1995). During World War II disabled persons demonstrated that they weren't necessarily disabled if placed on an appropriate job. This led to the establishment of the President's Committee on Employment of the Handicapped, which emphasized ability not disability (Roessler & Rubin, 1995). This was one of the first committees assembled to help persons with disabilities. In 1954 Public Law 565 authorized $30 million in 1955 to the states for rehabilitation purposes and appropriated an expansion in the annual funding to $45 million in 1956, $55 million in 1957, and $65 million 1958 (Oberman, 1967). During the 1960's vocational rehabilitation expanded even more. In the 1970's, however, vocational rehabilitation's age of expanding services began to wane due to the economic changes in the United States (Roessler & Rubin, 1995). The decade of the 1980's represented the philosophy of a limited role of the federal government in meeting the needs of disadvantaged persons and persons with disability. It also brought about sweeping changes in social security disability legislation (Roessler & Rubin, 1995). In the 1990's vocational rehabilitation in the United States experienced a tremendous shift in its philosophical tenets with the passage of the Americans with Disabilities Act.

A review of the literature has revealed that a comparison of the Australian federal vocational rehabilitation system (defined in this thesis as CRS Australia or formally known as the Commonwealth Rehabilitation Service) to the American state-federal vocational rehabilitation system has received little attention. Most of the literature has looked at just certain aspects. The intent of this researcher to look at several parts of both systems to compare and contrast them.

STATEMENT OF THE PROBLEM

The purpose of this extended literature review is an attempt to compare and contrast the differences in the American state-federal vocational rehabilitation system to the Australian vocational rehabilitation system. These differences will be determined by addressing the research questions stated below of each system.

Specific Research Questions to be asked:

1. What is the history of the American state-federal vocational rehabilitation system and the Australian federal vocational rehabilitation system up to the current time period?
2. What is the legislative basis of the American state-federal vocational rehabilitation system as compared to the Australian federal rehabilitation system?
3. What are the differences and similarities in the role's of the state-federal American vocational rehabilitation system to the federal Australian vocational rehabilitation system?
4. What is the current philosophic direction of American state-federal vocational rehabilitation system as compared to the Australian federal vocational rehabilitation system?

CHAPTER II

METHODOLOGY

Four research questions will be examined:

1. What is the history of the American state-federal vocational rehabilitation system and the Australian federal vocational rehabilitation system up to the current time period?
2. What is the legislative basis of the American state-federal vocational rehabilitation system as compared to the Australian vocational rehabilitation system?
3. What are the differences in the American state-federal vocational rehabilitation system to the Australian federal vocational rehabilitation system?
4. What is the current philosophic direction of the American state-federal vocational rehabilitation system as compared to the Australian federal vocational rehabilitation system?

Relevant information relating to the topic was obtained through researching the following resources:

1. University of Wisconsin - Stout Public catalog.

Reviewed the Public catalog for books relevant to the thesis topic. A keyword search was used with vocational rehabilitation and Australia, vocational rehabilitation and history, vocational rehabilitation and legislation, vocational rehabilitation and philosophy, disability legislation, disability policy, etc. Several books were identified that provided significant information on vocational rehabilitation in America but very little information on vocational rehabilitation in Australia.

2. Reviewing First Search (On-line data base for Social Science, Medicine, Biological Sciences & Physical Sciences). Information was gathered using the following search words: Vocational

Rehabilitation, History, Legislation, Australia, Philosophy, Disability Policy, and Disability Legislation. Several books and journal articles were identified as being pertinent to the thesis topic. In addition, the database WorldCat produced some useful articles pertaining to vocational rehabilitation in Australia.

However, not a lot of data was collected pertaining to the Australian vocational rehabilitation system. Many of the articles identified were available at UW-Stout with a few needing to be requested through interlibrary loan.

3. Review of Rehabilitation, Counseling, Psychology, and Medical journals.

Most of the information for the American vocational rehabilitation system was obtained through the review of Journal articles at UW-Stout, a review of First Search, and reviewing the PsycLit and ERIC databases. Several of the articles used in the thesis were found in the following journals: The Journal of Applied Rehabilitation Counseling, Journal of Rehabilitation, Vocational Evaluation and Work Adjustment, and Rehabilitation Education.

4. Curtin University of Technology in Perth, Western Australia.

Curtin University of Technology catalogue (CLUE) was reviewed using the following keywords: vocational rehabilitation, Australia, Australian vocational rehabilitation, legislation and Australian vocational rehabilitation, history and Australian vocational rehabilitation, and philosophy and Australian vocational rehabilitation. Several books and articles were identified as being pertinent to the Australian side of this particular thesis. In addition, PsychLit was also reviewed at this university and it produced even more articles pertinent to the Australian side of this thesis.

5. Conferences and personal communication. A small part of the information for this thesis was gathered via conferences and personal communication with the majority of them taking place in

Western Australia. Personal communication with employees at WorkCover (the worker's compensation authority for Australia) produced information on the history and current philosophic direction of vocational rehabilitation in Australia. In addition, personal communication with Mr. Peter Scott (Ad Hoc professor to Curtin University of Technology) produced some information on the current legislation, history, and philosophic direction of vocational rehabilitation in Australia. Also, an Employment Service Regulatory Authority (ESRA) conference attended (by the author) provided some insight on the privatization of the employment market in Australia. Finally, personal communication with various individuals in the employment field in Western Australia provided some information on the role of public vocational rehabilitation in Australia. This was accomplished through (the authors) day to day contact with such individuals while employed as a case manager working with the long-term unemployed for the private organization ORS Rehabilitation and Placement Services and CRS Australia (Australia's federal vocational rehabilitation agency) in Western Australia which gave (the author) direct contact with relevant individuals in the employment market in Western Australia.

Chapter III

Review of the Literature

An overview of the history of the two systems.

Rehabilitation in early America usually involved some sort of incarceration or monitored movement. Treatment afforded to persons with mental illness in the American colonies was dependent usually on two factors (1) the socio-economic status of the person's family and (2) whether the mental illness manifested itself in a violent or non-violent way. Members of families with money were usually kept at home. If violent or troublesome, they were locked up and chained by their families in strong rooms, cellars, and even flimsy outhouses (Roessler & Rubin, 1995). If non-violent, they were sometimes allotted a certain amount of freedom and movement, but even some non-violent persons were locked away for years in attics by their families (Roessler & Rubin, 1995). Poor persons who were mentally ill experienced a harsher plight - if non-violent they were treated the same as any other pauper. If violent, they were treated as criminals and incarcerated in jails if any existed in the community. In places where the jail was nonexistent, the pillory, the whipping post and the gallows afforded simple and inexpensive means of rapid punishment (Roessler & Rubin, 1995). In the nineteenth century humanitarianism and optimism generated a receptive environment for the initiation of programs designed to meet the needs of persons with disabilities (Roessler & Rubin, 1995). Despite these good intentions and a receptive societal attitude toward helping persons with disabilities it still didn't do much to lessen the plight of those with physical disabilities due to the lack of knowledge on human anatomy and physiology (Roessler & Rubin, 1995). On the other hand, this improved environment almost immediately affected those who were deaf or blind, and a little later those who were mentally retarded or mentally ill (Roessler & Rubin, 1995). Three

people emerged as champions for the disabled in the nineteenth century: (1) Thomas Gallaudet (hearing disabilities), (2) Dr. Samuel Gridley Howe (blind and mental retardation), and (3) Dorothea Dix (mental illness). These three people were responsible for many remarkable advances during the nineteenth century for the disability groups mentioned above. By the end of the nineteenth century medical advances increased the potential for both the survival and the medical restoration of persons with physical disabilities (Roessler & Rubin, 1995). At the beginning of the twentieth century the United States government began to realize the importance of the idea of rehabilitating persons with disabilities.

The Smith-Hughes Act of 1917 provided vocational educational programs for unskilled rural youths and upgrading of the skills of workers currently in the workforce and it also created the Federal Board for Vocational Education, which later administered both the veteran and the civilian vocational rehabilitation programs (Roessler & Rubin, 1995). In 1918 The Soldier's Rehabilitation Act was passed creating the first federal program for vocational rehabilitation of persons with disabilities (Roessler & Rubin, 1995). The act authorized vocational rehabilitation services for all veterans with disabilities resulting from service in the military that presented a handicap to employment (Roessler & Rubin, 1995). In 1920 the Smith-Fess Act was passed implementing the first civilian vocational rehabilitation program in the United States (Roessler & Rubin, 1995). This Act provided $750,000 of federal funds the first year and one million dollars for each of two subsequent years to be used for the rehabilitation of persons with physical disabilities who were either ″totally or partially incapacitated for remunerative occupation" (Roessler & Rubin, 1995, p.27). The amount of funding allocated to a state was determined by the ratio of its population to the total U.S. population, based on current census figures (Roessler & Rubin, 1995).

During the 1930's vocational rehabilitation in the United States stymied by the depression of the decade. In fact, President Roosevelt (a president with a disability himself) called for a 25% reduction in funding for vocational rehabilitation in 1933 (Roessler & Rubin, 1995). However, two acts were passed in the 1930's that increased the opportunities for persons with visual disabilities - the Randolph-Sheppard Act in 1936 and the Wagner-O'Day Act of 1938.

During World War II the rehabilitation movement increased sharply. The war created major labor shortages giving persons with disabilities a chance to demonstrate to the American public that could actually work certain jobs despite having a disability and expanded the types of physical restorative services that could be provided for persons with physical disabilities (Roessler & Rubin, 1995). This act also provided the first federal-state rehabilitation program support for rehabilitation of persons who were blind, making it a major piece of legislation for blind rehabilitation services (Roessler & Rubin, 1995).

From 1954 to 1972 several legislative acts were passed that would have a major impact on vocational rehabilitation in America (Roessler & Rubin, 1995). In 1954 President Eisonhower urged Congress to draft legislation for meeting the rehabilitation needs of the nation (Roessler & Rubin, 1995). This resulted in Congress passing the Rehabilitation Act Amendments of 1954 or Public Law 565 (Roessler & Rubin, 1995). These amendments increased the federal share of the funding of the federal-state vocational rehabilitation program from 50% to $3 for every $2 of state funds (Roessler & Rubin, 1995). Public Law 565 also resulted in the expansion of services to persons with mental retardation and mental illness in three key areas: research and demonstration grants, extension and improvement grants, and rehabilitation facility development (Roessler & Rubin, 1995). Public Law 565 also authorized

grants to colleges and universities for the training of professional rehabilitation workers leading to master's degree training programs and providing a foundation for the professionalization of the rehabilitation counselor (Roessler & Rubin, 1995). Vocational Rehabilitation Act Amendments of 1965 (Public Law 333) established six and eighteen month extended evaluation services for the purposes of determining the employment potential of some applications for services and it also expanded the definition of disability to include behavioral disorders diagnosed by a psychologist or psychiatrist and increased funding to a three to one federal/state ratio (Roessler & Rubin, 1995).

In the 1970's the disability consumer movement started to pick up momentum and influenced rehabilitation legislation with a huge impact. This impact was clearly felt with the passage of the Rehabilitation Act of 1973 that mandated federal-state rehabilitation programs to serve people with severe disabilities (Roessler & Rubin, 1995). States were required to provide services to persons with more severe disabilities before serving those with less severe disabilities (Roessler & Rubin, 1995).

Along with the emphasis on serving people with severe disabilities the Rehabilitation Act of 1973 stressed involvement of both counselor and client having a disability. It also stated that if the client was deemed eligible for services, then the client should jointly participate with the counselor in the service planning process by completing an Individualized Written Rehabilitation Plan (IWRP) (Roessler & Rubin, 1995). In addition, The Rehabilitation Act of 1973 also called for the development of a set of standards by which the impact of rehabilitation services could be assessed (Roessler & Rubin, 1995). The Rehabilitation Act of 1973 also incorporated provisions on addressing civil Rights for persons with disabilities. These provisions are represented in Sections 501,502, 503, and 504 of Title V (Roessler & Rubin, 1995). Section 501 mandates

"non-discrimination by the federal government in its own hiring practices and calls for each government agency to submit an affirmative action program plan for the hiring, placement, and advancement" of individuals with disabilities (Roessler & Rubin, 1995, p.56). Section 502 established the Architectural and Transportation Barriers Compliance Board (ATBCB) to enforce accessibility for persons with disabilities to buildings and various forms of transport (Roessler & Rubin, 1995). Section 503 prohibits discrimination in employment on the basis of physical or mental handicaps and requires all companies who have federal contracts exceeding $2,500 to make reasonable modifications in work settings and to ensure that policies of non-discrimination are followed in the recruiting, hiring, and promoting of workers (Roessler & Rubin, 1995). Section 504 mandated that "higher education facilities develop non-discriminatory practices to the admissions of persons with disabilities" (Roessler & Rubin, 1995, p.57).

In the 1980's Ronald Reagan was elected president and with his presidency came a more conservative view towards assisting persons with disabilities. Despite this, several important acts were passed in this decade, which furthered the cause of persons with disabilities. These include the; Voting Accessibility for the Elderly and Handicapped Act (1984), The Air Carrier Access Act of 1986, and The Fair Housing Act Amendments of 1988 (Roessler & Rubin, 1995). Another significant piece of legislation passed in the 1980's were the 1986 Amendments to the Rehabilitation Act of 1973. These amendments required state rehabilitation agencies to expand the use of rehabilitation engineering services to meet the needs of persons with disabilities (Roessler & Rubin, 1995).

The decade of the 1990's has brought about the biggest and most comprehensive piece of legislation passed by congress to date - The Americans with Disabilities Act (ADA). The ADA

prohibits discrimination on the basis of five titles or areas - employment, public accommodations, public services, and telecommunications (Roessler & Rubin, 1995). For the purposes of this thesis, (the author) will not go into detail on each of these five titles but recommend that the reader refer to pages 87-104 of the book Foundations of the Vocational Rehabilitation Process by Roessler & Rubin, 1995. This provides an overview of the history of vocational rehabilitation in the United States. We will now turn our attention to the history of vocational rehabilitation in Australia. (Readers should be aware that there are several good books on the subject of disability in the United States, Authors include Scotch, Smart, Bitter, Patterson. Each is worth the read and will add to the philosophic side of the discussion).

History of Australian vocational rehabilitation

In the early nineteenth century the approach of the Australian colonial Governments to the permanently sick and disabled were very similar to that of England. It was viewed that the primary responsibility for the "aged", "sick", "crippled", "demented" and "imbecile" was seen to be their families (Tipping, 1992, p.3). Towards the end of the century there came pressure to improve the conditions of ordinary citizens and those who were considered invalid (Tipping, 1992).

New South Wales was the first colony to introduce old-age pensions for people of 65 years of age or older and a provision for an invalid pension for people between 60 and 65 and permanently disabled (Tipping, 1992). The NSW Invalidity and Accident Pensions Act of 1907 further extended the eligible age group - these were the first non-contributory pension schemes for invalidity in the world (Tipping, 1992). The Commonwealth of Australia Parliament passed the Invalid and Old Age Pensions Act 1908 - this provided an invalid pension to people who were sixteen years or older and "permanently incapacitated for work" (Tipping, 1992, p.4).

Other community initiatives to help civilians with disabilities included establishing institutes for the blind and deaf with an emphasis on both care and training towards independence (Tipping, 1992). In addition, there was also an establishment of voluntary organisations for crippled children through the bequest of Lord Nuffield (the managing director of the Morris Motor Company) to the Commonwealth Government (Tipping, 1992). It was initially through these voluntary bodies that the concepts of "rehabilitation" for civilians began to first find expression (Tipping, 1992).

Rehabilitation for civilians was first attempted by the Commonwealth Government with the war-injured, after the First World War (Tipping, 1992). A Commonwealth scheme for the "repatriation" of injured soldiers was established following the early contributions of volunteers - involving disabled ex-servicemen through the new Repatriation Department (Tipping, 1992, page # 4). However, the social and economic advantages of restoring the working ability of civilians with disabilities did not occur until after the Great Depression and after the declaration of war against Germany (Tipping, 1992). By 1939 it was revealed that there had been a 50% increase in the number of applicants for invalid pensions since 1929 (Tipping, 1992). It was at this time that the Menzies United Australia Party (UAP) Government had begun to consider the role of social security in a post-war Australia establishing a Parliamentary Joint Committee on Social Security to report upon ways and means of improving social and living conditions in Australia (Tipping, 1992). This committee first met in 1941 and visited four capital cities and in its first report concluded (with a range of other proposals) that a scheme of vocational training for invalid pensioners be created (Tipping, 1992). Before the end of November 1941 the Minister for Social Services, E.J. Holloway had introduced legislation to Parliament to amend the Invalid and Old Age Pensions Act to include, among other amendments, a Vocational

Training Scheme for Invalid Pensioners (Tipping, 1992). The creation of the new position of Chief Rehabilitation Officer in the Department of Social Security (DSS) and the appointment of the first professional social worker to DSS ensured that there would be steady increase in the number of invalid pensioners undergoing training through the establishment of better links with referring agencies. Following the end of World War II the Curtin Government set up the Interdepartmental Central Demobilisation Committee to plan for the demobilisation of the 600,000 men and women returning from the war (Tipping, 1992). In addition, The Commonwealth Reconstruction Training Scheme (CRTS) was established to handle the retraining aspects of demobilisation where troops were given advice about options for training and other entitlements by the various government agencies involved with special consideration given to men and women who had disabilities (Tipping, 1992). The Sub-Committee on the Rehabilitation and Re-establishment of Disabled Members of the Forces (formed in 1944) acknowledged that, in cases where a disability occurred as the result "war services", the responsibility lay with the Repatriation Department (Tipping, 1992, p.10). However, in cases where a disability resulted by other means then those cases should be the responsibility of an alternative, single, civil authority and recommended that rehabilitation of this group of people should form part of a broader comprehensive scheme for the whole community (Tipping, 1992). This is the first mention of a scheme of rehabilitation for civilians that combined treatment and training and found that the establishment of rehabilitation centres was seen as critical (Tipping, 1992).

In 1945 and 1946 a disablement sub-committee continued to plan for the increasing number of cases being referred to the Department of Social Security (DSS) (Tipping, 1992). Their plan was to create a "service centre", in a central location in a capital city (Tipping, 1992).

It was here that applicants would apply and be interviewed by a doctor, a DSS rehabilitation officer, and sometimes a liaison officer or social worker (Tipping, 1992). Also, it was envisaged that a second type of facility be created as a day attendance clinic where treatment would be provided by a doctor and DSS staff, including a nurse, physiotherapist, remedial gymnast and when available, a occupational therapist (Tipping, 1992). In addition to these two ideas, a third model was also developed where clients and staff lived in a "residential rehabilitation centre" and which offered full-time programs based on models established by the services in the United Kingdom (Tipping, 1992).

In 1948 a bill was introduced to parliament and Part VIII of the Social Services Consolidation Act came into effect on 10 December 1948 thus creating the civilian rehabilitation scheme (Tipping, 1992). This Act provided for medical and hospital treatment and vocational training with the payment of an allowance (Tipping, 1992). Persons eligible for this scheme included invalid pensioners, sickness and unemployment beneficiaries, and people with disabilities who were sponsored by Commonwealth or State authorities (Tipping, 1992). Also, to be eligible for assistance it was necessary for the person to have had "a physical or mental disability" which had existed for thirteen weeks and was likely to exist for another thirteen weeks (Tipping, 1992, p.45). In addition, it was also necessary that the disability be a "substantial handicap to engaging in a suitable vocation" and that there were "reasonable prospects of engaging in a suitable vocation within two years" (Tipping, 1992, p.45). Although the new legislation was titled "Rehabilitation of Physically Handicapped Persons" persons with psychiatric disabilities were included in the eligible categories (Tipping, 1992, p.45). In 1955, the official title of Commonwealth Rehabilitation Service was applied to Part VIII of the Social

Services Consolidation Act avoiding the confusion as to who was actually eligible for the scheme (Tipping, 1992).

Following the change of the official title another significant piece of legislation was passed in 1955 - an amendment including “those who had reached fourteen years but not sixteen years, and who, without treatment and training would be likely to become qualified to receive pensions when sixteen” (Tipping, 1992, p.76). Also, in 1955, additional provisions authorized the Commonwealth Rehabilitation Service (CRS) to provide loans for people to engage in home employment, to make arrangements with individual non-beneficiaries to provide rehabilitation, and to increase the rates of training allowances (Tipping, 1992). In 1958 the thirteen-week waiting period before rehabilitation could begin was removed and in 1960 the Act was amended to remove anomalies so that the department could recover the cost of rehabilitation when a client received a compensation settlement (Tipping, 1992).

It was pointed out in 1965 by two severely disabled people, Hugh and Hazel Bedwin, that the concept of CRS is still the same - rehabilitation into full-time employment or nothing (Tipping, 1992). Although assistance was available to persons with severe disabilities through the Handicapped Children’s (Assistance) Act 1962 and the Sheltered Employment (Assistance) Act 1967 there was still a big gap between what voluntary agencies could provide by way of vocational rehabilitation and that available to eligible cases accepted by the CRS (Tipping, 1992). It should be pointed out that from 1941 until 1970 most severely disabled clients were assisted through voluntary organisations such as the Civilian Maimed and Limbless Association (Tipping, 1992). This climate generated three government reports about rehabilitation: the Griffith Report (1970), the Conybeare Report (1970), and the report of the Senate Standing Committee on Health and Welfare (1972) (Tipping, 1992). These reports emphasized the role of

the States in medical and educational aspects and the role of the Commonwealth in dealing with the vocational and social phase of rehabilitation (Tipping, 1992). In addition, these reports recommended that medical rehabilitation was the responsibility of the State Governments and the Commonwealth should be confined to vocational assessment through the CRS and Commonwealth Employment Service (CES), and retraining and resettlement (Tipping, 1992).

The 1970’s also brought about the establishment of the regional units for CRS in some major country regions (Tipping, 1992). Initially, CRS vocational counselors were sent to regional areas on a visiting basis however by 1972 it was recommended that the CRS provide “regional rehabilitation clinics” in major country centers these included Wollongong, Canberra, Geelong, Ballarat, Rockhampton, Darwin, and Launceston (Tipping, 1992). The success of the 1972 units led to further expansion in the following years at Bengido, Victoria and at Port Pirie (Tipping, 1972).

It was identified that the CRS had always accepted some clients with mental retardation and although there were some successes with these clients it was the general view that rehabilitation centers were not appropriate for this group and the success rate was poor (Tipping, 1992). In a conference in June 1972 (Pensions or Progress), held by the Australian Association for the Mentally Retarded (AAMR) it was recommended that work adjustment units be established as specific vocational/job training facilities for the mildly mentally retarded preparing for employment in the community (Tipping, 1992). As a result of this, two pilot programs, called work preparation centers (WPC), were started in Melbourne and Sydney (Tipping, 1992).

The release of the Griffith and Senate reports of the 1970's brought about the need to train vocational counselors (Tipping, 1992). Tipping recommended the aim should be the establishment of tertiary training courses in rehabilitation counseling, along the lines adopted in the United States (Tipping, 1992). In 1972 Hadgraft and Tipping held the first course for vocational counselors in Sydney - a six-month program, three months of academic study and three months of supervised experienced (Tipping, 1992). In 1973 approval was gained to establish a formal tertiary course in rehabilitation counselling and a pilot course was developed in 1974 (Tipping, 1992). Throughout 1974 the NSW College of Paramedical Studies consulted widely about the community need for trained rehabilitation counselors and proposed two courses in rehabilitation at two levels - the first one for undergraduates, to be of two years, and leading to an associate diploma; the other to be for post-graduates, leading to a graduate diploma (Tipping, 1992).

In October 1977, the Social Services Act was amended to widen the eligibility for rehabilitation assistance to include all people of working age "who would be likely to derive a substantial benefit from treatment and training" and to include in the goals of rehabilitation "the persons undertaking or resuming household duties" and "the person's leading an independent or semi-independent life in their own home (Tipping, 1992). This legislation was probably the biggest change to vocational rehabilitation legislation since 1948 (Tipping, 1992). This legislation came from the 1976 Commission of Inquiry into Poverty, which urged that the legislation be amended to enable the restoration of the individual to the highest functional level of which they are capable, regardless of employability (Tipping, 1992). With the focus on "social rehabilitation", increased attention was given to social workers in the Commonwealth Rehabilitation Service (Tipping, 1992). In addition, many changes were made in the

Commonwealth Rehabilitation Service to include these changes, such as a more senior role for social workers and changes in the CRS Rehabilitation Centers around Australia to focus on independent living as well as employment (Tipping, 1992).

In the 1980s the term "normalization" became a dominant influence on the Commonwealth Rehabilitation Service programs being delivered (Tipping, 1992). These ideas were adapted after several seminars by Dr. Wolf Wolfensberger, Professor of Special Education at the University of Syracuse in the United States (Tipping, 1992). Dr Wolfensberger ideas challenged many of the practices of institutions that, it was now, labelled and devalued individuals (Tipping, 1992). For some individuals in CRS normalization was a real threat as their livelihood depended on the institutional nature of the CRS centers - for the first time emphasis was placed on the client as the focus of the rehabilitation process (Tipping, 1992). Further attention was given to client rights in the mid-1980s with the development of written Individual Program Plans (IPP) by CRS (Tipping, 1992). Also, experiences in Western Australia and New South Wales with professionally trained counselors gave rise to the idea that full vocational rehabilitation programs could be carried out without having to attend an rehabilitation center (Tipping, 1992). In addition, CRS gave a commitment to an "outreach" approach to rehabilitation by increasing the number of country regional units with an emphasis on efficient use of available community resources (Tipping, 1992). Along with this, work preparation centers (CRS) in Western Australia and South Australia developed the "enclave model" out of necessity (Tipping, 1992). In these two states skills learned in catering, cleaning, car maintenance, and gardening (areas with the most opportunities in these two states) were much harder to replicate in the Work Preparation Centers so groups of trainees and members of staff went outside the Centers and worked with other employees (Tipping, 1992). This model soon

found that since the trainees and staff worked together there was a better degree of "modeling" and the training environment was very different to that of a school, where many of the trainees had failed (Tipping, 1992).

In 1979 a three-year plan was put into place for the years of 1981-1984 and had some important changes to the CRS (Tipping, 1992). Its mandate was to enable CRS to respond to the rehabilitation needs of disabled persons at their local or community level (Tipping, 1992). Some of the proposals included a regional role for the rehabilitation centers, changing the client accommodation arrangements and the expansion of the regional rehabilitation programs but there was little consultation with the staff before the plan was issued (Tipping, 1992). A second three-year plan was drawn up in 1984 called Community-based Rehabilitation for People with Disabilities and it had ninety-two recommendations (Tipping, 1992). This plan included major restructuring of the administration and programs of the rehabilitation centers, expansion of the regionalization and work preparation programs and a re-statement of the commitment to improve access of women, migrants, and Aboriginals (Tipping, 1992).

In 1983 the Handicapped Programs Review was commenced which was a direct result of the initiatives from the 1981 International Year of the Disabled Persons conference (Tipping, 1992). A report was issued in 1985 and reported the widely held view that the CRS needed to be more accessible and responsive to the needs of people with disabilities (Tipping, 1992). Also, it reported that many of the clients of the CRS were critical of the CRS centers and of their isolation from other community services (Tipping, 1992). In addition, it gave greater emphasis to the concept of community-based rehabilitation, stating, "the number of CRS centers should be reduced, to allow services to be rationalized for further regional development throughout

Australia" (Tipping, 1992, p.76). Finally, the review led to the framing of the Disability Services Act, which was introduced in 1987.

The 1986 Disability Services Act (DSA) reflected a preference for community-based services and gave a clearer definition of the client outcomes to be achieved by Commonwealth-funded programs (Tipping, 1992). It also included a statement of principles and objectives on the rights of people with disabilities to individual respect, freedom of choice and fulfilment of their potential (Tipping, 1992). One of the main objectives was to encourage the development of programs which would bring about better outcomes for people with disabilities - including competitive employment, training and placement (Tipping, 1992).

Today, CRS Australia delivers tertiary rehabilitation services to clients under the provisions of the Disability Services Act (DSA) with the goal of providing community based vocational and social rehabilitation close to where people live and with active participation by clients in developing their programs (Marwick, 1993). In 1998, the Commonwealth Rehabilitation Service was officially changed to CRS Australia and underwent massive and fundamental changes by reducing costs and using a purchaser-provider arrangement consisting of a service level agreement with the Disability Payments and Services Branch of Family and Community Services (FaCS)(Family and Community Services web page, 2000, section four). In addition, CRS Australia is currently forced by the federal government to participate in two trials that may have an enormous and profound impact on its future - the assessment trials and the contestability trials (S. Mamo, Personal Communication, October 10, 2001). These two trials will be further explained later in chapter three. We now turn out attention to the legislative basis of the two systems.

Legislative basis of the two systems.

Prior to the turn of the century, almost all American federal policy treated disability as a military matter (Batavia & Schriner, 1995). Beginning in 1776, the American government demonstrated its commitment to honoring wounded Revolutionary War veterans by establishing a system of monetary compensation (Batavia & Shriner, 1995). By 1890 more than 400,000 men were receiving disability pensions that were service-connected, and some were also provided with medical care (Batavia & Shriner, 1995). In 1918 the Soldier Rehabilitation Act established a program of vocational rehabilitation for military veterans to help them adjust to their return to civilian life (Oberman, 1965). Following this act the Smith-Fess Civilian Vocational Rehabilitation Act of 1920 was passed to provide federal money to the states for the development of programs for

> any person who, by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease, is...totally or partially incapacitated for remunerative occupation; the term rehabilitation shall be construed to mean the rendering of a person fit to engage in a remunerative occupation (Oberman, 1965, p.25).

This act established the state/federal system of vocational rehabilitation services (Batavia & Schriner, 1995).

In 1935 vocational rehabilitation for civilians was given a permanent status by the Social Security Act of 1935 (Batavia & Schriner, 1995). Each state and territory developed and funded its own rehabilitation programs, with matching funds and standards provided by the federal government (Pelka, 1997). These programs served as an impetus for research into rehabilitation, the development of assistive technology, and the training of rehabilitation professionals at universities and colleges (Pelka, 1997). The Bardon-LaFollette Act of 1943 expanded the types of vocational rehabilitation assistance offered by extending them to adolescents, and established

the federal Office of Vocational Rehabilitation (OVR) (Pelka, 1997). In addition, this act provided the first federal-state rehabilitation program support for the rehabilitation of persons who were blind (Roessler & Rubin, 1995).

In the 1950s vocational rehabilitation expanded dramatically in size and scope. In 1954 the U.S. congress passed the Vocational Rehabilitation Act Amendments (Public Law 565) (Nagler & Wilson, 1995). The 1954 Amendments increased the federal share of the funding of the federal-state vocational rehabilitation program from 50% to $3 for every $2 of state funds (Roessler & Rubin, 1995). In addition, Public Law (PL) 565 also resulted in the expansion of services to a larger number of persons with mental retardation or mental illness (Roessler & Rubin, 1995). Also, the 1954 amendments greatly expanded the ability of the federal Office of Vocational Rehabilitation to fund both government and private non-profit rehabilitation agencies (Pelka, 1997).

There were several other laws passed from 1954 to 1972 pertaining to vocational rehabilitation. The first of these was the Wagner-Peyser Act Amendments of 1954. This act required federal/state employment security offices to designate staff members to assist people with severe disabilities (Batavia & Schriner, 1995). Following this came the Social Security Act Amendments of 1956 which established a Social Security Disability Insurance Trust Fund and provided for payments to eligible workers who became disabled (Batavia & Schriner, 1995). Following this came the National Defence Act of 1958, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, the Social Security Act Amendments of 1965, the Elementary and Secondary Education Act of 1965 and its amendments in 1966, and the Fair Labor Standards Act Amendments of 1966 (Batavia & Schriner, 1995). In addition to these acts, the Fair Labor Standards Act Amendments of 1966 were passed, along

with the Elementary and Secondary Education Act Amendments of 1967, the Handicapped Children's Early Education Assistance Act of 1968, the Vocational Education Act Amendments of 1968, the Developmental Disabilities Services and Facilities Construction Act Amendments of 1970, the Javits-Wagner O'Day Act of 1971, the Social Security Act Amendments of 1972, and the Small Business Investment Act Amendments of 1972 (Batavia & Schriner, 1995).

Probably the biggest single piece of vocational rehabilitation legislation up to this time (1973) was the passage of the Rehabilitation Act of 1973. This act replaced the former Vocational Rehabilitation Act and refocused the state vocational rehabilitation services program on serving those individuals with the most severe disabilities (Stafford, 1996). The Rehabilitation Act of 1973 is also America's first major comprehensive civil rights law for people with disabilities (Pelka, 1997). This 1973 act introduced many of requirements that are currently part of the established state vocational rehabilitation program services in use today. For example, it required that each individual who is determined eligible for services have in place an individualized written rehabilitation program (IWRP) that is jointly developed by the individual and the vocational rehabilitation counselor (Stafford, 1996). The 1973 act also introduced a requirement for individuals with disabilities to have access and input to policymakers in the state agencies that provide services to them (Stafford, 1996). In addition, the 1973 act introduced the first Client Assistance Projects (CAPs), which were authorized as a pilot effort to develop ombudsman models to assist clients of the state vocational rehabilitation agencies in their relationships with those agencies (Stafford, 1996).

Testimony before Congress had brought to the forefront the failure of traditional vocational rehabilitation services to meet the needs of people with disabilities (Pelka, 1997). Because agencies were judged by their success in placing disabled clients in the workforce,

rehabilitation agencies often refused to provide services to people with more severe disabilities, judging them unable or unlikely to work (Pelka, 1997). Title I of the Rehabilitation Act of 1973 authorized federal grants to state vocational rehabilitation programs meeting minimum federal criteria and stated that such programs had to be open to any disabled individual who might become employable after receiving services (Pelka, 1997). In addition, Title I required State agencies to prepare a written rehabilitation program plan for each client, including long-range goals, details of the services to be provided, and methods of evaluating whether those goals were being met (Pelka, 1997). Also, Title I included provisions for "Innovation and Expansion Grants" to be used by "a public or non-profit organization or agency...to expand vocational rehabilitation services...to individuals with the most severe handicaps" (Pelka, 1997, p.263).

Title II of the Rehabilitation Act of 1973 provided funds for research and for experimental programs in rehabilitation, under the direction of the National Institute of Handicapped Research (Pelka, 1997). Title III provided federal funding for up to 90 percent of the cost of providing vocational rehabilitation services to eligible people with disabilities by public or private non-profit rehabilitation facilities (Pelka, 1997). It also required that special emphasis be placed on meeting the rehabilitation needs of people with the most severe disabilities (Pelka, 1997). Title IV of the Rehabilitation Act of 1973 authorized the secretary of Health, Education, and Welfare "to conduct studies, investigations, and evaluation of the programs authorized by this Act..." (Pelka, 1997, p.263).

Title V of the Rehabilitation Act of 1973 is considered by many to be the "Bill of Rights" for Americans with Disabilities. For example, under Section 501 all federal executive agencies and departments were required to submit affirmative action plans aimed at increasing the numbers and standing of federal employees with disabilities (Pelka, 1997). Section 502

established the Architectural and Transportation Barriers Compliance Board (ATBCB) to enforce the Architectural Barriers Act of 1968 (Pelka, 1997). Section 503 required affirmative action by federal contractors with contracts of more than $2,500 in the hiring, placement, and promotion of qualified people with disabilities (Pelka, 1997). Section 504 of the Act of 1973 prohibits the exclusion, based on disability, of otherwise qualified persons with disabilities from participation in any federal program or activity, or from any program or activity receiving federal financial assistance (Roessler & Rubin, 1995).

In 1978 a new title VII (PL. 95-602) was added to the Rehabilitation Acts of 1973 authorizing a program of comprehensive services for Independent Living for individuals with severe disabilities (Stafford, 1996). Public Law 95-602 contained four parts: a state program for independent living services to be conducted by the state vocational rehabilitation agency; a program of local, community based centers for independent living (CIL); an independent living program for older blind individuals; and a protection and advocacy program for all programs and projects funded under the Rehabilitation Act (Stafford, 1996). In addition, the 1978 amendments contained another important provision that sought to expand upon the rights and remedies for individuals seeking and receiving vocational rehabilitation services - it established a formal appeal mechanism for when an individual disagreed with a vocational rehabilitation counselor's determination on eligibility for or the delivery of services (Stafford, 1996).

The Rehabilitation Act Amendments of 1984, Public Law 98-221, greatly expanded the role and function of Client Assistance Projects, hereafter to be known as Client Assistance Programs (Stafford, 1996). The amendments mandated that each governor designate an agency within the state to operate a Client Assistance Program as a condition for the receipt of the state's grant award for the state vocational rehabilitation services program (Stafford, 1996). It also

stipulated that in those states that did not have existing projects, the designated agency to operate the CAP must be an agency that is independent of any agency or organization that provides services under the Rehabilitation Act (Stafford, 1996). Also, the 1984 amendments required the development of evaluation standards and performance indicators for two programs - Centers for Independent Living and Projects with Industry reflecting Congress's interest in making programs more accountable and results oriented (Stafford, 1996).

The Rehabilitation Act Amendments of 1986 created a new state formula program for supported employment services in response to demands from the disability community that this new approach was needed for serving severely disabled individuals (Stafford, 1996). The formula program created under the Rehabilitation Act was seen as providing time-limited services and that other public agencies or non-profit organizations would then pick up the costs of supported employment after the state vocational rehabilitation agency completes its time-limited course of services (Stafford, 1996). In addition, the 1986 amendments required that state agencies conduct public meetings to discuss and take input and comment on the state plan for vocational rehabilitation services (Stafford, 1996). Also, the 1986 amendments extended federal authority to make grants to tribal authorities to pay up to 90 percent of the costs of vocational rehabilitation services on Indian reservations (Pelka, 1997).

The America With Disabilities Act of 1990

The American With Disabilities Act of 1990 is the most important and comprehensive piece of disability rehabilitation legislation to be passed since 1973. This act affords persons with disabilities the same protections against job discrimination that women and minorities received in the Civil Rights Act of 1964 (Albrecht, 1992). Since this paper is mainly aimed at reviewing the state-federal system of vocational rehabilitation in America and Australia the

American with Disabilities Act of 1990 will only be discussed in how it relates to America's state-federal vocational rehabilitation system. On October 26, 1992, Public Law 102-569 (Rehabilitation Act Amendments of 1992) was enacted providing many pivotal changes to the act (Stafford, 1996). For the first time, the act requires that states define who are the individuals with the most severe disabilities and that priority must be given to these individuals - especially if the state is under an order of selection for services (Stafford, 1996). Also, the act clarified that only those with the most severe disabilities are eligible for supported employment services (Stafford, 1996). In addition, for the first time the act now contains a definition of an employment outcome for individuals with disabilities, giving priority or emphasis to full or part-time competitive employment in the integrated labor market or any other vocational outcome as defined by the Secretary of Education through regulations (Stafford, 1996). Another major focus of the 1992 amendments is on accountability - the amendments contain a new requirement for evaluation standards and performance indicators for the state vocational rehabilitation services program (Stafford, 1996). It stipulates that standards and indicators must focus on outcome measures and failure to meet such standards and indicators would result in the development of a performance improvement plan (Stafford, 1996). In addition to this, the 1992 amendments expanded opportunities for informed choice for individuals with disabilities and for consumer input in policymaking for programs and projects under the act (Stafford, 1996). It requires the Rehabilitation Services Administration (RSA) to promulgate regulations in a timely manner to expand upon what informed choice means for individuals receiving services under an Individual Written Rehabilitation Plan (IWRP) (Stafford, 1996). In addition, other provisions were included to require consumer choice in the selection of vocational goals, services, and service providers under the state vocational rehabilitation services program (Stafford, 1996). In fact, a

new demonstration program was established by the amendments for projects to increase client's choice in services and service providers (Stafford, 1996).

At the system level, a State Rehabilitation Advisory Council is mandated for each state vocational rehabilitation agency that is not already subject to consumer-controlled board or commission (Stafford, 1996). The state Rehabilitation Advisory Council has significant consumer representation and is involved in the development and review of the state plan for vocational rehabilitation services (Stafford, 1996). One of the most significant expansions of consumer input requirements was the establishment of the State-wide Independent Living Council (Stafford, 1996). The State-wide Independent Living Council is consumer controlled and must jointly submit the state plan for independent living with the vocational rehabilitation agency or agencies in the states (Stafford, 1996).

Another area of emphasis in the 1992 amendments was an attempt to streamline requirements (Stafford, 1996). Consumer and advocacy groups were concerned about the time it takes to establish eligibility for vocational rehabilitation services and the amount of time and money spent on testing and evaluation, the 1992 amendments require that eligibility be established within 60 days of application and that state agencies rely, to the extent appropriate, on existing medical and other information to establish and document eligibility for services (Stafford, 1996). In addition, consumer and advocacy groups were also concerned that state agencies were not serving those individuals with the most severe disabilities (Stafford, 1996). In response to this concern, the 1992 amendments establish a presumption that an individual can benefit from vocational rehabilitation services in terms of reaching an employment outcome and that a state vocational rehabilitation agency would have to establish clear and convincing evidence to refute this presumption (Stafford, 1996). Also, the 1992 amendments also make

clear that state vocational rehabilitation agencies can assume that an individual who is receiving social security benefits (SSDI and/or SSI) can be presumed to have met certain elements of the eligibility criteria but make clear that eligibility for vocational rehabilitation services is still determined on an individualized basis (Stafford, 1996).

The 1992 amendments also emphasized targeting populations that are traditionally unserved or underserved (Stafford, 1996). In addition, the 1992 amendments required 1 percent of funds appropriated for Titles II, III, VI, VII, and VIII to be used to recruit minority individuals into the field of rehabilitation; to financially assist historically black colleges and universities and other institutions of higher education whose minority enrolment is 50 percent or more to prepare students for careers in rehabilitation; and to provide outreach and capacity building to minority entities, including institutions of higher education and non-profit and for profit agencies (Stafford, 1996).

A major focus of the 1992 amendments is the integration of individuals with disabilities into society (Stafford, 1996). The term rehabilitation facility was replaced with the broader term community rehabilitation programs to acknowledge that services were being provided in alternative settings, especially settings in the community as opposed to segregated settings in facilities (Stafford, 1996). In addition, the 1992 amendments add new Individual Written Rehabilitation Plan (IWRP) provisions related to documentation of placements in integrated settings and mandate that assessment be carried out in the most individualized and integrated settings, consistent wit the informed choice of the individual (Stafford, 1996).

The most recent amendments to the Rehabilitation Act are the Rehabilitation Act Amendments of 1998. On Friday, August 7, 1998, President Clinton signed into law the Workforce Investment Act, which includes the 1998 Amendments to the Rehabilitation Act and

reauthorizes that Act for 5 years (Schroeder, 1998). There are several areas the 1998 Amendments will strengthen the public rehabilitation program and will be described below. The first area is in expanding consumer choice - State vocational rehabilitation agencies, in consultation with their State Rehabilitation Councils, are required to develop and implement policies and procedures to afford opportunities for applicants for services and eligible individuals to exercise informed choice throughout the rehabilitation process (Schroeder, 1998). The agencies must also provide information and the necessary support services to assist applicants and eligible individuals in making informed choices (Schroeder, 1998). Also, the 1998 amendments changed the name of the Individualized Written Rehabilitation Program to the Individualized Plan for Employment (IPE) in order to emphasize the employment focus of the vocational rehabilitation program (Schroeder, 1998). In addition, the IPE provisions in the 1998 Amendments expand upon the role of the eligible individual as a collaborating partner in the development, implementation, monitoring, and evaluation of his or her own plan (Schroeder, 1998). The 1998 Amendments also streamline the provisions for the state plan for vocational rehabilitation services by reducing the former 36 plan provisions to 24, and by limiting the circumstances under which a new State plan or plan amendment must be submitted to the Rehabilitation Services Administration (Schroeder, 1998).

The 1998 Amendments further simplify and streamline eligibility determinations by establishing presumed eligibility for disabled individuals who are recipients of Supplemental Security Income (SSI) or beneficiaries of Social Security Disability Insurance (SSDI) payments (Schroeder, 1998). The Amendments also streamline the Individualized Plan for Employment (IPE) by eliminating unnecessary content and by requiring that the plan be amended only when substantive changes in the employment goal, services, or in service providers are made

(Schroeder, 1998). The 1998 Amendments also requires that an individual's employment outcomes be consistent with the person's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice (Schroeder, 1998). In addition, the 1998 Amendments eliminates the need for an extended evaluation prior to determining that an individual with a significant disability is ineligible for vocational rehabilitation services allowing for the use of trial work experiences, including on-the-job supports and/or training, before a state vocational rehabilitation agency can determine an individual to be ineligible for services due to the severity of the individual's disability (Schroeder, 1998).

The 1998 Amendments also improve the due process requirements by requiring State Vocational Rehabilitation agencies to implement policies and procedures relating to mediation of disputes between individuals and the agency, in addition to providing for formal hearings before impartial hearing officers (Schroeder, 1998). In addition, the 1998 Rehabilitation Amendments includes numerous provisions designed to link the vocational rehabilitation program and the workforce investment system, including common definitions, common reporting requirements on program outcomes, and requirements for cooperative agreements between vocational rehabilitation agencies and other entities in the system (Schroeder, 1998). These linkages between state vocational rehabilitation agencies and other entities are intended to lead to greater training opportunities and high-quality employment outcomes for individuals with disabilities (Schroeder, 1998). This concludes an overview of the legislative basis for the American State-Federal vocational rehabilitation system and now our attention will be turned towards an overview of the legislative basis of the Australian federal vocational rehabilitation system.

The legislative basis for the Australian system

The main objective for this section is to provide an overview of the federal legislation pertaining to Australia's federal vocational rehabilitation system (for the purposes of this paper defined as CRS Australia or the Commonwealth Rehabilitation Service), however, other significant Australian disability legislation will also be reviewed. Vocational rehabilitation in Australia can trace its legislative roots back to World War II when the Invalid and Old Age Pensions Act was passed in 1941 (Tipping, 1992). These Amendments created a Vocational Training Scheme for Invalid Pensioners where it was felt that pensioners should be given the opportunity to rehabilitate themselves with a view to become self-supporting (Tipping, 1992). In December 1948 the new Part VIII of the Social Services Consolidation Act came into effect providing funding and giving authority to the Australian Department of Social Services (DSS) and is noted by DSS as giving rise to the civilian rehabilitation scheme even though Part VIII of the Social Services Consolidation Act was really an expansion of the scheme which began in 1941 (Tipping, 1992).

Another major piece of legislation giving rise to the Australian vocational rehabilitation system is the Aged or Disabled Care Act of 1954 which provided a more permanent title to the vocational training scheme - the Commonwealth Rehabilitation Service (CRS) (Tipping, 1992). Prior to this it was generally known as the "Civilian Rehabilitation Scheme", the "General Rehabilitation Scheme", and the "Community Rehabilitation Scheme" (Tipping, 1992). Other important pieces of legislation passed until 1986 include: the Disabled Persons Accommodation Act of 1963, the Sheltered Employment (Assistance) Act of 1967, the Handicapped Children's Assistance Act of 1970, and the Handicapped Persons Assistance Act of 1974 (Lindsay, 1996).

In 1977 a major amendment was made to the Consolidation of the Social Services Act of 1954 that had a profound impact on the vocational rehabilitation services that CRS Australia

provided (Marwick, 1993). Prior to this (from 1941 to 1977), the Commonwealth Rehabilitation Service or CRS Australia provided vocational rehabilitation services only to Department of Social Security (DSS) benefit recipients and ex-Servicemen (Marwick, 1993). In 1977, the eligibility requirements, which previously restricted services to those receiving Government pensions or benefits was widened to permit free social and vocational rehabilitation to almost any disabled person of working age who might benefit (Marwick, 1993). In addition, the goal of rehabilitation was also widened to include independent living, as well as vocational objectives (Marwick, 1993).

Following the recommendations of the Handicapped Program Review in 1985, the Government embodied the principles of normalization in the new enabling legislation - the Disability Services Act of 1986 (Marwick, 1993). This is the most significant piece of disability legislation to come up since the 1977 amendments and had a profound impact on the role and the way services were to be carried out through the Commonwealth Rehabilitation Service (or CRS Australia as it is named today). For example, the Commonwealth Rehabilitation Service's role was clarified nationally as a tertiary rehabilitation provider, with the States responsible for medical (acute and secondary stage) rehabilitation, ending a wasteful duplication of resources (Marwick, 1993). In addition, the Disability Services Act of 1986 provided the legislative basis for the funding of organisations and of States providing services for people with disabilities these services included: accommodation support, respite care, supported employment, competitive employment, training and placement, advisory and information services, individual assessment and program planning, and the Commonwealth Rehabilitation Service (or CRS Australia as it is called today) (Marwick, 1993).

One of the most significant aspects of the legislation was its attempt to link funding of organisations to their demonstrated capacity to achieve specific, agreed outcomes for participants in their services (Lindsay, 1996). In addition, the Disability Services Act established two new types of service - one was the competitive employment, training and placement (CETP) service, designed to assist people with disabilities to obtain and retain paid employment in the mainstream labour market and the second service type was supported employment services, developed to assist people for whom competitive employment at award wages is not a realistic option (Lindsay, 1996). The target group eligible for vocational rehabilitation consists of persons who:

> Have attained 14 years of age but have not attained 65 years of age and have a disability that: is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments and results in a substantially reduced capacity of the person to obtain or retain unsupported paid employment or to live independently (Disability Services Act, 1986, Part III).

Persons with psychiatric disabilities were initially excluded from coverage in the Disability Services Bill but later included in the Disability Services Act in response to pressure from advocates for this group (Lindsay, 1996). The Disability Services Act was also accompanied by a Statement of Principles and Objectives to be followed in the administration of the legislation and be applied to individual services (Lindsay, 1996). The principles recognised that people with disabilities have the same rights as do other members of society and advocated the application of "the least restrictive alternative" principle in assisting them to realize their individual potential (Lindsay, 1996). The Objectives related more directly to service delivery, covering issues such as a focus on consumer and integration of disability services with

mainstream services, where possible, or a community-based focus for specialist services where these are necessary (Lindsay, 1996).

In 1992 amendments were passed to the original Disability Services Act of 1986. The Disability Services Act set a limit of five years for existing services to upgrade in order to conform to the Principles and Objectives of the Act (Lindsay, 1996). On 30 of June 1992 many services had failed to satisfy the Government that their operations conformed to the Principles and Objectives of the Act - this was particularly the case for sheltered workshops and activity therapy centers (Lindsay, 1996). The major objective of the 1992 amendments to the Act was to extend the deadline for compliance from June 1992 to June 1995 when all services were required to comply fully with the original Disability Service Act (DSA) Principles and Objectives (Lindsay, 1996). In 1993, in response to sustained, intense opposition to the proposed changes to sheltered workshops the Government was forced to modify its position - sheltered workshops were to remain eligible for Commonwealth funding so long as they could meet the Disability Services Standards and improve their focus on open employment for the majority of workshop participants (Lindsay, 1996).

Another important piece of legislation worth mentioning is the Disability Discrimination Act of 1992. In 1992 the Federal Government passed the Disability Discrimination Act as part of its social justice agenda for people with disabilities (Ford, 1998). The objectives of this Act is to eliminate, as far as possible, discrimination against persons on the grounds of disability in the areas of: work, accommodation, education, access to premises, clubs and sport; and the provision of goods, facilities, services and land: and existing laws; and the administration of Commonwealth laws and programs; and to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and to

promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community (Disability Discrimination Act, 1992, Section three).

To recap and consolidate the above information the American federal vocational rehabilitation system is mandated or funded firstly by the Rehabilitation Act of 1973 and secondly by the Americans with Disabilities Act of 1990. On the other hand, the Australian federal vocational rehabilitation system (defined in this paper as CRS Australia or formally the Commonwealth Rehabilitation Service) is mandated or funded by the Disability Services Act of 1986. All of these Acts contain principles and objectives fostering the independence of persons with disabilities towards full participation as members of the community. We now turn our attention to comparing the roles of the American State-Federal vocational rehabilitation system with the Australian federal rehabilitation system.

Roles of the two systems

For the purposes of this paper the roles of the two systems will be compared and contrasted under the following themes but not limited to: funding sources, eligibility requirements of clients referred to the two different systems, role of the vocational rehabilitation counselor, and the role that the vocational rehabilitation system plays in servicing indigenous populations.

In America, the Rehabilitation Services Administration was established by Congress as the principal Federal agency authorized to carry out Titles I, III, VI, VII, and VIII, as well as specified portions of Title V of the Rehabilitation Act of 1973, as amended and the entirety of the Randolph-Sheppard Act, as amended, and the Helen Keller National Center for Deaf-Blind Youth and Adults Act (Rehabilitation Services Administration web page, 2001, page 1). The RSA provides national leadership for, and administration of, basic State and formula grant programs, the Randolph-

Sheppard vending facilities and Helen Keller National Center programs, and evaluates all authorized programs to improve management and effectiveness (Rehabilitation Services Administration web page, 2001, page 1). These programs develop and implement comprehensive and coordinated programs of vocational rehabilitation, supported employment, and independent living, for individuals with disabilities, through services, training, research and economic opportunities, in order to maximize their employability, independence, and integration into the workplace and the community (Rehabilitation Services Administration web page, 2001, page 1). The State-Federal Vocational Rehabilitation Services Program provides funding to approximately 56 states and territories to provide grants to states to support a wide range of services designed to help individuals with disabilities prepare for and engage in gainful employment consistent with their strengths, resources, priorities, concerns, abilities, and capabilities (RSA web page, 2001, Vocational Rehabilitation State Grants Section). Individuals with a physical or mental impairment that results in a substantial impediment to employment who can benefit in terms of an employment outcome and who require vocational rehabilitation (VR) services are eligible for assistance (RSA web page, 2001, Vocational Rehabilitation State Grants Section). Priority must be given to serving individuals with the most significant disabilities if a state is unable to serve all eligible individuals (RSA web page, 2001, Vocational Rehabilitation State Grants Section).

Funds are distributed to states and territories based on a formula that takes into account population and per capita income to cover the cost of direct services and program administration (RSA web page, 2001, Vocational Rehabilitation State Grants Section). Grant funds are administered by vocational rehabilitation agencies designated by each state (RSA web page, 2001, Vocational Rehabilitation State Grants Section). The state-matching requirement is 21.3 percent, except the state share is 50 percent for the cost of construction of a facility for community

rehabilitation program purposes (RSA web page, 2001, Vocational Rehabilitation State Grants Section). For the fiscal year 2001 approximately $2,375,792,000 was appropriated to the various U.S. States and Territories to carry out vocational rehabilitation services (RSA web page, 2001, Vocational Rehabilitation State Grants Section). In Australia, the funding source for vocational rehabilitation services is the Department of Family and Community Services (FaCS). The Department of Family and Community Services provides funding for CRS Australia to carry out vocational rehabilitation services (Family and Community Services web page, 2001, Section four). Last year, CRS Australia was allocated approximately $103,000,000 to provide vocational rehabilitation services to persons between the ages of 14 and 65 years of age; and have a disability that is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments; and results in a substantially reduced capacity of the person: to obtain or retain unsupported paid employment; or to live independently (Family and Community Services web page, 2001, Section four). Also, CRS Australia operates as a business unit within Family and Community Services (FaCS) under the Disability Services Act of 1986 with a purchaser-provider arrangement consisting of a service level agreement with the Disability Payments and Services Branch of FaCS (Family& Community Services web page, 2001, Section 4).

Eligibility

Who is eligible for state-federal vocational rehabilitation services in America and Australia (for the purposes of this paper is defined as CRS Australia or previously the Commonwealth Rehabilitation Service)? In America, a client is eligible for vocational rehabilitation services if that person: 1. Is an individual with a disability, i.e., has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment, and can benefit in terms of employment outcomes from vocational rehabilitation

services provided pursuant to title I, III, or VI. (Andrew, 2000) (a substantial impediment is one that will prevent or make very difficult obtaining, retaining, or preparing for employment consistent with the person's capacities and abilities) 2. Requires vocational rehabilitation services to prepare for, secure, retain, or regain employment (Andrew, 2000). Also, the 1992 Amendments to the Rehabilitation Act of 1973 require that eligibility be established within 60 days of application and that state agencies rely, to the extent appropriate, on existing medical and other information to establish and document eligibility for services (Stafford, 1996). In addition, priority must be given to serving those with the most severe disabilities first and the 1992 amendments requires that states define who are the individuals with the most severe disabilities and develop mechanisms for prioritizing services to those with the most severe disabilities (Stafford, 1996). In addition to this, the 1998 amendments further simplify and streamline eligibility determinations by establishing presumed eligibility for disabled individuals who are recipients of Supplemental Security Income (SSI) or beneficiaries of Social Security Disability Insurance (SSDI) payments (Schroeder, 1998).

In Australia, a person is eligible for vocational rehabilitation services if they have attained 14 years of age but have not attained 65 years of age; and has a disability that: "is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments; and results in a substantially reduced capacity to the person: to obtain or retain unsupported paid employment or to live independently" (Disability Services Act, 1986, Part III). In addition, a rehabilitation program is only to be provided to an Australian citizen; or a person resident in Australia whose continued presence in Australia is not subject to a limitation as to time imposed by a law of the Commonwealth (Disability Services Act, 1986). Unlike in America, Australia's federally funded vocational rehabilitation provider (CRS Australia) does

not have a provision stating that it must serve those with the most severe disabilities first (J. Cousins, personal communication, October 10, 2001). Individuals with more severe disabilities are usually referred to Specialized Employment Agencies who can provide both the funding and the on-the-job support that may be required (J. Cousins, personal communication, October 10, 2001).

In America, the role of the Rehabilitation Counselor in the state-federal vocational rehabilitation system seems to have changed from being a direct provider of services to being more of a coordinator and purchaser of services. The following information was gathered through phone interviews and research of the literature. The average caseload in the United States state-federal vocational rehabilitation system seems to vary from state to state but on average appears to be between 90-150 clients at any one time (J. Haugh, personal communication, October 19, 2001). Currently, the American state-federal vocational rehabilitation system does not have to compete with private vocational rehabilitation providers for clients (except in the case of the State of Florida) and are the sole agency designated for federal funding to provide vocational rehabilitation services (J. Haugh, personal communication, October 19, 2001). In terms of time spent with a client to achieve closure it appears that the average time an individual is a client of vocational rehabilitation services is approximately 2-3 years (J. Haugh, personal communication, October 19, 2001). It also costs on average approximately $1500 per case per year to deliver a vocational rehabilitation program (J. Haugh, personal communication, October 19, 2001). In regards to job placement, since there is an emphasis on servicing persons with the most severe disabilities, rehabilitation counselors tend to refer job placement services out to community rehabilitation program (CRP) vendor (Ford, 1999). In fact, only a minority (22%) of the individuals served by the public rehabilitation

system actually receive any job placement services from their counselors or do not receive any placement services (Ford, 1998). Independent living programs are carried out through the Independent Living Councils or Centers around the nation (J. Haugh, personal communication, October 19, 2001).

In Australia, it appears that rehabilitation counselors are more responsible for delivering services such as counseling and job placement. For example, the average caseload of a rehabilitation counselor working for CRS Australia is approximately 30-50 persons at any one given time depending on the counselor's role(s) within the organization (J. Cousins, personal communication, October 10, 2001). However, it appears that the average time a client spends in a vocational rehabilitation program is shorter - approximately 8 months to one year (Cousins, personal communication, October 10, 2001). This is probably due to the fact that Australia's vocational rehabilitation system does not emphasize servicing those with the most severe disabilities first (Cousins, personal communication, October 10, 2001). Persons with more severe disabilities and requiring on-going job support are served mostly by competitive employment, placement and training programs (CETPS) and supported employment programs (Ses) funded through the Disability Services Program - these clients are defined as having a permanent or likely to be permanent (with medium to high support needs) disability and who require ongoing support to gain and retain employment (Marwick, 1993). On average, it costs about $2500 to deliver a vocational rehabilitation program to a client until closure in Australia (A. Talbot, personal communication, October 10, 2001). In regards to job placement, some units of CRS Australia (mostly the bigger ones) often employ an Employment Consultant to provide job development and placement services otherwise they are provided directly by the rehabilitation counselor (or rehabilitation consultant as called in CRS Australia) or sometimes outsourced to

specialized employment agency especially in cases of persons with more severe disabilities (A. Talbot, personal communication, October 10, 2001). Also, Australia's vocational rehabilitation federal agency (CRS Australia) does provide independent living programs (800 nationally) and these are specifically for clients who do not have a vocational goal now or in the foreseeable future; or whose needs are not more appropriately or better met by a community, state or employer body or bodies (CRS Australia intranet web page, 2001, Independent Living Section). In addition, it appears that CRS Australia may have to compete with private vocational rehabilitation agencies in the future. For example, CRS Australia is currently involved in an integrated two-part trial - the assessment trial and contestability trial (Family and Community Services web page, 2001, A & C Trial Section). In the assessment part of the trial, CRS Australia is piloting a program designed at identifying needs of persons with disabilities and placing them into the appropriate services (there has been referral of persons with disabilities to inappropriate services due to inexperienced and untrained public servants) and in the contestability part of the trial private vocational rehabilitation agencies are getting a chance to see how effectively they can work persons with disabilities traditionally sent to CRS Australia (Family and Community Services web page, 2001, Section on A & C Trial). Time will tell whether or not CRS Australia will have to compete with private vocational rehabilitation providers in the future. We now turn our attention to what each country (USA and Australia) are doing to provide vocational rehabilitation services to indigenous populations. Indigenous being defined as the Native American or American Indian persons in America and Aboriginal or Torres Strait Islander persons in Australia.

Indigenous persons and vocational rehabilitation

To better meet the needs of one underserved group, Section 130 of the Rehabilitation Amendments of 1978 created provisions for special vocational rehabilitation programs for Native Americans (Faubion et al, 1998). Funding for the American Indian Vocational Rehabilitation projects did not become available until 1981, however, at which time the Navajo tribe received funding for the first project (Faubion et al, 1998). The American Indian Vocational Rehabilitation projects are typically referred to as "130 Projects" because the section of the Rehabilitation Act that authorizes the programs is Section 130 (Fabion et al, 1978). Since 1981, the number of 130 Projects has grown steadily from the initial Navajo project to the 39 projects that currently exist (Faubion et al, 1998).

The rationale for creating vocational rehabilitation service delivery system for American Indians that was supplemental to the state vocational rehabilitation (VR) agency included several issues (Fabion et al, 1998). These include: American Indians were (and remain) under represented in state VR caseloads, for American Indians who do apply for services from the state VR system, fewer are accepted, and those individuals who are accepted have poorer rehabilitation outcomes than white VR applicants (Fabion et al, 1998). Given the unique cultural experiences of the American Indians and their resulting distrust of dominant social institutions, representatives of programs such as the state-federal vocational rehabilitation system must develop greater sensitivity not only to the outcomes of history but also to the need to create service delivery mechanisms culturally relevant to this population (Fabion et al, 1998). For American Indians with disabilities, the 130 Projects are just such a mechanism (Fabion et al, 1998).

In addition to the above, I conducted a phone interview with Mr. Stephen (Corky) West on October 24th, 2001 from the Oneida Nation Vocational Rehabilitation Services Program. Mr. West (2001) indicated that the Oneida Nation, along with all the other tribes in receiving grants for Vocational Rehabilitation Service Projects for American Indians with Disabilities are authorized to provide vocational rehabilitation services specifically to American Indians under the Rehabilitation Act of 1973, Title I, Sec. 121, as amended by the 1998 Amendments (S. West, personal communication, October 24, 2001). Mr. West (2001) stated that the main difference he provides vocational rehabilitation services different to the traditional vocational rehabilitation program is by incorporating traditional American Indian healing practices into the Individual Employment Program (IEP) and providing lots of choice to the client as to whom they can use for such practices (S. West, personal communication, October 24, 2001). For the fiscal year 2001, the U.S. government provided approximately $23,998,000 for Vocational Rehabilitation Service Projects for American Indians with Disabilities (S. West, personal communication, October 24, 2001).

In Australia, there are no specialized programs of vocational rehabilitation services specifically targeted and run by Aboriginal or Torres Strait islander people unlike that in the United States. However, CRS Australia is currently conducting research into the vocational rehabilitation of aboriginal persons with disabilities (J. Cousins, personal communication, October 10, 2001). In addition, at the CRS Australia Katherine unit, rehabilitation consultants are providing outreach services to aboriginal communities on a once a month basis, firstly, to inform aboriginal communities and other outlying communities (i.e., cattle stations) regarding the services that CRS Australia provides and secondly providing those services when appropriate (J. Cousins, personal communication, October 10, 2001). Also, CRS Australia publishes special

pamphlets aimed at encouraging aboriginal persons to access CRS Australia's services in language that is understandable to them (J. Cousins, personal communication, October 10, 2001). In addition to this, CRS Australia employ aboriginal liaison officers and aboriginal rehabilitation consultants to provide information, advocacy, and rehabilitation services in areas of high aboriginal populations to encourage aboriginal persons to access our services (J. Cousins, personal communication, October 10, 2001). This concludes the comparison of Australia's federal vocational rehabilitation system to America's state-federal vocational rehabilitation system. It should be noted that the author has only covered a handful of areas between the two systems and further information about other areas can be found by reviewing the information found in today's current literature. We now turn our attention to the current philosophic direction of vocational rehabilitation in American as compared to Australia.

Current philosophic direction of the two systems

An overview of America's current philosophic direction of vocational rehabilitation will be presented in its entirety first then an overview of Australia's current philosophic direction will be presented. For the American section we will explore the following themes: brief history of philosophy in vocational rehabilitation, changes in the nature of work, growing diversity in the workforce, changes in the nature of disability, advances in rehabilitation and medical technology, and the effects of the changing nature and strategies of service delivery. In addition, we will explore the concept of consumer direction, rights awareness, rehabilitation education and the current philosophy of the rehabilitation education institutions, and recent legislation prompting change in vocational rehabilitation.

Traditionally, in America, rehabilitation has been a reactive rather than a proactive profession (Barrett & Benshoff, 1995). Rehabilitation laws, significant program developments,

rehabilitation education, and similar activities have been based on past experience, often with little thought given to future needs (Barrett & Benshoff, 1995). For example, the earliest rehabilitation efforts, in the 1920's, were aimed at rehabilitating World War I veterans and unemployed industrial workers who had experienced physical disabilities (Barrett & Benshoff, 1995). Later, as public and professional awareness of the other disability types grew and attitudes changed, additional disability groups were added to the rehabilitation caseload (Barrett & Benshoff, 1995).

There has been a shift in the United States from an industrially based manufacturing economy to a business-centered service economy, with the majority of jobs in the service sector (Barrett & Benshoff, 1995). Increasingly, service sector jobs will require technological training, familiarity, and skills to operate computerized equipment (and have greatly since the article being cited was published) (Barrett & Benshoff, 1995). This, in turn, will require more educational requirements for better jobs which will result in persons with disabilities needing even more access to educational opportunities (Barrett & Benshoff, 1995). While many jobs will continue to be available in large corporations, the greatest job growth will be in small, developing companies with fewer than 100 employees (Barrett & Benshoff, 1995). This will have major implications since the American with Disabilities Act (ADA) now holds small firms (those with at least 15 employees) to the same standards of non-discrimination on the basis of disability (Barrett & Benshoff, 1995).

In addition to the above, the work force will grow increasingly diverse, with one of the most profound changes being the aging of the workforce (Barrett & Benshoff, 1995). Older workers are more likely to become disabled as a result of the aging process and will use greater numbers of assistive devices, thereby boosting technology development (Barrett & Benshoff,

1995). Older workers will naturally have slower recovery and recuperation times, which could jeopardize successful rehabilitation and return to work (Barrett & Benshoff, 1995). In addition, the age of the workforce will directly affect training for and provision of rehabilitation services - many rehabilitation practitioners, administrators, and educators joined the rehabilitation field in the 1960's and 1970's and will leave the field in large numbers through retirement and career shifts in the near future (Barrett & Benshoff, 1995).

There will also be changes in nature of disability through changing population demographics in the United States (Barrett & Benshoff, 1995). For example, by the year 2050, one-half of the population will be African-American, Hispanic, Native American, or Asian American (Barrett & Benshoff, 1995). Except for Asian Americans, minorities tend to be less well educated and consequently qualify for the lowest paid, higher risk jobs and as a result are more apt to suffer disabling injuries on these jobs and are less likely to have health care coverage (Barrett & Benshoff, 1995). If disabled, they will more likely become clients of the state-federal vocational rehabilitation system than of the private sector rehabilitation (Barrett & Benshoff, 1995). Also, the trend toward a multicultural society will mean that rehabilitation counselor’s responsibilities will become increasingly diverse, requiring cultural sensitivity and second-language skills (Barrett & Benshoff, 1995). In addition, emphasis on serving people with severe disabilities will continue to drive service delivery, and the nature of these severe disabilities will become increasingly complex (Barrett & Benshoff, 1995).

Advances in rehabilitation and medical technology will also have effects (and already does) on how vocational rehabilitation services are carried out. For example, advances in computer technology will and in many cases already do provide immediate access to information and resources via databases, on-line discussion groups, and text files (Barrett & Benshoff, 1995).

Also, on-line discussion groups will become national and international in nature, providing rehabilitation administrators and practitioners with access to and exchange with national and international leaders (Barrett & Benshoff, 1995). This immediate access to help and expertise could positively influence the effectiveness and efficiency of rehabilitation service delivery (Barrett & Benshoff, 1995). The 1992 and later the 1998 amendments to the Rehabilitation Act have several implications for rehabilitation service delivery. The purpose of these amendments is to empower individuals with disabilities to: (1) maximize their employment, economic self-sufficiency, independence, and inclusion and integration into society; (2) ensure that the federal government plays a leadership role in promoting the meaningful and gainful employment and independent living of individuals with disabilities; and (3) assist states and service providers in these efforts (Barrett & Benshoff, 1995). In addition, the Rehabilitation Act amendments have streamlined the intake process and made eligibility requirements less stringent, suggesting a future of easier access and participation in a less bureaucratized state-federal rehabilitation system (Barrett & Benshoff, 1995). Also, Title VII of the 1992 amendments promotes the philosophy of independent living, a philosophy that affirms consumer control, peer support, self-help, self-determination, equal access, and advocacy (Barrett & Benshoff, 1995). In addition, there is a growing consumer rights and advocacy movement for people with severe disabilities, and the government's support of those rights, the concept of "unconditional inclusion" will eventually replace the traditional concept of ″employability" (Barrett & Benshoff, 1995).

Probably one the biggest things that will effect disability policy formulation and rehabilitation service delivery will be the concept of consumer direction. Consumer Direction is a philosophy and orientation whereby informed consumers have control over the policies and practices that directly affect their lives (Kosciulek, 1999). The unifying theme in Consumer

Direction is that individual's with disabilities have the authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services (Kosciulek, 1999). Consumer direction is based on three underlying assumptions (Kosciulek, 1999). One, the presumption that consumers with disabilities are the experts on their service needs; two, that choice and control can be introduced into all service delivery environments; three, consumer direction should be available to all, regardless of payer (Kosciulek, 1999).

The conceptual framework of Consumer Direction consists of four components (Kosciulek, 1999). These include: (1) the ability of consumers with disabilities to control and direct the delivery of services, (2) ensuring that consumers have a choice from a range of viable rehabilitation options, (3) information and support available that will enable consumers to take advantage of rehabilitation services, (4) level and quality of participation that consumers have at the policy making level; i.e., in policy formulation, design of rehabilitation services, and allocation of financial resources (Kosciulek, 1999). These four components merge to form a system that is directed by people with disabilities to meet their needs (Kosciulek, 1999).

Following along the lines of consumer direction we now turn our attention to the implications of advising persons with disabilities their rights regarding employment, etc. For example, if consumers are to successfully advocate for themselves in the workplace, they must be well-versed regarding both their rights and responsibilities set forth in the American with Disabilities Act (ADA) (Koch, 2000). Therefore, rehabilitation professionals are advised to conduct an initial assessment of the consumer's awareness of the provisions, eligibility standards, grievance policies, and remedies that are promulgated in ADA regulations (Koch, 2000). In addition, as part of the assessment process, consumers need to know what their rights

are, but they also need to know the limitations of the protections afforded by the American with Disabilities Act (ADA) and the Family and Medical leave Act (FMLA) of 1993 (Koch, 2000). The rehabilitation amendments of 1998 back this up with its emphasis on expanding consumer choice and ensuring that they have informed choice throughout the rehabilitation process (Schroeder, 1998).

The 1992 amendments to the Rehabilitation Act have also brought about changes and implications for Rehabilitation Education. For example, the 1992 amendments to the Rehabilitation act contain a definition of qualified personnel requiring that state vocational rehabilitation agencies establish procedures for hiring individuals who meet state or national certification, registry, or licensure standards applicable to that discipline (Stude, 1995). As a result, rehabilitation education programs will be called on to produce more graduates than ever before to meet state agency needs (Stude, 1995). Also, advances in technology both in terms of assistive devices for persons with disabilities and in the areas of education and learning will need to be assimilated into rehabilitation education programs so that they can produce personnel qualified to assist clients in accessing this new technology and reach students who would otherwise be deprived of the opportunity for professional education (Stude, 1995). In addition, universities will need to increase the opportunities for input and active involvement in the education process by the individuals whom the vocational rehabilitation delivery systems, both public and private, are designed to serve (Stude, 1995). Lastly, there is a distinct trend toward individual states passing licensing laws for counselors - many of these laws cover rehabilitation counselors (Stude, 1995). Rehabilitation education programs and rehabilitation educators will need to become more active within the professional organizations that are developing these laws (Stude, 1995).

In addition to the above, the 1998 Amendments to the Rehabilitation Act have had a big impact on service delivery in the state-federal vocational rehabilitation system. We will provide a quick overview of those changes in the following paragraph.

One of the things the 1998 Amendments did was expand consumer choice. For example, state vocational rehabilitation agencies are required to develop and implement policies and procedures to afford opportunities for applicants for services and eligible individuals to exercise informed choice throughout the rehabilitation process (Schroeder, 1998). The 1998 Amendments also streamlined administrative procedures by reducing the former 36 state plan provisions to 24, and by limiting the circumstances under which a new State plan or plan amendment must be submitted to the Rehabilitation Services Administration (Schroeder, 1998). Also, the 1998 amendments put a focus on increasing high quality outcomes (Schroeder, 1998). In addition, the 1998 amendments improved due process by requiring state vocational rehabilitation agencies to implement policies and procedures relating to mediation of disputes between individuals and the agency, in addition to providing for formal hearings before impartial hearing officers (IHO) (Schroeder, 1998). Finally, the 1998 Amendments include numerous provisions designed to link the vocational rehabilitation program and the workforce investment system, including common definitions, common reporting requirements on program outcomes, and requirements for cooperative agreements between vocational rehabilitation agencies and other entities in the system (Schroeder, 1998). We now turn our attention to the current philosophic direction of Australia's federal vocational rehabilitation program.

Australian philosophy

For the purposes of this paper Australia's current philosophic direction will be reviewed from the 1980's onwards since this is when foundation was laid for Australia's current direction

in vocational rehabilitation. This will be reviewed by covering legislation and political changes from that time period onwards. In addition, organizational changes will be examined to determine their impact on current philosophy.

By 1983 the scene was set for radical change to the organisation, provision and funding of disability services (Lindsay, 1995). A number of developments contributed to this and probably one of the most significant was the increasing influence in Australia of the philosophy of "normalization" which developed in Scandinavia and North America during the 1960's (Lindsay, 1995). Supporters of normalization argued that people with disabilities should be assisted to establish patterns of life that were close to, or the same as, those of society generally (Lindsay, 1995). The greater the adherence to this objective the greater the chances of enhancing the personal competence, presentation and self image of the disabled person (Lindsay, 1995) As these improved, so did the wider community's acceptance of the disabled person, thus contributing to their integration into the general community (Lindsay, 1995). These views found practical expression in moves to accommodate people with disabilities in their homes and communities rather than in institutions (deinstitutionalization), to assist them to access services developed for the general public rather than disability-specific services (mainstreaming), to participate in ordinary schools (integration), and to work in the open labour market rather than in sheltered workshops (Lindsay, 1995).

Another major force for change was the heightened community awareness of disability related issues as a result of the International Year of Disabled Persons, in 1981 (Lindsay, 1995). While it focused mainly on physical disabilities, the Year provided a vehicle for disabled people themselves, in their push for greater autonomy and wider recognition of their rights as manifested, for example, in the Independent Living Movement (Lindsay, 1995). At the same

time the Survey of Handicapped Persons conducted by the Australian Bureau of Statistics in 1981 provided, for the first time in Australia, national information on the numbers of people with disabilities, the nature of these disabilities, the services they needed and the extent to which these needs are met (Lindsay, 1995).

In 1983 the Australian Government instituted a review of programs developed under the Handicapped Persons Assistance Act that had been passed in 1974 and from which most current disability services derived their authority (Lindsay, 1995). The Review took the unprecedented step of involving people with disabilities themselves, and their families, as part of an extensive and comprehensive consultation process - this consumer focus has remained central to policy development ever since (Lindsay, 1995). The review reported its finding in 1985, in a document entitled "New Directions" and its conclusions were sobering (Lindsay, 1995). People with disabilities, their families and carers were all extremely critical of existing services based on institutional living arrangements, sheltered workshops and activity therapy centers (Lindsay, 1995). They objected to the authoritarianism and paternalism of service operators, which denied them any input, let alone control, over the way in which services were run (Lindsay, 1995). They were angry about the negative images of disability, and of people with disabilities, still held by the general community and by many service providers (Lindsay, 1995). Almost all of the disabled participants in the Review, regardless of the nature of their disability, wanted improved access to mainstream services rather than the further development of segregated services - they wanted to live in a community setting, have access to paid employment, opportunities for community participation, community acceptance and a choice in the services they used (Lindsay, 1995). In addition, it reported the widely held view that the Commonwealth

Rehabilitation Service (CRS Australia) needed to be more accessible and responsive to the needs of persons with disabilities (Tipping, 1992).

All of these things were to have a profound impact on the way the Commonwealth Rehabilitation Service (CRS Australia) were to provide services to persons with disabilities. The biggest of these was the sale of the Commonwealth Rehabilitation Service Centers with a view of moving to a model with more accessible regional units in the community and relying on more community services to provide the services traditionally provided at the Commonwealth Rehabilitation Service Centers (Tipping, 1992). For example, the Commonwealth Rehabilitation Service Centers typically employed a medical doctor who provided medical services - the future, smaller, regional units would begin sending clients to doctors at hospitals in the community for the same services (Tipping, 1992). In addition, further attention was given to client rights in the mid-1980's with the development of written Individual Program Plans by the Commonwealth Rehabilitation Service (CRS Australia) (Tipping, 1992). Also, the Commonwealth Rehabilitation Service (CRS Australia) gave a commitment to an "outreach" approach to rehabilitation by increasing the number of country regional units with an emphasis on efficient use of available community resources (Tipping, 1992).

The 1983 Handicapped Program's review led to the passage of the Disability Services Act in 1986 which replaced the Handicapped Persons Assistance Act (HPAA), which was repealed (Lindsay, 1995). The Disability Services Act was accompanied by a Statement of Principles and Objectives to be followed in the administration of the legislation and to be applied to individual services (Lindsay, 1995). The Principles recognized that people with disabilities have the same rights as do other members of society and advocated the application of "the least restrictive alternative" principle in assisting them to realize their individual potential (Lindsay,

1995). The Objectives related more directly to service delivery, covering issues such as a focus on the consumer and integration of disability services with mainstream services, where possible, or a community-based focus for specialist services where these were necessary (Lindsay, 1995). This led further attention to client rights and the development of such things as the written Individual Program Plans (IPP) by the Commonwealth Rehabilitation Service (CRS Australia) (Tipping, 1992). Complementing these principles and objectives was the passage of the Disability Discrimination Act in 1992 which are to eliminate discrimination, as far as possible, to ensure the right of people with disabilities to equality before the law, in so far as this is practicable, and to promote acceptance within the community of the fundamental rights of people with disabilities (Lindsay, 1995).

Another major change in direction occurred in 1987 when the Commonwealth Government encouraged the Commonwealth Rehabilitation Service (CRS Australia) to develop and adopt more business-like practices (McMullen & Mitchell, 1999). A Trust Account was established as part of the funding arrangements of the service that not only permitted the Commonwealth Rehabilitation Services (CRS Australia) to re-invest its revenue into services but also required the Commonwealth Rehabilitation Service to account for its operations using more business-like principles (McMullen & Mitchell, 1999). In only the first year of operation of the Trust Account there was clear evidence that this approach to rehabilitation delivery facilitated a more efficient approach to the use of resources, but more importantly this approach has resulted in a focus of maximizing client outcomes (McMullen & Mitchell, 1999).

The emerging neo-classical economic rationalist policies, driven by an increasing globalized economy, has pushed the Federal Government to embrace the policies of macro and micro economic reform (Paramenter, 1999). The role of macro-economic reform is to reduce

dependence on overseas capital and hence reduce the current account deficit (Paramenter, 1999). The implication of micro-economic reform is to enhance competition as a means to efficiency and thus reduce cost of production (Paramenter, 1999). It is about individuals using their resources to achieve the highest level of satisfaction possible - the main ingredient being that people must be free to choose how they use their resources (Paramenter, 1999). This is the very argument being used to support the privatisation of disability and other welfare services (Paramenter, 1999).

This very philosophy is being applied to CRS Australia at the moment starting with the view in 1998 of corporatizing CRS Australia. For example, CRS Australia now operates as a business unit within Family and Community Services under the Disability Services Act of 1986 (Family and Community Services web page, 2001, Section four). Also, it has a purchaser-provider arrangement consisting of a service level agreement with the Disability Payments and Services Branch of Family and Community Services (Family and Community Services web page, 2001, Section four). In addition, it has a strong focus on recovering costs in such markets as: worker's compensation, motor vehicle accident, disability insurance, income protection, and superannuation markets, and form occupational health and safety consultancies (Family and Community Services web page, 2001, Section four). However, CRS Australia maintains a primary responsibility to service clients unable to pay for rehabilitation services (McMullen & Mitchell, 1999).

In addition to the above CRS Australia is also participating in two trials that could have a profound impact on the way in carries out its services - assessment and contestability trials. The integrated trial will enable the Government to test: the potential for a more detailed assessment process including an assessment of: work capacity to provide more meaningful information than

current processes; the extent to which the more detailed assessment enables the identification of better targeted interventions; and the private sector's capacity to deliver specified vocational rehabilitation services (Family and Community Services web page, 2001, A & C Trial Section). In addition the trial will also look at the feasibility of separating purchaser functions including the more detailed assessment of people with disabilities and broad specification of necessary interventions, from actual program provision (Family and Community web page, 2001, A & C Trial Section). Basically, it is looking at the possibility of having CRS Australia compete with the private vocational rehabilitation providers as a way of reducing costs. However, these trials are to go for at least a couple of years and the full impact of the results of these trials may not be known until at least another 3 years. In addition, there is a good possibility that the conservative Coalition government may be voted out and replaced by the more liberal Labor government in the next couple of months so that could possibly change the way the current "in" government views these things.

That concludes a review of Australia's current philosophic direction in vocational rehabilitation and also concludes the review of the literature (chapter 3). In summary, America's state-federal vocational rehabilitation system is currently strongly focused on providing consumer driven vocational rehabilitation services with an emphasis on consumer rights and them being fully informed throughout the rehabilitation process. In Australia, the federally funded vocational rehabilitation service, CRS Australia, also has a strong consumer focus but in addition there is also a focus on operating more as a private company with a view towards possibly having to compete with the private vocational rehabilitation providers for services traditionally provided by CRS Australia. We now turn our attention to chapter four and evaluating the similarities and differences between the two systems.

Chapter IV

Results

Similarities between the two systems

Briefly looking at the two systems there appears to be several similarities between them, however, further investigation revealed many more differences than similarities. The similarities between the two systems will be briefly described below. In addition to a comparison of America's state-federal vocational rehabilitation to Australia's federal vocational rehabilitation similarities we will explore similarities in areas such as disability legislation and policy.

One of the first similarities between America's state-federal vocational rehabilitation system and Australia's federal vocational rehabilitation systems is they both had their history as being started as the result of rehabilitation of returning war veterans. For example, the first federal vocational rehabilitation program in America started with the passage of The Soldier's Rehabilitation Act of 1918 designed to rehabilitate injured soldiers from World War I which led to the passage of the Smith-Fess Act that started the first civilian vocational rehabilitation program and created the first state-federal vocational rehabilitation program (Roessler & Rubin, 1995). In Australia, the first vocational rehabilitation scheme was also started with the "repatriation" of injured soldiers through the Repatriation Department (Tipping, 1992). However, a civilian vocational rehabilitation program wasn't started until 1948 and in 1955 the Commonwealth Rehabilitation Service (CRS Australia) was officially created (Tipping, 1992).

Another similarity between the two systems is the use of the Individualized Plan For Employment (IPE) (formally known as Individualized Written Rehabilitation Program – IWRP) in the American state-federal vocational rehabilitation system (Roessler & Rubin, 1995) and the

use of Individual Program Plans (IPP) by CRS Australia (Tipping, 1992). However, America's Individualized Plan For Employment (IPE) name was purposely changed from Individualized Written Rehabilitation Program (IWRP) to emphasize the employment focus of the vocational rehabilitation program (Schroeder, 1998).

In addition to this, America has similar disability discrimination laws to Australia. For example, in 1990 the American's with Disabilities Act was enacted in America giving persons with disabilities the same protections against job discrimination that women and minorities received in the Civil Rights Act of 1964 (Albrecht, 1992). In addition, it is an attempt to eliminate discrimination in other areas such as transportation, telecommunications, and harassment (Clark, 1993). In Australia, the Disability Discrimination Act of 1992 was passed to eliminate, as far as possible, discrimination against persons on the grounds of disability in the areas of: work, accommodation, education, access to premises, clubs and sport; and the provision of goods, facilities, services and land; and the administration of Commonwealth laws and programs; to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community (Disability Discrimination Act, 1992, section three).

Another similarity between the American state-federal vocational rehabilitation system and Australia's federal vocational rehabilitation system is the focus on consumer rights. For example, in America's state-federal vocational rehabilitation system agencies are required to develop and implement policies and procedures to afford opportunities for applicants for services and eligible individuals to exercise informed choice throughout the rehabilitation process

(Schroeder, 1998). In addition, the 1998 amendments to the Rehabilitation Act in America put a focus on increasing high quality outcomes and improved due process by requiring state vocational rehabilitation agencies to implement policies and procedures relating to mediation of disputes between individuals and the agency, in addition to providing for formal hearings before impartial hearing officers (IHO) (Schroeder, 1998). In Australia, the passage of the 1986 Disability Services Act ensured that certain principles and objectives would be followed in the administration of the legislation and be applied to individual services (Lindsay, 1996). These principles recognized that people with disabilities have the same rights as do other members of society and advocated the application of "the least restrictive alternative" principle in assisting them to realize their individual potential (Lindsay, 1996). The objectives relate more directly to service delivery, covering issues such as a focus on consumer and integration of disability services with mainstream services, where possible, or a community-based focus for specialist services where these are necessary (Lindsay, 1996). We now turn our attention to the differences between the two systems.

Differences between the two systems

There were several differences between America's state-federal vocational rehabilitation system and Australia's federal vocational rehabilitation system (the federal agency of CRS Australia for the purposes of this paper). These were in areas including: when each program was started, when the first rehabilitation counseling program was started, differences in types of clients served, how services where traditionally carried out, and eligibility requirements. In addition, there were differences in the average caseload of rehabilitation counselors in the two systems, time spent until closure of a vocational rehabilitation program, and services provided to the

indigenous populations. Each of these areas will be covered in an attempt to contrast the differences between the two systems in these particular areas.

One obvious difference between the two systems is that the American state-federal vocational rehabilitation system has been around a lot longer than the federal Australian vocational rehabilitation system (CRS Australia). For instance, the American state-federal system was created in 1920 with the passage of the Smith-Fess Act that allocated funding to each state – funding was determined by the ratio of its population to the total U.S. population, based on the then current census figures (Roessler & Rubin, 1995). On the other hand, Australia's federal vocational rehabilitation system (CRS Australia) was first created in 1941 with the Vocational Training Scheme for Invalid Pensioners and officially given the title of the Commonwealth Rehabilitation Service (CRS Australia) in 1955 (Tipping, 1992).

Another difference between the two systems is when the first professional rehabilitation education programs were created. In America, Public Law 565 authorized grants to colleges and universities for the training of professional rehabilitation workers leading to master's degree training programs and providing a foundation for the professionalization of the rehabilitation counselor in 1954 (Roessler & Rubin, 1995). Australia, on the other hand, did not establish a tertiary training course in rehabilitation counseling until 1974 following the release of the Griffith and Senate reports of the 1970's (Tipping, 1992).

Another major difference between the American state-federal vocational rehabilitation system and the Australian federal vocational rehabilitation system (CRS Australia) is the types of clients each system serves. For example, under current guidelines, the American system now has policies in place which require rehabilitation counselors to serve persons with more severe disabilities before those with less severe disabilities and require the state agencies to establish

clear and convincing evidence to determine an individual ineligible for services through such things as the use of trial work experiences (Schroeder, 1998). In addition, the 1992 amendments to the Rehabilitation Act presumes eligibility for disabled individuals who are recipients of Supplemental Security Income (SSI) or beneficiaries of Social Security Disability Insurance (SSDI) payments (Schroeder, 1998).

In Australia, on the other hand, eligibility to receive CRS Australia services is determined against Sections 18 and 21 of the Disability Services Act 1986 (Family and Community Services web page, 2001, section four). For instance, to be eligible to be considered for rehabilitation assistance from CRS Australia a person needs to meet certain criteria for the statutory target group, which is – between the ages of 14 and 65 and having a disability which is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments and the disability substantially restricts their capacity to obtain or retain unsupported paid employment or to live independently (Family and Community Services web page, 2001, Section four). The key words being unsupported paid employment, meaning those individuals that require supported employment are usually referred to other specialized employment agencies who can provide the funding and on-the-job continued support – meaning CRS Australia is not obligated to provide programs to persons with severe disabilities. Another main difference in eligibility is that CRS Australia provides programs to clients whose jobs are in jeopardy. For example, in some cases a vocational rehabilitation program is provided when: a client is at considerable risk of losing their job without provision of the service, the disability or injury is not work related, the needs of the client are best met through the provision of vocational rehabilitation services and not by another agency/service, and the requirements of the needs of the client are not the employers obligations under the State Equal Employment Opportunity

Legislation (Family and Community Services web page, 2001, Section four). Another major difference between America's state-federal vocational rehabilitation system and Australia's federal vocational rehabilitation system is caseload size. The research revealed that the average caseload size in America can range anywhere from 90-150 people whereas in Australia it is much smaller with between 30-50 persons at any one time. It appears that the different eligibility requirements would be responsible for this. Also, time spent until closure is considerably longer in America compared to Australia 2-3 years versus 8 months to a year in Australia. Again, this probably is due to the different eligibility requirements and the fact that the Australian system does not have to provide programs to persons who require on-going job support.

Another area where the American state-federal vocational rehabilitation system differs is that it provides separate services for its indigenous people while Australia does not. In fact, there is legislation in America that provides funding specifically for the creation of vocational rehabilitation services for Native Americans and these projects have been going for over 20 years. These projects are commonly known as the "130 Projects" or since the 1998 Amendments to the Rehabilitation Act the section 121 Projects.

One very blatant area the two systems differ is that during the course of finding research materials for this paper there was a significant difference in the amount of information available on the American state-federal vocational rehabilitation system as compared to the Australian federal vocational rehabilitation system. This is probably due to the fact that there has been legislation passed by Congress providing funding for research grants in vocational rehabilitation and for a much longer period of time. In Australia, Paramenter (1999), states that successive Australian governments have failed to recognize the need for a well-coordinated disability

research and development effort, which does not rely almost exclusively upon inexperienced public servants and accountancy firm consultants. Also, Paramenter (1999) states that there is often a tying of research monies to consultancy contracts which, in most cases, prevent peer review and open publication of the findings.

Another difference the author found is that the American state-federal system has legislation (1992 Amendments the Rehabilitation Act) in place mandating 1 percent of funds appropriated for Titles II, III, VI, VII, and VIII to be used to recruit minority individuals into the field of rehabilitation: to financially assist historically black colleges and universities and other institutions of higher education whose minority enrolment is 50 percent or more to prepare students for careers in rehabilitation; and to provide outreach and capacity building to minority entities, including institutions of higher education and non-profit and for profit agencies (Stafford, 1996). In Australia, the author came across no such legislation while researching for this paper.

Another difference the author came across when researching the two systems is the fact that the Australian federal vocational rehabilitation system (CRS Australia) appears to be heading towards privatization and may have to compete with private vocational rehabilitation providers in the future for clients traditionally served by them. In America, the state-federal system remains the sole provider and funding source of vocational rehabilitation services and does not currently compete with private vocational rehabilitation providers for clients it has always traditionally served (except in the case of the State of Florida). Also, the Australian vocational rehabilitation system (CRS Australia) does not serve or fund persons with disabilities that require on-going on-the-job support unlike the American state-federal vocational rehabilitation system that often provides services to these individuals. However, more often than

not, acts only as the funding source directing and coordinating the services and refers these individuals to community rehabilitation facilities for the assessment, placement, and on-the-job support. Another major difference between the two systems is the fact that the Australian vocational rehabilitation system (CRS Australia) is able to provide much more direct services due to having much smaller caseloads.

This concludes the results portion of this thesis and we now turn our attention to the implications of the similarities and differences between the American state-federal system and the Australian federal vocational rehabilitation system (CRS Australia).

Chapter V

Implications and Recommendations

The major difference between the American state-federal vocational rehabilitation system to the Australian vocational rehabilitation system is that it has been around a lot longer so has had more chances to review and refine the way in which it carries out its services to persons with disabilities. Also, the American system appears to have more legislation mandating funding for its services – providing funding for research, education, consumer rights, minority recruitment, etc. In addition, the sheer size of the American population (approximately 260, 000,00) to Australia's population (approximately 20,000,000) means that there will to be a lot more people to do research on and a lot more researchers providing research on the American state-federal vocational rehabilitation system. The similarities and differences will be examined from the last chapter to determine the implications for the two different systems.

Both the American and Australian vocational rehabilitation systems had their origins with the rehabilitation of returning war veterans. However, the Australian federal vocational rehabilitation system (CRS Australia) did not officially start a civilian vocational rehabilitation system until 1941. America's state-federal vocational rehabilitation system had already been operating for 21 years allowing it to gain significant experience of delivering vocational rehabilitation services, hence, more comprehensive vocational rehabilitation services earlier.

The two systems have similar disability laws but the American state-federal system seems to have legislation mandating how it is to carry out its services specifically to that system (most recently specific aspects of the 1998 amendments to the Rehabilitation Act – please see the section on the overview of the legislation presented earlier in this paper) unlike Australia's

federal vocational rehabilitation system (CRS Australia) which has general broad legislation such as the 1986 Disability Services Act. This seems to provide much clearer guidelines as to how to carry out services. The author currently works for CRS Australia and finds that this is a reoccurring problem among rehabilitation consultants – how to interpret the broad legislative language of the Disability Services Act to specific parts of service delivery whilst providing services to a person with a disability referred to CRS Australia. The author believes that if there were specific legislation mandating more specifically the appropriate action to take in certain circumstances of service delivery then there would be less confusion by current rehabilitation consultants at CRS Australia. Also, it would force CRS Australia to provide specific training in these areas, as they would be obligated to do so legislatively or be held accountable.

One difference between the two systems is in the area of rehabilitation education. In America, the Rehabilitation Services Administration provides funding to universities to provide grants to students to attend rehabilitation education programs. In five years working as a rehabilitation counselor in Australia and whilst gathering research for this paper the author came across no information stating that Australia does the same thing. Providing this type of funding would probably encourage more students to enter the field of vocational rehabilitation and hence provide more professionally qualified persons to the field of vocational rehabilitation in Australia and do research. In addition, the author knows of only one master's level rehabilitation education program in Western Australia (where the author currently resides) and that is at Curtin University of Technology in Western Australia. In addition, international exchanges with other countries such as the United States, United Kingdom, Netherlands, and Germany, etc would provide rehabilitation professionals to learn new ways of doing things and bring about the "cross-fertilization" of ideas between two countries such as Australia and the United States.

In regards to eligibility the American state-federal vocational rehabilitation system states that they must provide vocational rehabilitation services to those with the most severe disabilities first. The Australian federal vocational rehabilitation system (CRS Australia) does not have that same requirement. This appears to have made the caseloads of a typical rehabilitation counselor much higher than of a rehabilitation counselor in Australia and has led rehabilitation counselors in America to become more like rehabilitation coordinators – purchasing and coordinating services. In Australia, the caseloads are much smaller and rehabilitation counselors seem to be able to provide much more direct services to clients such as counseling and job placement and provide a lot more face-to face contact with clients. Also, it appears that the more severely disabled clients in Australia are sent directly by social services to alternative specialist employment providers – those requiring on-going on-the-job support. This set-up may prove costly to the Australian federal vocational rehabilitation system (CRS Australia) especially if they are forced to compete for clients with other private vocational rehabilitation providers.

Another area that varied greatly between the two systems was that time spent until closure. In America, the average time until closure was approximately 2-3 years. In Australia in was approximately 8 months to one year. This difference is most likely attributable to the fact that American state-federal vocational rehabilitation system is mandated to serve persons with severe disabilities first. Future research between the two systems on what services it actually provides to clients would probably bring interesting results.

Whilst compiling research for this paper, it was noted that there was enormous amount of information on the American state-federal vocational rehabilitation system and very little on the Australian federal vocational rehabilitation system. One obvious reason for this is that the American system has been around quite a bit longer (at least 21 years). However, in America,

there also has been legislation-mandating funding for research in these areas for several years. It would probably serve Australia well if more federal funding could go for disability research instead of giving money to consultants to conduct research which prevents peer review and open publication of the finding. The 1986 Disability Services Act does mandate funding for disability research however more needs to be done by Australia in this area so it can keep on improving its vocational rehabilitation services and to better identify on how to deliver services within its own unique circumstances (i.e., in its vast unpopulated geographical areas).

Another difference the author came across was in the delivery of vocational rehabilitation services to indigenous persons in the two countries. America has had legislation since 1978 mandating separate special vocational rehabilitation programs for Native Americans. Australia should seriously explore the idea of providing a similar service to Aboriginal and Torres Strait Islander people since it appears that the Native American situation parallels that of the Indigenous Persons of Australia and they have successfully been providing services for 20 years now. Attending the indigenous vocational rehabilitation conference in December 2001 in Seattle would be a good start to get ideas, etc. Also, sending Aboriginal and Torres Strait Islander rehabilitation staff to observe vocational rehabilitation practices currently provided in such places as the Oneida Nation in Wisconsin and the Navajo reservation in the south-western United States would also be a good place to start. In addition, it may be worth looking at the idea of creating similar vocational rehabilitation legislation for Aboriginal and Torres Strait Islander disabled persons.

Lastly, the possible privatization of Australia's federal vocational rehabilitation system may have profound impact on the way it provides its services. In America, the state-federal vocational rehabilitation agencies are the sole funding body for public vocational rehabilitation

services. In Australia, the federal system or agency (CRS Australia) is currently taking part in a two part integrated trial which could profoundly shape the way it provides services. They are currently trialing how effectively private vocational rehabilitation providers can provide vocational rehabilitation services to clients currently exclusively serviced by CRS Australia. If the government determines that they are effective then it may tender out the services and CRS Australia will have to compete with private vocational rehabilitation providers. However, it appears that this may take some time and early results so far indicate that CRS Australia is actually doing a pretty good job. We now turn our attention for suggestions for future research and the conclusion of this thesis.

Suggestions for Future Research

The author is the first to admit that only certain aspects of comparing and contrasting the public American state-federal vocational rehabilitation system to the Australian federal vocational rehabilitation system was covered and suggests several areas of potential further research in this area. These include but are not limited to: a comparison of vocational rehabilitation services for indigenous persons in both countries, a comparison of vocational rehabilitation services of the mentally disabled (which really wasn't covered in this thesis), and a comparison of what types of services a rehabilitation counselor actually provides in America and Australia as the caseload size of each varies greatly.

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