
**INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED**

PART 1

GENERAL PROPOSALS

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MARCH 1983

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INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED

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1. CHAIRMAN'S INTRODUCTION

On 27 August 1982 the Minister for Health, the Hon. L.J. Brereton, M.P., announced the establishment of an Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled. The Inquiry was conducted by an independent Chairman with the advisory assistance of two assessors, all operating on a full-time basis for its duration. Professional and administrative staff were provided by the (then) Health Commission and advice was also available from a number of part time consultants (full details of staffing and consultancy assistance are listed in Part 5).

The major focus of the Inquiry's investigations has been the services provided by the public sector (i.e. particularly State run "Fifth Schedule" psychiatric hospitals, public hospitals and the community health programme) and the services provided by non-profit community organisations. The activities of the private sector have not been exhaustively examined except where they have impinged on the services being examined by the Inquiry.

I would like to express my appreciation for the invaluable assistance provided by the two assessors appointed to the Inquiry (Dr. M. Sainsbury, nominated by the then Health Commission of New South Wales and Mr. T. Conoulty, nominated by the Labor Council of N.S.W.) whose task has been to evaluate all material presented to the Inquiry and to advise me on all issues raised. Responsibility for the final analysis, conclusions and recommendations, however, is mine alone.

I am pleased to record that we have been in accord on all major principles of service delivery and on the need for initiatives of the type proposed in the Report. Views did differ, however, on methods designed to give effect to some of these principles and initiatives; therefore all specific recommendations do not necessarily reflect consensus.

The staff of the Inquiry have also all worked with great enthusiasm and professionalism and I am particularly indebted for the excellence of the contributions of Ms. P. Rutledge, Executive Officer, and Mr. P. Primrose, Research Officer. I also gratefully acknowledge the contributions from the many health service employees who expressed views to the Inquiry and the wide range of community organisations and individual citizens who presented formal submissions and subsequently participated in discussions.

Constructive and helpful advice was also provided by the Inquiry's part time consultants.

Decisions about the nature of public health services are the prerogative of government, based on the best advice available to it. Much of the value of an Inquiry such as this lies in the opportunity to ensure that, within the scope of specific terms of reference, a wide range of viewpoints, available data and material, is gathered and analysed and specific proposals then presented to government. This process has been facilitated by the extent of the response to the Inquiry's establishment, resulting in the receipt of more than 300 formal separate submissions and the opportunities through forums, meetings, inspections and interviews for contact and discussion with many hundreds of concerned people.

The process of addressing the terms of reference involves a weighting of the available evidence in the light of evaluation of desirable values and principles. These values and principles have been made as explicit as possible throughout the Report.

In spite of the extensive range of research and data available and the variety of views expressed to the Inquiry, the reality is that in areas of social policy such as health there has to be full recognition of our hazy knowledge of the many cause and effect relationships that we intuitively assume exist. Our capacity to predict with certainty the outcome of particular policies is far less than we are often prepared to admit.

Judgements must therefore be made about likely outcomes. A major theme of this Report is the evaluation of the probability that services for clients are likely to be better or worse as a result of adoption of specific policies and strategies. This, of course, presupposes particular views about client needs and how they are best serviced and as far as possible these views have been explicitly identified in the Report.

It must also be recognised that the resources available to government are severely limited and will continue to be so for some considerable time. Consequently any new proposals have to be funded largely by a redistribution of existing health care resources rather than by their supplementation.

The Report therefore sets out to:-

- (i) Identify preferred patterns of service in the light of specific service delivery principles and client needs.
- (ii) Develop plans for the achievement of these patterns of services using minimum resource costs.
- (iii) Outline proposals for implementation of these plans.

The Report is presented in five parts. Part 1 deals with general issues relating to integration of services and staffing, broad principles of service delivery, funding, proposals for rationalisation of institutional care, staffing and industrial relations and implementation mechanisms.

Part 2 covers developmental disability services, Part 3 mental health services, Part 4 services for the aged, and Part 5 contains appendices and supporting data.

Each Part of the Report contains specific recommendations relating to the issues discussed in that Part.

2. TERMS OF REFERENCE

- (1) To determine the appropriate nature, extent and distribution of services for the psychiatrically ill, psycho-geriatrics and the developmentally disabled in New South Wales.
- (2) To review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.
- (3) To identify priority areas for the development of new services.
- (4) To assess resource requirements for the psychiatric system in the light of the findings in (1), (2) and (3) above.
- (5) To review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies.
- (6) To identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.

3. RECOMMENDATIONS

The following recommendations arise from Part 1:

1. That services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required.
(refer to Section 5)
2. That the two prime operational objectives be to -
 - (i) fund and/or provide services which maintain clients in their normal community environment;
and
 - (ii) progressively reduce the size and the number of existing Fifth Schedule hospitals by decentralising the services they provide. (5)
3. That services for the developmentally disabled, as far **as** possible, be funded separately and services delivered under separate management from mental health services and

that priorities for funding in developmental disability be -
 - (i) provision of additional community services staff to provide diagnostic assessment, early intervention and home support services;
 - (ii) development of small community residential units to re-house residents from existing institutions;
 - (iii) development of small community residential units particularly for adults unable to continue living with their families;

(iv) provision of opportunities for training of existing Fifth Schedule hospital staff for new roles in community services. (5)

4. That priorities for funding in mental health be -

- (i) provision of additional community based crisis teams;
- (ii) provision of staffing to provide adequate follow up for mentally ill people in the community;
- (iii) provision of psychiatric staff for assessment services in general hospitals;
- (iv) provision of linked networks of hostels and satellite housing;
- (v) provision for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services. (5)

5. That the current direct provision of services for the mentally ill, developmentally disabled and the aged through Fifth Schedule hospitals and community health services be transferred from the direct administration of the Department of Health and provided instead under the management of Boards of Directors, in the form of either an Area Board, a newly created Board for a particular specialised service, or the reconstituted Board of an existing public hospital as appropriate to particular services or locations as proposed in this Report. (7)

6. That staff presently employed in the provision of these services in Fifth Schedule hospitals and community health services be transferred from the provisions of the Public Service Act, 1979, on the basis and conditions provided for in Schedule Three of the Health Administration Act, 1982, to become employees of the above Boards. (7)

7. That staff commencing employment in these areas in future receive salary and other employment conditions applicable to staff employed under the current Second and Third Schedules of the Public Hospitals Act. (7,8)
8. That membership of existing and proposed Boards of Directors encompass representation reflecting the range of client interests of the services covered by this Report and that the size of existing hospital boards be expanded, where appropriate, to achieve this end. (7)
9. That provision be progressively made for elected representation from employees on all Hospital and other Boards. (8)
10. That the Department of Health and the Public Service Board establish a Task Force to implement Recommendations 5 and 6 in consultation with the Labor Council of New South Wales. (11)
11. That these services be managed through a management structure based on -
 - administration by a Chief/Area Executive Officer;
 - . a global and incentive budget system as proposed by the Parliamentary Public Accounts Committee rather than a staff number and establishment control. (7)
12. That as a priority the Health Department develop a programme budgeting approach to the funding of these areas of health care in order to monitor the level of resources utilised for particular programmes or client groups. (7)

13. That in funding of health services generally a higher priority for the next three years be given to the provision of improved services to meet mental health needs and those of the developmentally disabled. (7)
14. That the distinction in current New South Wales Government budget allocations between "recognised" and "non recognised" hospitals be eliminated to provide for a total allocation to the Minister for Health. (7)
15. That for each of the next three years an amount of half of one percent per annum (approximately \$9 million per annum) of these funds be "earmarked" for specific purpose funding of the new services proposed by this Report which are necessary to provide adequate community based support and to facilitate reduction in the size of the existing institutions, including priority projects in deficit Regions. (7)
16. That a specific budget (commencing with \$1.7 million in 1983/84) be allocated to fund community non-profit organisations to provide supportive accommodation and innovative services. These funds, separately earmarked for mental health and developmental disability services, to be provided from Recommendation 15 above, and by redirection of existing health funding of non-government organisations. (7)
17. That as savings are achieved from the rationalisation and reduction of existing hospitals, these savings be committed to the development of community services. (7)

18. That from 1984/85, these savings be progressively used to fund the community services proposed by the Inquiry and their future expansion; from 1986/87 these savings to be the major source of funding for such services, replacing the allocation proposed for 1983/84, 1984/85, and 1985/86 in Recommendation 15. (7)
19. That fees policy for long stay patients in specialised psychiatric hospitals be reviewed and that the patient contribution be increased from 66.6 percent to 87.5 percent of the pension to bring this contribution into line with that required by private and deficit financed nursing homes. (7)
20. That subject to "heritage" and environmental considerations land currently unused on the existing sites, or released through the rationalisation programme be released for other purposes and any proceeds realised be available for expansion of community health services. (7).
21. That action be taken to progressively introduce 8-hour shifts to replace 12-hour shifts in the care of the psychiatrically ill and developmentally disabled. (8)
22. That greater emphasis be given to the use of part-time staff to cover excessive workload periods in hospitals (to reduce overtime expenditure and excessive work demands on full time staff). (8)
23. That in the process of transfer of these services to the Second Schedule system a review be undertaken of the number of promotional positions in the specialised hospitals to ensure that adequate numbers are maintained to meet ward management requirements. (8)

24. That a more effective independent grievance procedure be established within the health system to deal with complaints of individual staff against management decisions affecting their employment. (8)
25. That at the level of individual hospital or Area Boards, improved consultative mechanisms be established with the Unions through the upgrading of existing "welfare" meetings. (8)
26. That in the development of a Single Register Nurse education programme, adequate theoretical and clinical psychiatric nursing content be included, and that the views of experienced psychiatric nurse educators be sought in this regard. (9)
27. That clinical education of psychiatric nurses be provided through an integrated arrangement involving community services, general hospitals and rehabilitation services in specialised hospitals and that the Nurses Registration Board remove existing procedural constraints on this arrangement. (8)
28. That the curriculum of the First-line Management Course be reviewed to produce a refresher course for nurses trained prior to the introduction of the 1000 hour syllabus. (9)
29. That the Department of Health consult with the College of General Practitioners regarding appropriate programmes designed to encourage improved co-ordination between general practitioners and public sector mental health services. (9)

30. That clinical education of psychiatrists be provided through an integrated arrangement involving community services, general hospitals and specialised hospitals, (both public and private) and that the Department, the training bodies, and the College of Psychiatrists review current arrangements in order to achieve this objective.
(9)

A number of hospitals are now however, instigating programmes which involve rehousing clients in the normal community with appropriate support services.

In Second, Third, Fifth Schedule and authorised private hospitals in New South Wales today there are around 2,280 available adult beds and 950 child beds for the developmentally disabled. The bulk of these beds however are in Fifth Schedule hospitals with the five mental retardation hospitals having a bed capacity of 1,601. Long waiting lists are common.

Involvement of community health services with the developmentally disabled varies depending on resources particularly the adequacy of community teams to provide assessment, early intervention and family support services. As outlined in Part 2 a range of Federal and State government departments and non-government agencies are involved in providing services for the developmentally disabled and therefore co-ordination is a major issue in service provision.

4.3 Psychiatric Illness

The emphasis and expenditure in public sector health care still largely revolves around large Fifth Schedule hospitals. This is despite a steady decline in bed usage relative to the State's population since the early 1940's. Since 1965 for instance, bed usage has declined by more than 50%. The number of available psychiatric beds in New South Wales began to decline in the mid-1960's as a result of this lessened demand. The new beds which were opened in the psychiatric units of general hospitals and private psychiatric hospitals during the 1960's and 1970's were more than offset by reductions in the Fifth Schedule system.

Many psychiatric and, 4x-psychiatric patients are catered for by the nursing home sector and others live in the community assisted by hospital domiciliary services, community health services and non-government agencies. Some psychiatric hospitals have been associated with development of community accommodation and support services for former patients.

The Fifth Schedule psychiatric hospitals contain about 3,700 available beds for the psychiatrically ill, giving a Statewide ratio of around 0.11 beds per thousand of population. Psychiatric units in general hospitals presently provide about 580 beds.

Private hospitals licensed under Section 11 of the Mental Health Act (1958) contain about 470 beds (virtually all of these can be considered to be for the psychiatrically ill as the proportion of developmentally disabled patients is negligible). Other private hospitals provide varying numbers of psychiatric beds and private hospitals used almost exclusively for the treatment of psychiatric illness account for a further 487 beds.

There are about 4,000 beds in public and private nursing homes used by patients with a psychiatric reason for admission (650 beds) or by ex-psychiatric patients (3,350 beds).

In total, there are around 1.07 hospital beds per thousand population in the metropolitan regions overall, compared with 0.88 per thousand in the non-metropolitan regions. Finally, there are about 425 psychiatric places in hostels, although this figure varies.

The extent of community health staff involvement with the psychiatrically ill is difficult to gauge and varies from location to location depending on resources. Where community mental health teams and assessment services have been well resourced considerable success has been achieved in maintaining clients in their normal living environment.

A growing number of non-government agencies provide advocacy, accommodation and support services in this area.

4.4 Care of the Aged with Psychiatric Problems

Most of the aged with psychiatric problems live at home although a significant group reside in private nursing homes. More than half the patients in private nursing homes have dementia, though this is not always the primary reason for their admission.

Within the Fifth Schedule hospital system (psychiatric and mental retardation hospitals) around 11% of all inpatients are over 65 years of age. The Fifth Schedule nursing homes primarily care for the physically frail but have a potentially greater role in this area.

Comprehensive geriatric services with both community and hospital components are also provided from a number of general hospitals. Some geriatric services are also provided from within the community health programme.

5. SERVICE DELIVERY VALUES AND PRINCIPLES

The organisation and delivery of any public welfare service inevitably reflects a range of values about people and their problems, and community expectations of government.

Health services are one part of government intervention designed to improve people's welfare. In responding to people's needs services provided under a health label must inevitably overlap with other public sector services with a welfare component (such as Youth and Community Services, Education, Housing, etc.). The important issue is to ensure adequacy of co-ordination and consultation between service providers in the light of changing technology, service demands and attitudes.

To a certain extent therefore some blurring of boundaries is inevitable and while reasonable efforts ought to be made to clarify these issues these efforts should not absorb too many resources. Experience indicates that at the point of service delivery reasonable co-operation can be achieved by front line staff with the primary emphasis on servicing the client rather than a particular organisation.

This section sets out the values and principles which the Inquiry considers should underpin services for clients and represents its assessment of primary client needs and how they are best met. These values and principles subsequently serve as benchmarks for recommendations which embody proposals designed to ensure that these preferred values and principles predominate in service delivery.

The broad service delivery strategy adopted by the Inquiry is one involving a continuing policy of decentralization and deinstitutionalisation, based on a philosophy which emphasises early assessment and intervention, home-based care and support for client and family and provision of alternative residential care which is small in scale and homelike in atmosphere.

This is derived from the following value preferences:-

(i) Values About People and Society

- . that a wide range of behaviour should be tolerated within the community and not arbitrarily labelled as "mental illness".
- . it is desirable for people to have as many opportunities for social and physical contact in the normal community environment as possible, irrespective of their level of physical, intellectual or social functioning.
- . further, they have a right to these opportunities.
- . these opportunities are more likely than not to help them and others cope with the perceived and real problems of those who are developmentally disabled or who are psychiatrically ill.

(ii) Values About Illness and Disability

In the area of mental health:

- . that those with emotional or behavioural problems are best treated as troubled individuals, not necessarily as "mentally ill", chronically dependent patients, demon-possessed or criminals.
- . that care of the mentally ill should promote independence with support and minimise restraint.
- . that care of the mentally ill should not be segregated from other aspects of health services.
- . that controls should be exercised over the mentally ill for the protection of themselves and others only as a last resort.

In the area of developmental disability:

- . that these clients are not ill as such although like all other people their need for specialised medical treatment will vary with particular individuals and their circumstances.
- . that emphasis should be placed on education and training rather than treatment.
- . that services should be based on principles of normalisation (i.e. living a normal life in a normal environment) and least restraint (i.e. being able to take the risks associated with a normal life).
- . that services for the developmentally disabled should be separate from those for the mentally ill.

(iii) Values About Health Care

- . that responsibility for health care should be shared between the professions and the community.
- . that public sector health services should give priority to the needs of the socially and economically disadvantaged.
- . that health services should actively aim to minimise stigma associated with mental illness and developmental disability.
- . that health services should aim to maximise benefits on resources invested.
- . that intervention to assist people is socially valuable but there are limits to intervention.

- . that standards of health care should be set, should not vary between the public and private sectors, and should be open to evaluation.

that health services should be open to public scrutiny.

(iv) Values About the Role of Government and Other Sectors

- . that government has an important role to play in the provision of services, but need not always act in the role of direct provider.
- . that government should make better use of the private "for profit" sector to assist the disadvantaged, within clearly defined limits and controls.
- . that government should have a formal negotiated relationship with the not-for-profit, "voluntary" sector regarding policies and resources to support their role in service delivery.

. (v) Values regarding the Nature and Style of Health Service Delivery

- . that services should be decentralised.
- . that services should be provided on a "human", domestic scale.
- . that services should emphasise early intervention.
- . that wherever possible assessment should be provided without removing the person from their normal living environment
- . that care should be comprehensive, taking into account the social, emotional and physical needs of the client.

- . that there should be formal links between service components for co-ordination and continuity of care.

(vi) Values About Residential and Hospital Care

- . that wherever possible admission to residential or hospital care should be avoided.
- . that where other services have been unable to provide the necessary care or restraint short term residential or hospital care can be useful to stabilise the situation and provide support for family or other carers.
- . that wherever possible, the decision to place clients in residential or hospital care should be made outside the control of the facility.
- . that services provided should be specialised (e.g. separate facilities for the developmentally disabled) and focus on particular client needs (e.g. long term care for the chronically ill).
- . that residential or hospital care should emphasise active programmes to maximise independence not simply custodial care.

Arising from these values and the analysis in Parts 2 and 3 the Inquiry proposes:-

- (a) that services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required with the two prime operational objectives of -
 - (i) funding and/or providing services which maintain clients in their normal community environment; and

(ii) progressively reducing the size and the number of existing Fifth Schedule hospitals by decentralising the services they provide.

(b) that services for the developmentally disabled, as far as possible, be funded separately and services delivered under separate clinical management from mental health services and that priorities for funding in developmental disability be

- (i) provision of additional teams to provide diagnostic assessment and early intervention services;
- (ii) development of small community residential units to re-house residents from existing institutions;
- (iii) development of small community residential units particularly for adults unable to continue living with their families;
- (iv) provision of opportunities for training of existing Fifth Schedule hospital staff for new roles in community services.

(c) that priorities for funding in mental health be -

- (i) provision of additional community based crisis teams;
- (ii) provision of staffing to provide adequate follow up for mentally ill people in the community;
- (iii) provision of additional psychiatric staff for assessment services in general hospitals;

- (iv) provision of linked networks of hostels and satellite housing;
- (v) provision for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services.

Central to the Inquiry's deliberations has been the development of a general set of service delivery values and principles as outlined in the previous section to attempt to identify client needs and how to meet them. In the other parts of this Report these are translated into specific proposals which are reflected in recommendations for services to meet the needs of particular client groups.

The approach that has been adopted to develop these values and principles and subsequent proposals and recommendations is summarised in this section and is shown diagrammatically below

Research					R E C O M M E N D A T I O N
Evaluation		Development	Analysis		
		of	of		
Consultation		Values	Specific	Proposals	
		and	Client		
Community/ Client Input		Principles	Services		

Research

- Review of previous inquiries, reports and research documents.
- Review of overseas and Australian literature.
- Assembly of data indicating current level/usage/ distribution of service provision, etc.
- Definition of terminology.
- Preparation of background papers by Inquiry assessors and staff and experts in particular areas (e.g. definition of client needs, models of service delivery, etc.).
- In depth reviews of particular issues.

Evaluation

- Identification of key issues in the light of the terms of reference.
- Evaluation of data relating to current level/usage/ distribution of services, etc.
- Examination and analysis of submissions to the Inquiry.
- Evaluation of written material, data and views gathered by the Inquiry with the assistance of the assessors and experts in particular fields.
- Analysis of models of service delivery to evaluate the costs and benefits of particular methods and forms of service.

Consultation

- Visits to hospitals and other public sector, private and community organisations delivering services.
- Formal and informal discussions with major participants in service delivery - staff, unions, management, service recipients, other service providers and public sector organisations.
- Separate forums with management, unions and community groups examining particular issues of concern to each.

Community/Client Input

- Assessment of existing surveys and literature on client needs.
- Evaluation of service providers' views of client needs.
- Receipt of more than 300 submissions in response to public advertisement of Terms of Reference seeking submissions.
- Evaluation of submissions received from community groups, clients and others with special knowledge of client needs.
- Consultations with authors of selected submissions.
- Forums and discussions with community groups either providing services to clients or representing client interests.
- Partial sponsorship of a "phone in organised by the N.S.W. Mental Health Co-ordinating Council.

7. FIVE MAJOR INITIATIVES

Subsequent parts of this Report focus on specific proposals related to particular client needs. Part 1 identifies the general values and principles which ought to underpin service delivery and considers some general proposals designed to enhance the probability that services will in future promote these values and principles.

There are five major initiatives which relate to the overall management and delivery of services which should be addressed immediately as pre-conditions of improved service delivery:-

- (i) Integration of Services and Resources
- (ii) Improved Accountability and Management
- (iii) Specific Funding
- (iv) Prior Provision of Community Based Services
- (v) Rationalisation of Existing Institutions

(i) Integration of Services and Resources

and

(ii) Improved Accountability and Management

As indicated previously public sector services are provided through three main avenues - state run Fifth Schedule psychiatric hospitals, general public hospitals and community health services. Community health services and the psychiatric hospitals are administered directly by the Department of Health and the employees

are public servants. Except for a few successful examples these three areas tend to operate separately with co-ordination inhibited by a variety of factors including different management and employment arrangements, separate funding and sometimes varying philosophies of service delivery.

Most of the Inquiry's deliberations have focussed on the psychiatric hospitals which absorb most of the resources for the services being examined. In the Inquiry's view the perpetuation of a segregated system (Fifth Schedule State Hospitals) of service delivery dealing largely with a population of socially and economically disadvantaged clients denies these clients the possibility of access to better treatment and assists in maintaining their disadvantage.

(a) Alternative Management Systems

Services for the psychiatrically ill and for the developmentally disabled are at present relatively unco-ordinated with most of the resources locked into the provision of institutional care within Fifth Schedule hospitals. These hospitals are often relatively isolated from the delivery of health services in both the general public hospital and community health systems. Both the psychiatric hospitals and the community health programme operate under a different management system to that of the main stream public hospitals and this inhibits any proposals for integration.

Listed below are some of the management features of the two hospital systems:-

<u>Second/Third Schedule</u>	<u>Fifth Schedule</u>
<u>Public Hospitals</u>	<u>Psychiatric Hospitals</u>
Hospitals administered by Board of Directors (local citizens) responsible to Minister for Health.	Administered by the Department of Health (through Regional Directors) as part of centralised public service system.

Second/Third Schedule Hospitals

Managed by Chief Executive Officer.

Staff employed directly by Board of Directors and subject to their control through Chief Executive Officer on a day to day management basis.

For industrial relations issues (awards, disputes, etc.) employer is Department of Health.

Management control is exercised by budget control with direct day to day accountability from Chief Executive Officer to Board.

Clinical management provides for significant mix of private and public service provision (e.g. private visiting medical officers on sessional arrangements).

Direct accountability of Board to Minister through budget control.

Fifth Schedule Hospitals

Managed by Medical Superintendent.

Staff employed by Department of Health and subject to regional control and compliance with central agency rules (Public Service Board).

For industrial relations issues employer is Public Service Board.

Management by combination of budget, centralised staff number and staff establishment with attenuated line of direct day to day responsibility to Region, Department, Minister. Premier and Public Service Board exercise statutory controls under Public Service Act, 1979 in respect of staff numbers and establishment.

Almost total reliance on salaried public sector medical staff with a reluctance to and constraints on use of private sector.

Indirect accountability through Region, Department, etc., to Minister.

Second/Third Schedule Hospitals

Local citizen involvement in management though Board enhances opportunities for localised support for services through fund raising and political lobbying.

Fifth Schedule Hospitals

Support usually based on, for example, patients' families rather than more general constituency through Board membership, etc.

(b) The problems of a separate system

It is considered that the Fifth Schedule hospital system has developed a particular ethos which is not conducive to achievement of the service delivery principles the Inquiry considers desirable.

Some features of this "ethos" are listed below:-

- . an isolated system of service delivery which separates the care of the disadvantaged from the rest of the community;
- . the stigma of working in institutions dealing only with a disadvantaged client population;
- attitudes about lack of community acceptance of clients resulting in attempts to "protect" them by keeping them away from the community;
- a genuine belief that clients will suffer outside of the care and control of a hospital;
- . the staff and, their unions have become the main advocates for these clients;

- . perceived and actual reductions in resources available, which take away incentives to do anything but "basics". This further reinforces client dependence;
- . the training of the mainstream profession (i.e. psychiatric nurses and mental retardation nurses) has been isolated from modern tertiary education and even to some extent from its own mainstream profession.

The above comments should not be construed as indicating that there are not positive aspects of Fifth Schedule hospitals. Despite the constraints there is still an overwhelming level of enthusiasm, dedication and care and concern for clients among the staff with whom the Inquiry came into contact. The Inquiry has seen a number of examples of innovative service delivery operating within the system. However, because of the management structure of the system, its inability to attract community support and therefore more resources and the "ethos" outlined above it is not considered that these innovations will ever become real alternatives to institutional care unless the system is changed significantly.

(c) Integration of services

Numerous submissions to the Inquiry stressed the need for greater integration of services from a variety of perspectives including:-

Improved client service/access to better quality clinical expertise

"Within the one Area one finds psychiatric services provided by Schedule II hospitals, Schedule V hospitals and Community Health Services, with quite separate administrations. For a patient to move from one of these services to another, as changes in his health often

demand (e.g. need for voluntary or involuntary hospitalisation) he most characteristically must change psychiatrist.

That is, continuity of care is poor by comparison with other specialist health services, and by commonsense standards.

....Clinicians should be appointed to an Area Health Service, not to either a hospital service or a community health service. Clinicians would then attend their patients through all phases of illness, whether at home, in a community health centre, or in hospital."

(Extracts from Submission No. 141 - N.S.W. Branch of the Royal Australian and New Zealand College of Psychiatrists).

Improved work experience and training for staff

"(c) Schedule II,V, and community services should be integrated, with free interchange of staff. (Industrial issues involved in this have been the subject of a previous inquiry.) It is wasteful and inappropriate to run down one or more parts of the services, hoping they and the issues will disappear, rather than tackling the problem directly. The advantages of Public Service employment have kept many employees in the less attractive conditions of schedule V hospitals. It would be grossly irresponsible to remove schedule V hospitals from the Public Service unless they were markedly upgraded at the same time."

(Extract from Submission No. 229 - Public Medical Officers Association.)

"The current system of training, which is also exclusively confined to 5th Schedule hospitals, is grossly inadequate to the task of preparing nurses for those roles mentioned above.

Lack of student and teacher contact with the 'outside' leads to a self perpetuating process of institutional acculturation which in a vicious circle reinforces the estrangement of the large institutions from the providers of short term and community care."

(Extract from Submission No. 107 - Australian Congress of Mental Health Nurses - N.S.W. Branch.)

(d) Access to Resources

The capacity of the psychiatric hospitals to attract resources is considerably constrained when compared with the general public hospital system which not only attracts the bulk of public sector funding for health services but also has a number of other advantages:-

- (i) Patients treated in general hospitals attract Commonwealth government subsidies through medical benefits.
- (ii) Public hospitals have a wider appeal in raising funds direct from the community.
- (iii) Community based hospital boards perform an advocacy function with government to attempt to attract resources for particular needs.
- (iv) Public hospitals attract the highest standard of private clinical resources through visiting medical officer arrangements etc.

Access to these resources and the opportunity to make use of them for the clients the Inquiry is concerned with would be facilitated under an integrated system.

(e) Proposed Changes

The Inquiry therefore proposes the following changes

- (i) services for both major client groups would be provided under a decentralised community based management structure with Boards of Directors providing services on an area or regional basis and directly employing the staff involved.
- (ii) funds for services would be allocated on a global and incentive budget system and services would be managed by a Chief Executive Officer.
- (iii) the services for the particular client group currently provided under separate management would be integrated e.g.:- community teams, Fifth schedule hospital services and second schedule hospital services would be administered by the one board.

In respect of mental health services in addition to the functional integration of the service components the services would also be integrated with the management of mainstream general health services (i.e. the boards concerned would administer all general health services including mental health services).

The Inquiry proposes that as far as possible the existing services of psychiatric hospitals be decentralised to the local areas which they service - acute psychiatric services and community mental health services should be managed by local general hospitals. Hostels may be managed by local hospitals or non-government organisations.

The services which remain in the psychiatric hospitals will be specialised, regional or supra-regional services. As such they should be linked, where possible to other regional, specialised services in a general teaching hospital. These services and community health services for that area will be managed by a single Board.

To reflect these changes it is essential that many of these Boards be reconstituted to reflect the diversity of community interest necessary to foster all services equitably and that their role in the management of area health services be formalised. Some existing hospital boards may have to be expanded in size to achieve this end.

In respect of developmental disability services, a different management model is proposed with the creation of a Regional Board of Management for all the health-based developmental disability services in the Region. The Board would be community-based, including representatives of parent and voluntary groups, and should establish advisory mechanisms to include representatives of the other relevant government departments.

The care of the developmentally disabled (unlike mental health services) is distinctly different from mainstream acute health services, in that the focus is life-long and educational. This distinction and the need for close collaboration with other agencies and departments can best be reflected in a distinct management structure with broad representation from the various interest groups.

The Inquiry is aware that in some areas of the State, the provision of developmental disability services has been linked to existing general public hospital Boards. Clearly, management arrangements need to be flexible to suit local needs and capabilities, and it may well be appropriate to expand such local arrangements. Appropriate contractual arrangements will need to be negotiated between the Regional Board and general hospital boards providing these services within that Region, or Area Boards as they develop.

The Inquiry believes the type of systems proposed are more likely to improve client services for the following reasons:-

- . Clients would be more likely to obtain local and geographically accessible services particularly if linked to a community health network which was also part of the same system.
- . The chances of ever "normalising" and reducing the stigma of these services are increased in an integrated system which does not unduly, perpetuate the separation of these clients, from other groups.
- . Normalisation for these services and their clients is more likely to occur within a system which links community based influence through hospital or area boards with the needs of these services.
- . Advocacy of the best political kind (i.e. based on local community pressure) is more likely to be improved in this system as local boards are required to meet the needs of these client groups as well as others and provide resources accordingly.
- . A higher quality of clinical expertise is available for clients.
- . Integrated services are more likely to facilitate continuous co-ordinated care and flexibility of care either in hospital, outpatients, community health centre, nursing home, half-way house, hostel or domiciliary setting rather than in one dominant form of care such as institutional care.

- . Improved accountability and more efficient management which will emphasise better exploitation of resources is more likely under a management system with the characteristics of the public hospital system.
- . There is greater scope for staff to be better trained and have access to more fulfilling work experiences in a system which provides a wider range of models of delivering services.

(f) Integration of the major resource - staff

Although decisions about general policies and priorities for health services are expected to be taken at government level, there is nothing intrinsically worthwhile in the notion that these actual services have to be delivered by government directly through its own employees. Indeed within the public hospital system this has never been the case and in fact most staff providing health services in New South Wales are not public servants but employees of local hospital boards.

The exceptions are the services provided in the Fifth Schedule hospital system and through the community health programme and it was argued to the Inquiry by the (then) Health Commission, that delivery of health services under a public service system is inappropriate:-

"The single most important factor which has not assisted in an improvement in industrial relations has been the considerable uncertainty imposed on the system, by financial and staffing constraints. This has led to increased frustration on behalf of staff over what they perceive as their lack of ability to influence decisions affecting staff and patients.

"The conflict between the various constraints, viz. staff establishments, staff numbers and available funds, compounded by general staff freezes has led to confusion, with resultant industrial disputation. The Commission has consistently argued that there should only be one prime constraint imposed on the management of these hospitals, i.e. the availability of funds.

The Commission considers most strongly that all public hospitals (i.e. those listed in the Second, Third and Fifth Schedules to the Public Hospitals Act) in respect of broad staffing and management aspects, should be placed on a similar basis. The 'stop-start-stop' basis which has characterised recruitment activities in Fifth Schedule hospitals in recent years has not occurred to nearly the same extent in other public hospitals, and the Commission would contend it is unsatisfactory from an industrial relations viewpoint and makes the provision of services at a satisfactory level most difficult.

The obvious answer is to remove the staffing of these hospitals from the requirements of the Public Service Act. It is only for reasons of history that Governments assumed direct responsibility for services for the psychiatrically ill and developmentally disabled - the community was never able or willing to meet the costs of such services - whereas for the earlier part of the State's history, hospitals catering for the physically ill required no Government financial assistance."

(Extract from S 95: Health Commission of N.S.W.)

Ideologically within the health system, at senior and middle management level, there is a tendency to maximise the disadvantages and minimise the advantages of the public service system. However, if services are to be integrated it should be on the basis of one system of management and staffing or the other and a movement to the main stream management system of public sector health services is proposed.

To effectively integrate services requires that local management has full control of resources. This means budget and staffing systems which enable funds and personnel to be utilised flexibly to meet needs and priorities as they evolve. All staff should therefore be under direct local control and it would be inappropriate to attempt integration while retaining some staff as public servants.

This does not preclude co-ordination of employment conditions and other industrial issues across the health system, as is the case currently (*e.g.* by the Department of Health acting as employer for industrial purposes) but does mean staff should be employed as far as possible on the same basis under local control.

To integrate services and maintain a dual system of employment would be to build in the continuing potential for industrial conflict and confusion. This is not to suggest that the integration of some 9,000 Fifth Schedule hospital staff and ultimately all community health staff will not present industrial difficulties. However, the opportunity to achieve an integrated and more co-ordinated health service will continue to yield benefits long after the industrial disputation has been resolved.

The transfer of a relatively large group of employees with more attractive employment conditions, particularly superannuation benefits, will give some long term impetus to union objectives of achieving similar conditions for all health services staff.

The industrial issues associated with these proposals are discussed subsequently in this part of the Report in the section on staffing and industrial relations.

(iii) Specific Funding

and

(iv) Prior Provision of Community Based Resources

Two of the clearest concerns arising both from research and evaluation and from submissions are:-

- . Because many of the clients of psychiatric and developmental disability services are socially and economically disadvantaged and therefore have difficulty mobilising support through normal political processes advocacy for their needs is not strong. Consequently resources are less likely to be targeted at these groups particularly when competing with more attractive acute health services.
- . Genuine efforts to deinstitutionalise services must be preceded by the planning and development of comprehensive community services and adequate links must exist not only within health services but also to other welfare services. There is already a backlog of demand within the community created by previous reductions in institutional care.

The prior need is to develop services which can effectively intervene and assess in the client's normal living environment with the object of avoiding hospitalisation wherever possible.

These issues are dealt with in more detail in subsequent parts of the Report on the needs of client groups. The important points are that, at least initially, funding must be earmarked for these services to provide adequate community facilities and that the needs of these groups should be given higher priority than previously in the distribution of health resources.

The capacity of the Minister for Health to provide for flexibility in funding and to allocate priorities is inhibited by the fact that funds are made available within the State budget on the basis of "recognised" and "non recognised" hospitals reflecting the eligibility or otherwise of these hospitals for Commonwealth Medical Benefits. Along with the proposal to integrate management and service delivery it is considered that funding should also be integrated to enable resources to be allocated on a more rational basis and to facilitate "earmarking" of funds to special needs and the ultimate transfer of resources from specialised hospitals to community services.

As assessed in Parts 2 and 3 the minimum necessary specific earmarked funding to stimulate the provision of community based services and facilities for both mental health and developmental disability services is \$9 m per annum over the next three years. This represents about half of one percent of the total hospital budget in N.S.W. Without this level of funding it would be extremely difficult to make any positive progress towards the desirable services considered necessary to more effectively meet client needs.

Funding arrangements should be structured on a programme budgeting format to enable clearer identification of the level of resources being allocated to particular programmes and client groups.

It is considered that what is required is a funding programme which takes the following sequence:-

- . Allocation over the next three years of a fixed proportion of total hospital funds (say half of one percent per annum) to fund new services to provide adequate community based support to facilitate reductions in the size of existing institutions and meet existing deficits.
- . From these funds allocate money to fund community non-profit organisations to provide community supportive accommodation and innovative services - commencing with \$1.7 million in 1983/84.
- . From 1984/85 further additional services would be funded by progressive reductions in the size and number of existing institutions (mainly transfer of staff to community services).

Related to the issue of funding is the question of pricing for services particularly accommodation and related facilities provided to clients. The current arrangements are that short stay patients (less than 60 days) do not contribute, however long stay patients pay 66.6 percent of their pension (or equivalent) for accommodation and care in State hospitals and nursing homes. It is estimated that if the State were to increase the patient contribution from 66.6 per cent to 87.5 per cent of the age pension (or equivalent), this would increase revenue by \$7.5 million. Such a level of patient contribution would bring it into line with that required by private and deficit financed nursing homes which are subsidised by the Commonwealth. It would therefore remove any financial disincentive facing patients and their families in seeking nursing home placement.

(v) Rationalisation of Existing Institutions

Implicit in the above proposals is the notion that the level of institutional care should be reduced and rationalised.

There are five principal reasons for this view:-

- the predominance of institutional care is inconsistent with the service delivery philosophies developed by the Inquiry and, by and large, is an inappropriate way of caring for clients. Its predominance as the main form of care needs to be reduced.
- resources currently "locked" into institutional care are inequitably distributed in two senses. First, disproportionate amounts of resources are provided in particular regions while others are deficient. Secondly, these resources (representing approximately \$200 million of recurrent expenditure per annum plus enormous capital investment) could be better utilised and more fairly shared around so that greater numbers of people could get some benefit from this large expenditure of public money.

with the funding of community based services enormous scope exists to utilise the staff of institutions in a more effective and more satisfying range of service delivery activities.

- . rationalisation would enable specific hospitals to develop more specialised services based on more clearly defined clinical services (e.g. children's services for developmentally disabled, adult services for developmentally disabled; rehabilitation programmes for the mentally ill, etc.).

rationalisation and reduction of the number of institutions will eventually free land and capital resources which can, if appropriate, be put to alternative uses and any proceeds used, in part, to fund health services.

Experience, both overseas and in the 1979 hospital rationalisation programme in New South Wales, has indicated that it is difficult to achieve real savings on a large scale from bed reductions which do not result in the closure of "whole" functioning units. This experience led the Parliamentary Public Accounts Committee in their Second Report in 1982 to recommend:

"Future rationalisation programmes should concentrate to the maximum extent practicable on the re-direction of whole services or service units."

(Second Report of the Parliamentary Accounts Committee of N.S.W., 1982)

The Inquiry's implementation timetable has consequently been formulated with the objective of facilitating the closure of "whole units" at the same time as gradual reductions are made in all institutions.

The capacity for redistribution both within and between Regions is constrained however by the prior need to develop the alternatives which will make it possible to reduce the size of the institutions with minimal disruption to residents, families and staff. Genuine efforts to deinstitutionalise services must be preceded by the investment of resources in community services and adequate links must exist not only within health services but also to other welfare services.

The initial investment should be clearly targeted to services and facilities which will explicitly facilitate the reduction in the size of the existing institutions. Resources thus freed would provide the impetus for the on-going expansion of community-based services.

Opportunity exists to ultimately redistribute resources now provided within institutions and achieve savings which will fund improved services. In respect of developmental disability services experience elsewhere indicates that around 10% to 15% of costs can be saved by providing accommodation services in small community residential units. In the psychiatric area greater scope exists because of the potential to reduce utilisation through the provision of community services. To provide adequate clinical services (other than accommodation) these savings must be utilised for effective community based services including assessment, crisis care, home support etc. The evidence is however, that with these services linked into an appropriate network scarce professional resources can be more effectively utilised, community support services mobilised and a wider range of people provided with services.

The potential level of savings available for improved service delivery is more fully appreciated when even the low conservative figure of a 10% saving is applied to the current operating costs of 5th Schedule hospitals of around \$200 m per annum. Whether this can be realised will only be known if an effective programme of provision of community based services and rationalisation of hospitals is actually implemented and monitored.

Some scope probably already exists to dispose of properties on the periphery of some institutions and the detailed proposals in this Report will ultimately in the future release larger sites which could be put to alternative uses. There are various environmental planning and "heritage" constraints on this process but these should be resolved progressively and a mechanism established to ensure that as the institutions are scaled down alternative uses are found for sites (including, where appropriate, disposal).

Initially, in the light of this Report's proposals studies should commence in conjunction with the Department of Environment and Planning and the Heritage Council on the feasibility of alternative uses for:-

some peripheral sections of Rozelle Hospital

the north side of Gladesville Hospital

the south side of Rydalmere

the site of Marsden Rehabilitation Centre

the whole of Peat Island hospital

When appropriate and suitable sites are actually disposed of and the proceeds realised the issue arises of whether or not the funds should be returned to the health budget. The fact that at some point in time the community, through government decision, invested some resources in capital for health services does not enshrine these resources in the health system. The resources should be realised for the best current community use.

The outcome of this view is an arrangement whereby the proceeds of sales are returned to consolidated revenue for general government use. The difficulty with this approach is that there is no incentive for those administering the resource to develop proposals to realise on these assets as their particular service may gain nothing from the process.

Accordingly, some incentives need to exist whereby at least a proportion of the revenue is available for re-investment in the service from which the asset is realised if warranted by continuing need. This does not impinge on the philosophy outlined above if a conscious decision is made by government that these resources should be reapplied to the health budget.

In view of the continuing need for the services discussed in this Report, and as improved service provision is dependent on a process involving rationalisation of hospitals and possible disposal of property, there is a strong case for re-applying a proportion of these proceeds to the health budget subject to meeting any existing capital debt requirements relating to these assets.

8. STAFFING AND INDUSTRIAL ISSUES

(i) Staffing Levels

1. Context

This Inquiry was established partly as a result of concern expressed by health industry unions about a whole range of industrial issues including the following:-

recurrent staffing freezes;

inadequate staffing levels to maintain services;

. dissatisfaction with actual staff numbers set at levels below establishment;

excessive stress and burden on staff;

concern about the adequacy of patient care and safety.

Indeed it was during the proceedings of a compulsory conference in the Industrial Commission concerning staffing levels in Fifth Schedule hospitals, that a statement was made that an Inquiry would be held into health services covered by the Fifth Schedule psychiatric hospitals and that its Terms of Reference would cover appropriate levels of service delivery and staffing.

The other issue motivating the establishment of the Inquiry was the concern by a wide range of community groups that the nature of services should be reviewed to assess their adequacy and appropriateness particularly in the larger institutions.

In undertaking a broad ranging inquiry of this type it has been necessary to make a basic assessment of the services under review and the methodology underpinning the Inquiry's approach has been previously outlined. In essence this has meant a review of the basic nature of services and not simply accepting the status quo as an appropriate way of delivering services.

To some extent this has probably created some confusion as there has been some suggestion that the Inquiry ought to have been undertaking a traditional staff review on a detailed ward by ward basis. It has been necessary to explain that while the Inquiry has dealt with staffing issues, there are a number of things that it could not do.

- "(a) The Inquiry could not in the short term, resolve the immediate staffing shortages and morale problems perceived by the unions and may not necessarily deal with these issues at a disaggregated level (e.g. on an individual hospital and ward basis).
- (b) The Inquiry could not resolve constraints upon the 5th Schedule system occurring as a result of current or future resource allocation decisions made by the Government as a result of its legitimate evaluation of the competing claims on the Government's very limited resources (although the Inquiry may present proposals on these matters).
- (c) The Inquiry could not treat staff shortages as a fundamental issue because to do this would be to accept at the outset that the existing system was the appropriate mode for service delivery. This type of approach would preclude the Inquiry from dealing with a major element of its basic task, i.e. 'to determine the appropriate nature' of services generally and to 'review the appropriateness of the existing range of care and services'."

(Extract from Inquiry's letter to the Minister for Health referring to representations from the Public Medical Officers' Association.)

2. Representations by the Unions

Aside from the issues relating to the Inquiry's proposal to transfer staff employed in the Fifth Schedule hospital system to a public hospital model of management of service delivery, the main issues raised by the unions relate to the following:-

- (1) The difficulties of operating under recurrent staff freezes and staff number controls set at less than establishment.
- (2) The difficulties of reconciling budget allocations with staff establishment levels.
- (3) Concern with the use of overtime to maintain adequate services instead of the employment of additional staff.
- (4) The lack of information about staffing and funding provided by management.
- (5) The importance of using the 1979 staff review as a base line for the determination of future staffing levels.
- (6) A preference for an integrated mental health service centrally run by the government.
- (7) Improved mechanisms for consultation.

3. Analysis of Union Concerns

There are a number of difficulties in dealing with these issues individually because they are so bound up with the nature of the system and in particular with the following issues:-

- (1) There is a reluctance to accept the notion that government can impose controls whether they be of a staff number, establishment or budgetary control on these types of services. This is not confined to the unions but is reflected generally through the health administration.
- (2) The use of three sets of controls (staff numbers, establishment and budget) creates considerable difficulties and confusion throughout the system.
- (3) This is particularly so when in the health system the notion of staff establishment (i.e., the number of positions - each with its own salary and classification of work - to which staff can be recruited) has become synonymous with the minimum essential number of staff necessary to provide specified services on virtually a 24-hour basis.
- (4) The commitment to the notion of maintaining staff numbers and staff establishment levels at the same levels has attraction to both management and unions. It is the easiest way for management to operate and it is compatible with the interests of the unions and their individual members who can plan with reasonable certainty an employment arrangement which suits their individual needs, e.g. availability of overtime, sick leave, etc.
- (5) In this environment when budget constraints are imposed the inappropriateness of attempting to run these services under these types of controls is highlighted. The real issue of managing within budgets is obscured by debate about entitlements to particular levels of staffing because participants in the system believe that the level of establishment has become an entitlement.

- (6) Management's perception that the establishment and staff number constraints limit their ability for flexible recruitment of staff appropriate to service needs.
- (7) Staff number constraints and the imposition of staff freezes have a deleterious effect on maintenance of clinical care and recruitment of students to meet both service and training needs.
- (8) The constraint of staff numbers combined with the preference for the use of full-time employees generates an inordinate expenditure on overtime and an often unacceptable burden on individual staff.
- (9) Finally, as mentioned elsewhere these issues are complicated by the fact that by default unions and staff are placed in the position of being the sole advocates for the clients. It is seen as appropriate to "take up the cudgels" against government decisions about priorities in the absence of any community based structure to represent the clients' needs.

Irrespective of the above factors, the over-riding issue raised was that the level of staffing is generally inadequate, and that staff are thereby forced to return to a custodial care approach, with limited time for active habilitation and rehabilitation programmes. It was constantly argued by both staff and Union representatives that patient care could not improve unless the 1979 Staff Review proposals were implemented. Although there has been a continuing gradual decline in the utilisation of the hospitals, the Unions argue that the actual numbers of staff proposed in the staff review are needed to effectively staff the services, as in their view, a decline in utilisation does not dramatically effect the ward staff requirements in these physically scattered facilities.

The Inquiry has compared the cost of implementing the 1979 Staff Review proposals to the 1982-83 budget estimates for staff costs. This comparison is included in the Appendices (Part 5). The full cost of implementation would be an additional \$9.3 million. This amount excludes the cost of overtime, a reduced percentage of which would continue to be worked and which would therefore increase this amount. This clearly raises the question of priorities. The Inquiry faces a dilemma in this regard because it shares the concern about the level of care available in some of the hospitals which could be improved by spending more funds in the institutions themselves. While this should not be ruled out in all instances the Inquiry considers this should not be a priority as it is likely to reinforce continued provision of inappropriate residential care in large institutions.

The Inquiry has argued that the two prime operational principles should be:

- (i) fund and/or provide services which maintain clients in their normal living environment; and
- (ii) progressively reduce the size and number of existing Fifth Schedule Hospitals by decentralising the services they provide.

The competing priorities in these areas would appear to be:

- . the improvement of the level of care within the existing hospitals, by increasing the ratio of direct care staff and programme staff to residents and upgrading physical facilities.
- . the establishment of community teams and residential units;

The choices however are not always clear and the pace at which the process of change can occur will be dependent on both the resources to establish the alternative services and the level of preparation of residents within the institutions.

In the current economic climate, with governments seeking to reduce expenditure in all areas, any new initiatives or programmes must be funded within existing resources, that is, by a re-organisation of priorities and redistribution from other service areas.

The Minister for Health and the government have clearly indicated their commitment to redistribution in favour of disadvantaged groups such as the developmentally disabled, by inclusion of \$2.6 million for community residential services in the Eastern Suburbs and Wollongong and assessment services in Wollongong (the highest Statewide priorities) within the current programme of health services redistribution. These funds will be made available as savings are achieved through the closure or change of role of four general hospitals.

The Inquiry is convinced that in the long-term there are adequate resources available within the current services of the Fifth Schedule psychiatric hospitals to develop an effective network of alternative services once the institutions are reduced in number and size. The only way to test this view is to commence to fund a programme of community based residential care and services which reduces the size and number of institutions and to closely monitor this process.

The harsh reality of current economic constraints is that a choice has to be made, and although individual exceptions may be warranted, the Inquiry in the light of its evaluation of needs and preferred principles of service delivery comes firmly down on the side of funding for community based services in preference to services within institutions. The Inquiry does not therefore propose any overall increase in the staff budgets of these hospitals.

The Inquiry in its research examined different ways of setting staffing levels in this type of system and has concluded that any attempt to set aggregate staff numbers and staff establishment for this type of service is an illusory exercise which only locks services into a particular mode of provision and builds up unrealistic expectations among both management and staff.

Staffing levels should be established within the constraint of a local budget having regard to a range of well documented factors:-

- patient dependency studies;
- mix of available staff (e.g. nursing, non-nursing, other professions, etc.);
- use of full-time and part-time staff, including sessional arrangements;
- physical layout of facilities;
- the extent to which services are provided in the community or within hospitals;

the necessity to meet Award requirements in respect of working hours/shift structures.

- provision for overtime and sick leave;
- educational and training supervision.

The issues canvassed above only reinforce the view expressed earlier that a total change of management system is necessary for these services to operate effectively with emphasis on more professional management and primary control of operations through budgetary process. This will not overcome the fundamental difficulty of reduced resources available for particular services, however a different management system should provide more incentives for both management and staff to deal with a lot of these problems in a more flexible way.

4. Some Proposals for Change

The Inquiry believes that in association with its major proposals there are a number of other actions which should be taken to assist in overcoming some of the staffing issues mentioned above.

- (1) The need to progressively introduce 8-hour shifts to replace 12-hour shifts in the care of the psychiatrically ill and developmentally disabled.

As argued by the (then) Health Commission:-

"Another major area requiring consideration is in respect of nursing rosters. Fifth Schedule hospitals provide nursing services in ward areas on the basis of either 2 x 12 hour shifts or 3 x 8 hour shifts daily. The introduction of 8 hour shifts has been progressive over the past 20 or so years and has generally been regarded as having the following advantages over 12 hour shifts:-

- (a) allows later evening meal time for patients;
- (b) allows evening activities for patients and later bed times;
- (c) allows later rising each morning for patients;
- (d) reduces stress on staff due to shorter daily span of hours (but frequent working of double shifts, i.e. 16 hour span can negate this benefit)."

(Extract from Submission No. 95: Health Commission of New South Wales.)

- (2) The introduction of greater emphasis on the use of part-time staff to cover excessive workload periods in institutions (to reduce overtime expenditure and excessive work demands on full time staff).

- (3) Introduction of new categories of staff:-

the Enrolled Nursing Aide within rehabilitation and long term care services;

(to make better use of qualified nursing staff in the implementation of therapeutic programmes. See Part 3)

•

residential care assistants for the provision of residential care for the developmentally disabled.

(to provide consistency of caring and an educational approach in the direct care of the developmentally disabled - See Part 2)

- (4) Increased use of Programme Officers in the care of the developmentally disabled to upgrade the structured educational component of their care. (see Part 2)
- (5) As community services are developed and patient numbers decline, staff numbers should be adjusted to provide more intensive staffing in areas of priority, particularly the developmentally disabled (see Part 2)

(ii) Conditions of Employment - Proposed Transfer to Second Schedule System

1. Union Views

The essence of the Inquiry's proposals previously outlined is to integrate the provision of services. There is no outright opposition to this notion from the unions in fact most would appear to support the idea:-

"The Health Commission in the early 1970's proposed the re-scheduling of all of the Fifth Schedule Hospitals with the view of establishing a common Health System.

"The Association is not, and never was, opposed to this proposition despite the continuous contentions by the Health Commission that it cannot be done because of the Unions. The truth of the matter is that the Association has maintained that the pre-requisite for this change should be the granting of common conditions of employment having regard to the conditions currently enjoyed by the public servants. To that end, a Common Conditions of Employment Committee was established to report to the Health Commission on the ways and means by which this could be achieved.

The report referred to was submitted to the Health Commission in mid-1980 and, to date, there has been nil response to any of the recommendations contained therein."

It is our view that no adequate costing of this proposal has been carried out nor has there been any consideration of implementing common conditions over a set time scale. Had this been actively considered ten years ago, common conditions would now be a reality."

(Extract from Submission No. 231 - Health & Research Employees Association of Australia - N.S.W. Branch.)

"(c) Schedule II, V and community services should be integrated with free interchange of staff."

(Extract from Submission No. 229 - N.S.W. Public Medical Officers' Association.)

"Area Health Boards

The P.S.A. supports the principle of broadly based area administration of all health services. We are aware of some discussion by this inquiry and the Interim Evaluation - Community Health Services, into the feasibility of area health boards. This debate covers wider ground than can be canvassed here, but we feel some basic issues are -

- (i) That all services (including teaching hospitals) should be accountable to area boards, if not, there seems little point, as the current type of ad hoc arrangements and resistance to change, will be maintained.

- "(ii) That consumers and staff should have guaranteed access to membership of such boards. If this is to be more than ritualistic (or token), then resources such as staff or funding should be allocated to consumers/consumer groups, to give them the opportunities that other interest groups enjoy".
- (iii) That Government must keep responsibility for basic standard setting, evaluation of services and staff, and protective legislation, e.g. standards for boarding houses; trusteeship for protected persons."

(Extract from Submission No. 310 - Public Service Association of N.S.W.)

Specific opposition is to the method of change i.e. involving loss of public service employment and conditions for staff. For example:-

"Labour Council of New South Wales 30th November, 1982.

Statement by Health Unions

To: The Minister for Health
The Chairman Richmond Enquiry

While applauding any move aimed at upgrading and improving the supply of Health services to psychiatric, developmentally disabled and psycho-geriatric patients, this meeting of unions with members employed by fifth schedule hospitals states:

1. No argument advanced as purporting to be in favour of the transfer of fifth schedule hospitals to schedules 2 and 3 is in any way supportive of such transfer. All improvements in service, methods or organisation alluded to could be achieved without such transfer.

- "2. No justification therefore, exists for the inevitable dislocation in continuity and conditions of employment and career security which will arise if any suggestions in favour of transfer which are currently before the Richmond Enquiry are adopted.
3. If the Minister elects to take such a radical and unnecessary step the Unions state that they will only accept industrial arrangements which guarantee full continuity of all remuneration, terms, conditions and progression of employment for all present and future employees.

Carried Unanimously."

(Resolution conveyed to Inquiry from Labor Council of N.S.W.)

"Role of the Public Sector

This Association believes that the responsibility for provision of services in the area of psychiatric care, psycho-geriatric and developmentally disabled persons should remain in the direct control of Government.

There is evidence to suggest that the majority of people who consume public sector (psychiatric and developmentally disabled persons) services are poor and that these relatively powerless consumers are not able to obtain quality care, viz. medical care rehabilitation and accommodation in an 'open market' system."

"Industrial Issues

Retention of Public Service Conditions and Rights

The P.S.A.'s members employed in the fifth schedule hospitals and community health services are career public servants. They have, therefore, interests and career prospects outside of the narrower confines of the health services."

"In recognition of this, P.S.A. policy is that our members' and future members' public service conditions and rights remain intact and are not open to negotiation."

"Retention of Public Service Positions

The P.S.A. supports changes to the services subject now to review by this inquiry. In any proposed changes, it is essential that foreshadowed services make best use of existing human resources. Future health care services for the psychiatrically ill and the developmentally disabled, requires the maintenance of strong professional input.

The P.S.A. recommends that all public service positions be retained to ensure the provision of high quality services for the developmentally disabled and the psychiatrically ill."

(Extracts from Submission No. 310 - Public Service Association of N.S.W.)

Notwithstanding this opposition the Inquiry for reasons previously outlined believes that its proposal is appropriate and that it should be adopted. Specifically, it is proposed that the conditions of transfer be as provided for in Schedule 3 of the Health Administration Act, 1982.

The Act provides for a retention of public service conditions of employment for a period of three years and for the permanent continuation of superannuation rights for those public servants transferred to the employment of hospital boards. These provisions have already been applied in respect of the transfer of certain functions from the former Health Commission to Second Schedule hospitals with considerable opposition from the unions concerned who as well as being opposed in principle to the movement of services outside the public service are seeking indefinite retention of existing conditions for these employees.

Indeed the union position seeks uniform conditions for all health employees with the objective of obtaining the conditions which embody the best of both the public service and public hospital systems.

This position if ever feasible is certainly not achievable under current depressed economic conditions.

2. Conditions of Employment

Some of the main problems with the differing conditions of employment are as follows:-

(1) Salaries

Basically the salaries are in line for the various categories of staff. A public hospital employee generally has a corresponding classification in the public service and to a large degree all relevant parties are working towards the goal of bringing them completely into line.

Differences do occur in basic medical salaries where the public servant is distinctly better off than his/her counterpart in the public hospital. When it comes to medical specialists the public hospital employee receives the same remuneration. However, the salaried doctor in public hospitals has additional rights of private practice.

The P.M.O.A. expresses some concern in this regard:-

"The Health Administration Act. There are specific areas of disadvantage to our members, which the Inquiry should also look at, particularly if it is going to recommend a shift of Schedule 5 to Schedule 2. As well as the matters affecting all other unions (permanency, leave differences, etc.) there are the following problems:-"

- "(a) Differences in basic salary of \$8,000 to \$9,000 p.a. between Schedule 5 and Schedule 2 Medical Officers. The Schedule 2 M.O.'s on the lower basic rate, have a better overtime clause in their award, and work more overtime, so that I should think earnings are similar. However, if Schedule 5 M.O.'s are transferred to Schedule 2, after three years they will revert to the Schedule 2 basic rate, and working half as much (or less) overtime will be very significantly disadvantaged.
- (b) The salary rates of Medical Superintendents in Schedule 2 hospitals depend on the size of the hospital, measured by the number of beds. Rates of Schedule 5 Medical Superintendents do not. Therefore, transfer to Schedule 2 will disadvantage many anyway; and if this is combined with reduction in official bed capacities (even though alternatives such as hostels, and the staff to run them, might still be the Medical Superintendent's responsibility) they will be disadvantaged further.
- (c) Equivalent positions do not exist in Schedule 2 for some members, e.g. Public Health; and there will be no promotional opportunities for them."

(Extract from letter of 13 December, 1982 from Public Medical Officers' Association to Inquiry.)

In respect of these views it is relevant to note:-

(a) Medical officers are employed in 5th Schedule hospitals primarily (but not exclusively) as trainees-in-psychiatry and are engaged for a five-year term. Consequently, they would not be greatly disadvantaged for any lengthy period once they qualify because they then become eligible for employment as specialists. In any event one must question the equity of allowing Registrars (i.e. trainees-in-psychiatry) in Fifth Schedule hospitals to be paid differently to the hundreds of their colleagues in Second and Third Schedule hospitals, including Psychiatric Registrars.

(b) The salary rates for Medical Superintendents in Second and Third Schedule hospitals are determined by grading each hospital. While the number of beds is a factor in determining an appropriate grading, it is only one factor (albeit an important one). For example, of equal or greater importance is whether or not a hospital is a University Teaching Hospital.

(c) In any case any disadvantages may well be offset by improved rights of private practice and the above comment does assume that medical officers will continue to work in the one setting which is much less likely under an integrated system.

(d) Further the last issue of the creation of equivalent positions is a matter which can be negotiated.

(2) Promotional Opportunities

Generally speaking, apart from the situation as outlined above, the opportunities for promotion for the majority of employees remain unchanged. However the nursing structure in the Fifth Schedule hospital allows for more middle management positions and nurses could lose promotional opportunities. In the process of transfer of these services to the Second Schedule System of management, a review should be undertaken of the number of promotional positions in these hospitals to ensure that adequate numbers are maintained to meet ward management requirements.

The virtual sole right of medical practitioners to the "Chief Executive Officer" position in the Fifth Schedule hospital would no longer exist as the position would be more competitive. However, it is noted that the most recently negotiated award covering Medical Superintendents in public hospitals provides a salary structure for Chief Executive Officers (medically qualified) across the whole range of hospitals. In theory, at least, the previous position is now open to change.

(3) Leave Entitlements

Leave conditions in the public service relating to sick leave provide for 30 days per annum after two years as opposed to 10 days per annum in public hospitals. Short and special leave, etc., are also superior.

Although subject to management discretion the opportunity to take recreation leave one day at a time is more readily available in the public service system whereas public hospital employees are limited by stronger exercise of management discretion and/or the provisions of the Annual Holidays Act. Scope also exists in the public service system to accumulate annual recreation leave to a greater extent.

(4) Promotional and Disciplinary Appeals

The Government and Related Employees Appeal Tribunal available to public servants is considered far superior by the unions to the use of the Conciliation Commission, the avenue available to public hospital employees.

The Conciliation Commission system of dealing with these grievances through a dispute lodgement mechanism is not compatible with an arrangement like GREAT (Government and Related Employees' Appeals Tribunal) which provides effective rights of appeal to an individual against certain management decisions.

A more effective grievance procedure should be established within the health system to provide for consideration of these issues when they affect the livelihood of individual staff without the necessity to invoke dispute notification arrangements.

(5) Mobility

One further area of difficulty is the loss of mobility within the public service. This could be especially important to administrative and clerical staff who seek careers elsewhere in the public service although it could be offset against the opportunities to move throughout the public hospital system.

(6) Other Issues

Other matters relating to loss of existing conditions would include such matters as hours of work (some public hospital clerical staff still work 40 hours per week), flextime, Easter/Christmas concessions, etc.

3. Union Coverage

A move to public hospital employment could bring about a number of inter-union disputes including, for example, demarcation issues between the N.S.W. Nurses Association and Health & Research Employees Association over coverage of nurses, between Health & Research Employees Association and Public Service Association over coverage of some technical staff, and between Public Medical Officers' Association and Public Service Association over coverage of medical staff.

The main unions and appropriate coverage are as follows:-

	<u>Fifth Schedule Hospitals</u>	<u>Public Hospitals</u>
Nurses, State Hospitals and Homes	Health & Research Employees Association	All nurses are covered by the N.S.W. Nurses' Association
Psychiatric and Mental Retardation Nurses	Joint coverage of Health & Research Employees Association and N.S.W. Nurses' Association	All nurses are covered by the N.S.W. Nurses' Association

	Fifth Schedule Schedule	Public Hospitals
Resident Medical Officers, Registrars and Medical Administrators	Public Medical Officers' Association	Public Service Association
Medical Specialists	P.M.O.A.	P.M.O.A.
Other Professional staff	P.S.A.	P.S.A.
Clerical	H.R.E.A.	H.R.E.A.
Administration (non-medical)	H.R.E.A.	H.O.A.
Hotel	H.R.E.A.	H.R.E.A.
Tradesmen	Craft Unions	Craft Unions

The Inquiry anticipates that industrial coverage of the new category of worker, Residential Care Assistant, in the care of the developmentally disabled, would be appropriately provided by H.R.E.A. In addition, it would be appropriate to seek continued joint coverage of nurses in psychiatric services through establishment of a special award, with the agreement of the Unions involved.

It would be naive to underestimate the potential for industrial conflict in this situation in the light of the unions' views on conditions of employment and the problems of inter-union disputes. This however, has to be balanced against the advantages which would flow from service and staffing integration of the kind proposed by the Inquiry.

(iii) Job Satisfaction and Consultation

The other important issue is that of job satisfaction. The Inquiry has been very concerned at the low level of job satisfaction of many staff, particularly in hospitals. It is clearly a desirable objective to try and improve job satisfaction along with changes that are proposed. Staff are the key resource and much thought has to go into deciding how they are best utilised in a productive manner for both themselves and the clients and what training and education might be needed.

To a large extent this problem is related to uncertainty about the future role of Fifth Schedule hospitals and is aggravated by the issues discussed previously.

For example:-

"Essentially solutions must be found to the staffing controversy as standards for both patient care and staff education should be maintained. The vital concern of the Association is that in spite of any changes in health care delivery of the psychiatrically ill and developmentally disabled whether fundamental or superficial, the profession of nursing and individual nurses must be allowed to operate free from the problems outlined above."

(Extract from Submission No. 260 - N.S.W. Nurses' Association.)

As already argued resource constraints which impinge on all activities of government (and indeed the community as a whole) must be faced in all areas and it is impossible to protect any service from these constraints. What can be done however, is to provide an improved management system subject to less confusing constraints than those operating in the Fifth Schedule hospital system. This should assist to resolve some of the current tension and constraints but will not eliminate resource constraints.

Further the Inquiry has been presented with considerable evidence to suggest that the alternative models of delivering care in a more community oriented setting offer improved opportunities for better job satisfaction:-

"The hostel as a social model is therefore more relevant in terms of increasing independence with less dependency on the institutional resources previously required. Perhaps less appreciated is that there is a higher degree of staff motivation and morale because of the relevance of their occupational role in teaching skills which are immediately applicable to the social environment. In addition there are real economic benefits, insofar as hostels on a per capita basis are more cost-efficient than an institution and have the 'potential' to be more so."

(Extract from Submission No. 300 - William Street Hostel Staff).

It is proposed to develop programmes for training of existing staff to assist them in the transition to more community based service delivery.

A related theme constantly put to the Inquiry is the concern for improved mechanisms for staff consultation. While it is likely that the demand for "consultation" is as insatiable as the demand for "health", the Inquiry has been concerned that information does not flow easily in the Fifth Schedule hospital system, that staff are not well-informed by management, and that mechanisms for consultation are in many places poorly structured.

One philosophy about consultation was outlined in "The Hospitals Consultative Committee - Report to the Premier - June, 1980", which commented as follows:-

"The Committee sees effective consultation, and other forms of participation, as a means of improving industrial relations.

Objectives of consultation -

- (a) to allow management to consult with or seek advice of subordinates.
- (b) to give representatives the right and opportunity to influence manager's decisions.

Joint consultation does not mean joint decision making. Management holds that right and responsibility.

The consultation process involves both manager and representatives raising problems and offering suggestions."

A specific suggestion for improved consultation at hospital level which is endorsed by the Inquiry, is that of upgrading the role of local welfare meetings in individual hospitals:-

"Unions are often told that there is adequate consultation and to cite examples management point to the formal 'consultative' processes, i.e. local welfare meetings and Joint Consultation meetings at Head Office level.

Whilst not suggesting for one minute that these meetings are not valuable, I would ask you to have a look at the minutes of those meetings and count the number of items that are initiated by management. That is to say that the vast majority of the items are the unions' reaction to decision taken by the administration or their reaction to rumours of decisions pending.

These forums would seem to be ideal opportunities for discussion of pending management decisions with a view to -

- (i) gauging possible staff reaction;
- (ii) receiving feedback on suggested improvements or alternatives.

The issue of providing adequate consultation would appear to be one that can be easily resolved if there can be a little trust and confidence from all parties."

(Extract from - T. Conoulty - "A Union Perspective on Management" - Paper presented to Management Forum held by Inquiry.)

At the level of individual hospitals or area boards, improved consultative mechanisms should be established with representation from key health unions to provide local management with views on issues affecting staffing and service priorities. It is also desirable that provision be made for elected representation from employees on all health service Boards and this is recommended for progressive introduction, perhaps commencing with the proposed Regional Boards for Developmental Disability Services.

9. TRAINING AND EDUCATION

The Inquiry's attention has been drawn to the issue of training and education for the wide range of staff providing services in the fields under review. It has not been possible to deal with each professional group in any detail and as nursing is the largest category of staff involved this section is devoted largely to nurse training.

(i) Nursing

1. Psychiatric Nursing

(1) Basic training

Basic training is currently undertaken in hospital training schools to standards set by the Nurses Registration Board involving a combination of theory and clinical experience in a number of specified areas (i.e. acute short stay; long stay/rehabilitation nursing; community nursing and geriatrics). A shorter post basic training programme is also available to nurses on other registers (e.g. general nurses) and covers similar ground to the basic programme.

The current syllabus of 1000 hours' duration was introduced in 1980.

There are four major issues related to basic training:-

- . the implications of its proposed transfer to the education sector (Colleges of Advanced Education)
- . the importance of students obtaining an adequate range of clinical experience

- . the implications of the move of basic training to a Single Register nurse ("comprehensive" rather than specialist training).
- . the adequacy of training for nurses aides.

The Inquiry has had considerable evidence placed before it about the problems of gaining adequate clinical experience under current training arrangements particularly within Fifth Schedule hospitals, for example:-

"In assessing resource requirements for the psychiatric service it is clear that psychiatric nurses will continue to play a major role in the care of psychiatric patients in a widening range of clinical and community settings. Already many patients are nursed in the community, in units attached to general hospitals and in private facilities. In addition there is a growing awareness (for financial as well as humanitarian reasons) of the need for primary prevention and health promotion programmes in the area of mental health.

It thus becomes of great importance that psychiatric nurse education be tailored to accommodate contemporary developments and the projected roles of the future.

The current system of training, which is almost exclusively confined to 5th Schedule hospitals, is grossly inadequate to the task of preparing nurses for those roles mentioned above."

(Extracts from Submission No. 107 from the Australian Congress of Mental Health Nurses - N.S.W. Branch)

"It is clear that increases in the educational requirement for admission to nursing and the extension of academic training during nurse training have resulted in a more intelligent and better trained group of young nurses. It is equally clear that the lack of education and appropriate training of the present group of senior nurses and supervisors has resulted in a group of managers ill-equipped to guide these young nurses.

Unfortunately it is the senior nurses who hold the power and have the greatest need to retain their job security. The final result is frustration for the younger nurses, lack of good models for these nurses, leading to a high level of turnover of young nurses and an insidious process of converting the young nurses who remain to acceptance of old and counter therapeutic standards."

(Extract from Submission No. 83: A Fifth Schedule Hospital Psychology Department)

On the other hand concern has been expressed that a movement towards training in Colleges of Advanced Education and to a Single Register is likely to reduce the psychiatric content of training (both theoretical and clinical) to an unsatisfactory level.

The Inquiry does not consider that it should traverse in detail these general training issues except to express support for the principle of training nurses in Colleges of Advanced Education. Training in Colleges of Advanced Education on a Single Register basis is consistent with the Inquiry's primary proposals for integration of services providing the psychiatric nursing content (both theoretical and clinical) in the curriculum is appropriate.

To this end it is important that existing practitioners be provided with an adequate opportunity to contribute to the development of the psychiatric content of the Single Register programme and also to appropriate post basic programmes.

A strong sentiment along these lines is expressed as follows:

"That decisions and control of psychiatric nurse education be made in conjunction with psychiatric nurse educators actively involved in psychiatric nursing and not by general nurses, nursing administrators or non-nursing personnel, which is the current practice."

(Extract from Submission No. 279 - Psychiatric Nurse Educators - Hunter Region.)

The Inquiry is recommending the expansion of the use of Enrolled Nursing Aides in staffing of specialised psychiatric hospitals. However, this category of staff would require improved training with input from experienced practitioners (including psychiatric nurse educators) designed to equip them to perform specific functions within these hospitals.

(2) Retraining and continuing education

The new 1,000 hour Psychiatric Nursing Syllabus introduced in 1980 has the stated aim of producing a nurse capable of working both within the hospital and within the community. Whether or not current training will fulfil this aim, there is still the issue of the large pool of institutional-based registered psychiatric nurses trained before 1980 under a less broadly based syllabus which among other things provided for no community experience.

Optional programmes of training, either in-service or externally conducted, should be instituted or upgraded to improve the knowledge and experience of those nurses who completed training under older syllabi and this should be undertaken as community services are expanded and institutional care reduced.

With the development of new techniques in management of patients/clients the continuing education needs of all registered nurses should continue to be met through access to courses run by other institutions and through formal in-service provision.

2. Mental Retardation Nursing

(0 Basic training

The interim 1,000 hour Mental Retardation Nursing Education Programme introduced in 1980 while a great improvement on the previous programme is still criticised for the paucity of community orientated training and community experience required. It does however reflect the thrust in the field of developmental disability towards "normalisation".

A developmental model of care applying educational principles would appear to be a prerequisite for the majority of developmentally disabled persons, though with the multiply handicapped there may need to be a heavier emphasis on basic nursing care, and with the emotionally disturbed a heavier emphasis on management aimed at modifying behaviour. The present course would appear to meet many of the requirements of this developmental model of care.

The basic issue in this area is the appropriateness of nursing as a discipline as such to provide services for the developmentally disabled given the needs of these clients for a developmental model of care applying educational principles. The recommendation in Part 2 of the Report is for a new arrangement for staffing of developmental disability services with a new category of direct care worker (the Residential Care Assistant) and increased use of Programme Officers (with upgraded training). The current nurses would be able to move into positions of Programme Officer provided they are prepared to undertake the necessary training.

As these alternative programmes are developed, the Inquiry proposes that training designed to produce specialist mental retardation nurses should be phased out.

3. Geriatric Nursing

It is considered appropriate that the current practice of undertaking geriatric nursing as a post basic course be continued. A number of post basic courses are currently available however, greater emphasis needs to be placed on developing skills in the care of the disturbed elderly. Those staff trained under previous basic geriatric courses should be encouraged to undertake further training.

(ii) General Medical Practice

The role of general medical practitioners as primary care providers is important, particularly in the areas of mental health and care of the elderly. Where a general practitioner is involved, public sector health services should make every effort to actively consult and coordinate their services with that practitioner. Conversely, it is important that general practitioners are educated and informed about the role and functions of public sector mental health services and their potential benefits for the client. The Inquiry therefore proposes that the Department of Health consult with the College of General Practitioners regarding the development of appropriate programmes to assist in this area.

(iii) Psychiatry 1. Special

Training Requirements

While the high standard of psychiatry practised by doctors in Australia and examined by the Royal Australian and New Zealand College of Psychiatrists is internationally recognised, the segregation of services into Second, Third and Fifth Schedule systems in New South Wales has led to some restriction in broad clinical experience for some trainee psychiatrists.

The Inquiry views with some concern the fact that it is possible for one Second Schedule hospital group and one private facility to provide all the clinical experience necessary, without the psychiatrist having to work in a Fifth Schedule hospital. The point has been forcibly made to the Inquiry that there are some categories of patients for whom acute general hospital psychiatric units are unable to provide a service, and for these groups the general hospital units look to the Fifth Schedule system to provide back-up facilities. The current practice of not requiring all psychiatrists-in-training to gain experience in institutional psychiatry could lead to a situation where an inferior service is provided to those patients in the specialised rehabilitation hospitals of the future.

The suggestion has been made that it would be advantageous for psychiatrists-in-training to receive some training in private facilities or by attachment to private psychiatrists.

Some of the difficulties in gaining a broad clinical experience inherent in the current segregated system may be overcome by the Inquiry's major recommendations but it would seem that more effort should be directed to ensure that psychiatrists-in-training receive the widest possible clinical experience.

(iv) Other Professional Disciplines

It is not intended to deal separately with each category of health professional forming the other components of the multidisciplinary health team. The major groups are psychologists, social workers, occupational therapists and speech therapists.

The standards of training of each discipline are set by universities or colleges and/or by professional bodies.

11. IMPLEMENTATION

in view of the industrial issues surrounding the Inquiry's recommendations proposing that services be managed by Boards of Directors rather than the Department of Health, it is proposed that a Task Force be established by the Department of Health and the Public Service Board to implement the transfer of staff from under the Public Service Act 1979 to become employees of the above Boards. This Task Force should consult actively with the Labor Council of New South Wales.

In respect of proposals for funding of community services and rationalisation of hospitals implementation timetables are included in Parts 2 and 3. It is considered that to monitor this process and to coordinate implementation of the Inquiry's other proposals, the Department of Health should establish an Implementation Steering Committee (with Regional involvement) and Project group similar to the mechanisms used in the current health services redistribution programme.

Appropriate consultative mechanisms need to be utilised or established at different levels to involve the unions and staff concerned. The Health Services Industrial Consultative Committee should be utilised as a peak group in this regard and formal mechanisms established or utilised where appropriate at Regional and hospital level. In those Regions such as Hunter, Southern Metropolitan, Western Metropolitan, Northern Metropolitan, South Eastern and Central West, where significant numbers of staff are affected by change, a senior officer should be given full time responsibility for dealing with staffing issues arising from the proposed change in employment auspice.



**INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL AND
DEVELOPMENTALLY DISABLED**

PART2

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1. INTRODUCTION

Part 2 of the Report of the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled examines services for the developmentally disabled, and sets out to:-

- (i) identify preferred patterns of service delivery in the light of the general values and principles outlined in Part 1, and the special needs of the developmentally disabled
- (ii) translate these into specific proposals to meet needs using minimum resource costs
- (iii) develop plans to achieve and implement these proposals.

2. RECOMMENDATIONS

The following recommendations arise from Part 2:

That the Minister for Health -

(i) endorse the principle that the provision of services for the developmentally disabled within the health administration should be based on:

(a) promotion of maximum development and education of each individual;

(b) pursuit of the objectives of normalisation and integration;

(c) promotion of the rights of people with disabilities; and

(ii) recommend to the government their adoption and application to all areas of government policy relating to the care of the developmentally disabled. (refer to Section 3.2)

3. That the role of health services in the area of developmental disability be endorsed as follows:

(i) Development and implementation of preventive programmes;

(ii) Provision of comprehensive diagnostic/assessment and associated counselling.

(These services should be available to all developmentally disabled children and their families);

- (iii) Provision of early intervention programmes (in consultation with the Education Department and the Department of Youth and Community Services to ensure a range of programmes are developed);
 - (iv) Provision of home support services (in consultation with the Department of Youth and Community Services, the Home Care Service of N.S.W. and Local Government as appropriate);
 - (v) Development of small community residential units to rehouse residents from existing institutions;
 - (vi) Development of small community residential units for the severely disabled, particularly the severely intellectually handicapped, and others with severe physical conditions, both children and adults, who are unable to continue living with their families;
 - (vii) Provision of respite and shared care arrangements within these units;
 - (viii) Provision of specialised therapeutic services as required;
 - (ix) Access to general health services for the "routine" physical and mental health needs of the disabled.
- (5)

3. That an amount of \$200,000 be allocated in 1983/84 from the Hospital Health Promotion Programme for a public education programme on the importance of ante-natal care and the availability of screening and genetic counselling services. (6.1)

4. That from the specific allocation referred to in Part 1 (approximately \$9 million per annum for the next three years), an amount of \$4 million per annum be allocated to developmental disability services. (6.1, 8.1).
- S. That \$1.5 million of these funds be allocated per annum to the expansion of diagnostic, assessment and community support services, with priority to the Western Metropolitan, Hunter, South-East and Central West Regions in the first year. (6.1, 8.1)
6. That all public hospitals implement a policy to ensure that parents of all handicapped children identified at or soon after birth are automatically given access to counselling and assessment and early intervention services. (6.1)
7. That the Health Department implement a policy that all admissions to health services residential facilities and participation in programmes be dependent on prior assessment and subject to regular review by community assessment services. (6.1)
- a. That each Region establish a Residential Placement Committee (6.1).
9. That Regional and local management review the location of work oriented facilities and initiate their relocation to community-based premises. (6.1)
10. That the Department of Health consult with the Department of Social Security regarding the potential expansion of co-operative arrangements in the provision of activity and work-related programmes. (6.1)

11. That the Health Department adopt a long term policy of providing all health care residential services for the developmentally disabled in small residential units (with varying staffing levels depending on particular clients' levels of disability).
12. That in each Region a network of community residential units which would normally be ordinary houses each accommodating from 5-10 people be established to provide both short (including respite) and long term residential care and social and living skills training for developmentally disabled people. (6.2)
13. That from the specific allocation (\$4million per annum) referred to in Recommendation 4, an amount of \$2 million be allocated to Regions to assist in the development (either directly or through non-government organisations) of community residential units to re-house adults currently resident in institutions and those at home urgently in need of placement. (6.2)
14. That priority for the funding of such units in the first year should go to the Hunter, Western Metropolitan, Southern Metropolitan and Northern Metropolitan Regions. (6.2).
15. That initially these services be funded from the total hospital budget; and that from 1984/85 resources for this purpose be augmented from savings to be achieved through proposed reductions in the size and number of existing institutions. (6.2)
16. That from the specific allocation (\$4million per annum) referred to in Recommendation 4, an amount of \$500,000 be earmarked for the support of innovative programmes such as supportive accommodation for developmentally disabled women with children ("Women in Limbo" proposal). (6.2)

17. That the Minister for Health, in consultation with the Minister for Youth and Community Services, negotiate with the Minister for Social Security to improve co-ordination of planning and service delivery and to develop proposals for joint Commonwealth/State funding of these services. (6.2)
18. That the Minister for Health negotiate an arrangement with the Minister for Housing whereby a proportion of welfare housing stock in existing and proposed developments is specifically made available as community residential units for developmentally disabled people. (6.2)
19. That within existing hospitals emphasis in client care be based on the implementation of independent living training programmes. Direct care staff to be responsible to the programme staff for programme maintenance and achievement. (6.2)
20. That as resident numbers decrease the ratio of direct care staff per resident at Stockton Hospital be gradually increased. (6.2)
21. That Regional Directors negotiate formal contractual arrangements between hospitals and Regions to provide social work, psychology and occupational therapy services, where recruitment difficulties are experienced. (6.2)
22. That a new category of direct care staff be established -to be titled "Residential Care Assistant". This category to be used in the expansion of community residential units and eventually as direct care staff in hospitals. (7.1)
23. That the Department of Health negotiate with the Department of Technical and Further Education for the development of an appropriate "apprenticeship-type" educational programme for this category of staff. (7.1)

24. That the employment of "Programme Officers" be expanded as a major staff category in community developmental disability teams, and in specialised hospitals. (7.1)
25. That the Department of Health negotiate with the appropriate education authorities for the development of a suitable undergraduate or postgraduate programme at College of Advanced Education level for this category of staff. (7.1)
26. That at the appropriate level (Regional or supra-Regional) a community based Board of Directors be established with the responsibility for the management of all services within the health administration for the developmentally disabled, both residential and non-residential. Appropriate advisory mechanisms should be established to ensure input from parent and voluntary groups and from local government and the Departments of Youth and Community Services, Education and Social Security. (7.2)
27. That these services be managed by a Chief Executive Officer responsible to the above Board. (7.2)

That care of the developmentally disabled in specialised hospital settings should be separated from the care of the psychiatrically ill by the establishment of a distinct management organisation, responsible to the above Boards, and by the degazettal and physical separation of services. (7.2)

That the role of the Senior Specialist for Developmental Disability Services in the Central Administration of the Health Department be strengthened by involving him or her to a greater extent in budget decisions affecting provisions of services. (7.2)

That the Minister for Health consult with the Attorney-General regarding the development of appropriate guardianship legislation for these clients. (7.4)

31. That the following targets be adopted for the expansion of community residential services recommended above and the reduction of existing institutional services for the developmentally disabled by 1986. (The following targets should be viewed as interim pending the further expansion of community services). (8.2)

Region	FIFTH SCHEDULE Current	HOSPITALS Reductions	Target	Community Residential Target	Target Total 1986
Western					
Southern Metropolitan	276	244	32	300	332
Northern Metropolitan	316	174	142	150	292
Hunter	1052	382	670	390	1060
South-East	200	100	100	100	200
Central West	198	100	98	100	198
Illawarra				12	12
North Coast				12	12
Orana & Far West				12	12
South-West				12	12
New England					
Total	2913	1301	1612	1478	3090

3. HOW ARE CLIENTS' NEEDS BEST SERVED?

3.1 What are Clients' needs?

Aside from advice from health and welfare professionals, the Inquiry's views of clients' needs in this area have been formulated largely on the basis of submissions received from non-government service provision and advocacy groups, and the limited amount of Australian and overseas research which is available. These non-government groups are in the main composed of parents of disabled people, with some interested professional involvement, and represent by far the strongest and most articulate advocacy for the needs of disabled children and adults and their families. Their perspective which comes from such a deep and close involvement in the problem is invaluable, however their capacity to fully represent the views or needs of disabled persons themselves can be constrained by this very closeness which may lead to an over-protective approach. This limitation only highlights the need for a broader base of advocacy for the disabled and the need to develop mechanisms which actively enable them as far as possible to speak for themselves.

The term "developmental disability" means a severe chronic disability which -

- (a) is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments:
- (b) is manifested before the person attains age 18:
- (c) is likely to continue indefinitely:
- (d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency: and

- (e) reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and co-ordinated.

For practical purposes this includes persons with intellectual handicap, severe epilepsy, cerebral palsy, brain damage acquired in childhood, and those with other neurological disorders needing similar provision.

This term was adopted by the (then) Health Commission to:

- (i) replace the stigmatised expression of "mental retardation" and "intellectual handicap"
- (ii) emphasise the developmental or educational/learning nature of the disability and the services required to assist clients.
- (iii) encourage increased access to comprehensive multi-disciplinary diagnostic and assessment services to enable assistance to be provided as early as possible.
- (iv) minimise partial or inappropriate diagnosis and therefore labelling especially of children with a range of physical and other disabilities prior to comprehensive diagnosis and assessment.
- (v) recognise that a proportion of the handicapped have both intellectual and physical disabilities.
- (vi) encourage paediatricians and others associated with early childhood health services to refer clients for more effective assessment.

In 1982 the (then) Health Commission published a draft policy document entitled Health Services for the Developmentally Disabled which outlined policies and proposals for services and sought public comment. This document together with comments on it was referred by the Minister for Health to the Inquiry for consideration in its deliberations.

The use of the term has raised the anxiety of several groups (who would in principle support the widening of access), for example:

"The use of the term "developmentally disabled" without clear direction as to the implications of this is causing some confusion to parents and others. The change of name would seem to imply more than simply re-naming "intellectual handicap", or "mental retardation". Using the definition of "developmentally disabled" incorporated in the recent draft Health policy it would appear that the Health Commission is now responsible for services to a much wider range of people, e.g. cerebral palsied people, and those with physical handicaps. By contrast, most of the individuals and groups presently relating to the term "developmentally disabled" are those concerned with intellectual handicap."

"Services provided presently to those people with intellectual handicap are understaffed, inadequate and unevenly distributed throughout the State. Because of the expansion of the role of the Health Commission, even more resources are now required to meet the needs of the additional clientele. In addition, community nurses within Health Commission teams are not trained in developmental disability. Rather, it is the Action Group's understanding that the nurses are "mental retardation" nurses."

"It is the Group's opinion that parents of children with disabilities other than intellectual, but who now fall within the definition "developmentally disabled", and disabled people themselves, do not realise"

"that the Health Commission has a responsibility to provide services for them."

(Extract from Submission 5.313, Action for Handicapped Citizens, a Northside Group.)

One of the underlying concerns as expressed in this and other submissions is that the broadening of eligibility will result in reduction of resources to the already inadequately resourced area of care of the intellectually disabled.

The Inquiry is also concerned that the unforeseen effect may be to generalise stigma on to those people with purely physical handicaps.

The Inquiry endorses the intent of the change of name, to broaden access of disabled people to comprehensive assessment services and to reduce the stigma of intellectual handicap. These desired changes may also be achieved in other ways. For example, comprehensive assessment services will be more accessible if linked to the paediatric services of general hospitals. The stigma associated with the term "intellectual handicap" will only be reduced as community perceptions change through more positive contact with handicapped people.

On balance, it is considered that the term "developmental disability" covers the broader range of needs and the complexity of the inter-relationship between physical and intellectual disabilities more adequately than other alternative terms and should continue to be used.

It should be recognised that the largest group within this category are those whose primary disability is intellectual, and services are largely directed to this group.

It has been stressed consistently to the Inquiry that developmental disability (in all its forms) is not primarily a medical problem but an educational and developmental problem. This was expressed most coherently by the N.s.w. Council for the Mentally Handicapped, in their submission in response to the (then) Health Commission draft Policy Document:

"Council's Philosophy & Policy Document defines a person who is intellectually impaired as one who has one or more impairments which limit that persons rate and extent of learning so that he or she cannot achieve competence for living or working as an adult without assistance related to the areas of the persons limitations."

"IN OTHER WORDS ... intellectual handicap of itself is a learning condition and does not require medical treatment in the sense that there is a sickness to be managed or treated."

"PRIMARY NEEDS OF AN INTELLECTUALLY HANDICAPPED PERSON

The result of an intellectual handicap is that - if uncorrected - the person affected may exhibit behaviour below the standards of personal independence and social responsibility expected of non-handicapped persons of the **same** age and cultural group.

This behaviour can be improved and remedied by developmental and educational programmes which will differ according to the age of the individual concerned."

¹¹ AGE GROUP	POSSIBLE DELAYED BEHAVIOUR IN	SERVICE REQUIRED
Infancy/ early childhood	Sensory skills Motor skills development Communication skills Self help skills Socialisation	Early assessment Early intervention Appropriate pre-school
Childhood and Early adolescence	Application of basic academic skills in daily living Application of appropriate reasoning and judgement in mastery of the environment Social skills	Specialised education Independent living Socialisation

Late adolescence Adult life	Vocational and social responsibilities and performance	Job training Sheltered employment accommodation Personal advocate"
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"All services listed above are educational/welfare in orientation and are designed to promote independence and integration into the community."

"SECONDARY NEEDS OF AN INTELLECTUALLY HANDICAPPED PERSON

"Intellectual handicap may have associated with it physical conditions that require remedial non-medical therapies such as physiotherapy, speech therapy and occupational therapy."

"Such services are educational/welfare in orientation since the r purpose is to develop the capacity of an intellectually handicapped person for independence and integration into the community."

"TERTIARY NEEDS OF AN INTELLECTUALLY HANDICAPPED PERSON

Like the rest of the community, the intellectually handicapped person may contract an illness, develop a condition or have an accident that requires treatment from general community health services and hospitals."

As the Council went on to emphasise, the interrelationships between these needs clearly indicate the necessity for co-ordinated inter-departmental and interagency planning, involving both government and non-government services.

"Council's Board does not consider that all the needs described (above) should be met by the Health Commission. Many could be more appropriately met by other Departments and/or voluntary organisations, and vice versa. Many services are not being provided in a meaningful way by ANY organis-ation.

In addition, the Board believes that there has to be a radical re-organisation of the services currently provided by the Health Commission, with a shift from institutional care to community based care."

The consensus from submissions, the Inquiry's forum with community groups and general discussion further emphasised the importance of a developmental and educational approach, the need for continuity of care through a highly integrated network of services, and for emphasis on normalisation, through services provided in the home or settings which as closely as possible reflect a home environment.

3.2 Principles of Service Delivery

The following extracts from the N.S.W. Anti-Discrimination Board Report on Discrimination and Intellectual Handicap (1981) provide some basic principles underlying the provision of services and these are endorsed by the Inquiry:-

"... in general the services for people with intellectual handicaps need to be transformed to promote the maximum development of each individual, to pursue the objectives of normalisation and integration and to promote the rights of people with handicaps. This transformation is required in many areas of health services at present being delivered to people with intellectual handicaps."

"... intellectual handicap does not by itself call for medical treatment."

"... intellectual handicap itself calls for developmental and educational programs and non-medical health therapies such as physiotherapy and speech therapy."

"The health services have a proper and important role in preventing conditions that can result in intellectual handicap in diagnosis, in medical treatment where it is required and in providing non-medical health services ..."

"The dominance of the medical model has unfortunate consequences for some health services ... these include services for people with disabilities and chronic conditions ... (who) are often poorly served at present because services provided do not match needs and the methods of delivery are ineffective and expensive."

" the delivery of community health services should in many instances depart from the medical model and ... serve the developmental model ..."

"The first principle underlying our examination of accommodation for people with intellectual handicaps is the right of access to a residence that is appropriate to the capacities and desires of each person, located in reasonable proximity to family and friends. Further principles are normalisation, the right to developmental programs, and the right to live in the least restrictive situation that can be provided."

"Only a very small proportion of people with intellectual handicaps are actually physically ill .. the major need is for programs to develop skills and social competence."

These principles have been accepted and adopted internationally, and incorporated in significant planning documents in other States of Australia, most recently in the South Australian Report - "A new pattern of services for intellectually handicapped people in South Australia" (1981).

The Inquiry from its investigations believes that there is acceptance in all service systems in New South Wales that the predominant form of service delivery should emphasise effective multi disciplinary assessment of clients and on-going services in an educational/ developmental mode with "medical" health input varying to meet the needs of particular individuals or groups.

A developmental approach is already in operation in many parts of the health system and can be improved with appropriate management, staffing and service delivery arrangements. Such an approach should be formally adopted as policy in this area of health services and in other government services for these clients.

The Inquiry proposes that the Minister for Health endorse the principle that the provision of services for the developmentally disabled within the health administration should be based on:

- (a) promotion of maximum development and education of each individual
- (b) pursuit of the objectives of normalisation and integration
- (c) promotion of the rights of people with disabilities.

Adoption of these principles will reinforce the directions already developing within health services:

"It is important that the system of health care be based on principles of normalisation and integration of disabled people in the community."

(Extract from S254: Social Workers for the Developmentally Disabled)

"It is now realised that a community orientation is the most appropriate if the person with developmental disability is to achieve 'behaviours and characteristics which are as culturally normative as possible' (Wolfensberger, 1972)"

(Extract from S226: Occupational Therapy Study Group in Developmental Disability).

4. CO-ORDINATION OF GOVERNMENT SERVICES

n

Some advocates have argued to the Inquiry that the services currently provided within the Health Department should be transferred to another administration such as the Department of Youth and Community Services.

All departments are constrained by their existing practices and approaches and although a sound theoretical argument may be developed to move services away from Health, the Inquiry is not convinced that this will really make much difference to the quality and range of services available to these clients. A real concern is that they could decline.

The Inquiry has seen some very effective services provided from within the health administration and the emphasis needs to be placed on improving these services along with a reduction in large scale institutional care. A change of administrative auspice will not, at this stage, facilitate this process particularly when most of the available and potential resources are located within the health system.

The Inquiry believes a focus for all service providers can be provided by improving co-ordination and advocacy for these services and allowing the respective service departments to continue to develop better services in accordance with the philosophies outlined in this and other recent reports.

It is a truism that the care of the developmentally disabled requires a highly co-ordinated interdepartmental approach, yet it has not been possible for the relevant departments in New South Wales to achieve a joint co-operative policy on the care of this group.

For example a long-standing arrangement in this area has been the 1964 agreement between the Health Department and the Department of Youth and Community Services that the welfare department would care for the mildly and moderately retarded, and that the Health Department would primarily care for the severely and profoundly retarded and also for the less retarded with specific physical health problems. Such an arrangement has of course never been fully implemented because the bulk of the government's resources in this area have been located in the large hospitals which have by default continued to provide long-term placement for the whole range of intellectually disabled people, in the absence of other services. In 1979, the (then) Health Commission again endorsed this agreement and clarified its role in the provision of preventive and assessment services.

From the client's point of view, the critical issue is that service is provided on the basis of their total functioning capacity rather than one aspect of their problem.

Assessment services must be accessible to the whole population and are appropriately provided by the health system. Once assessment takes place, the issue of continuing intervention by the appropriate service can only really be resolved at the point of service, in the light of the client's total functioning and needs. Some clients depending on the services available could be equally well assisted in either the health system or the welfare system.

The gradual expansion of Education Department services in recent years, based on a policy of universal access to education and integration within schools, and the more recent entry of the Department of Technical and Further Education (providing programmes to develop independent living and employment skills) and the Housing Commission into this area of service delivery has added further weight to the arguments of the non-government sector for improved co-ordination.

The Commonwealth government is also active in this field, primarily through the Department of Social Security and the Department of Health, and more recently through Schools Commission funding of early intervention programmes. Effective planning of services must involve these organisations.

The need for improved co-ordination has been argued by the non-government organisations for some time, and was a theme of submissions to the Inquiry. The issues relating to this matter have not changed since 1981 when the Anti-Discrimination Board ("Discrimination and Intellectual Handicap") concluded:-

" Many submissions to the Board described shortcomings in services which can largely be attributed to a failure of diverse service-providing agencies to integrate and co-ordinate their activities within an overall plan. Well documented problems include difficulty in obtaining appropriate referrals from one agency to another, overlap and duplication of services in some localities and gaps in others, and the needs to consolidate staff training programs, career structures and industrial agreements. The Board has given careful consideration to various strategies that have been proposed to overcome these difficulties. The proposals range from reactivating the Inter-Departmental Standing Committee on the Intellectually Handicapped, to establishing a new statutory authority to provide a wide range of special services for people with handicaps."

"The Board rejects the option of attempting to reactivate the Standing Committee. This decision is based partly on the apparent failure of the committee to provide effective leadership and co-ordination in the past, but more importantly because the Board perceives a need for an authority with overall policy responsibilities, separate from departments with responsibility for providing services. The Board believes that the agency would, among other functions, act as an advocate for people"

"with intellectual handicaps by monitoring and evaluating services and pressing for improvements. The agency should also be prepared to act as an advocate for individuals who complain about aspects of service provision. This advocacy could create a conflict of interests if the agency itself is involved in service-delivery."

"The major role envisaged for the authority is the co-ordination and rationalisation of delivery of services required by people with intellectual handicaps. Experience has shown that a co-ordinating body cannot succeed in its tasks if it is within or attached to one of the service departments."

On the basis of its investigations and the history of inter-departmental relationships in this area in New South Wales, the Inquiry endorses the need for a co-ordinating mechanism. In the Inquiry's view, ideally such a mechanism should be attached to a Department which is independent of the main service providers, and should not itself take on a role in service provision.

Co-ordination involves the following functions:

advising the various responsible
Ministers on matters relating to
services for developmentally disabled

persons:

co-ordinating policy development and
planning of the various State government
departments in consultation with the
Commonwealth and the non-government
sector:

considering submissions from
parent groups and service providers
relating to the ongoing development of
service provision:

recommending priorities for the expansion of existing services and the establishment of new services;

advising on the allocation of funds for service• between departments and for the provision of funding to non-government bodies;

recommending the development of appropriate performance and provision standards;

recommending guidelines to be followed in considering applications for funding from non-government organisations;

performing an overall liaison role;

recommending on evaluation and reaearch programmes, and the development of necessary data bases.

5. THE ROLE OF HEALTH SERVICES

The Health Commission's Draft Policy Document, ..Health Services for the Developmentally Disabled.., released during 1982 summarised "the purpose.. of health services for persons with developmental disabilities as:-

- "1.1 Early identification and treatment followed by early intervention.
- 1.2 The provision of normal patterns of life within the community as far as is conceivably possible.
- 1.3 Individually tailored programmes designed to maximise their potential and their quality of life.
- 1.4 Ready access to aid and support both for themselves and their families throughout their lifetime...

It also argued that there are only a minority who cannot live either at home or in small units within the community, that developmental disability services should be divorced from psychiatric services and identified two main problems in present health services:-

"The main problem for the Health Commission of New South Wales is to devise ways of moving away from the past provision of services in large isolated institutions to a community-based integrated service for the majority of its clients at a time of severe financial constraints. There is evidence to suggest that initially there will be additional costs but in the longer term the cost of such care will be cheaper. At present our largest institution has 800 beds and our smallest 5."

"Not only is there the problem of the large institution, but also a geographic maldistribution of the available beds with a very significant shortfall of adult beds and services as most of the

developments since regionalisation have been provided for children."

The draft policy document identified the role of health services as follows:-

"The Departments of Education and Youth and Community Services have major roles to play in the provision of services, and, indeed, together with voluntary and church organisations, provide for the vast majority of persons with developmental disabilities. The Commission accepts ongoing responsibility for the care of the severely and profoundly affected and for those less intellectually handicapped who have additional problems of a neurological, behavioural, physical or sensory nature which require a high health input."

The components of the health service role were identified in the draft Policy Document as:

Prevention

(including community education re antenatal hazards, genetic counselling and screening).

Identification and Intervention

(including specialised diagnostic and assessment services, support and counselling services and early intervention programmes).

Accommodation

(including community-based residential services "for those needing care in a health setting", and specialised hospital facilities).

Long-term Support Services Co-ordination

(including co-ordination committees and identification of a responsible person for each client.

Responses to this draft policy document from a number of organisations and groups reflected major concerns.

Firstly, that the draft policy represents the intention of the health service to retract resources by limiting eligibility to residential care to the more profoundly disabled and those with physical health needs. The Inquiry understands that the policy is a restatement of the earlier agreement with the Department of Youth and Community Services, however the agencies have a legitimate concern about the availability of resources to other Departments, particularly Youth and Community Services and their ability to develop the necessary services for the less disabled.

As expressed by Action for Handicapped Citizens:

"Action for Handicapped Citizens recognises that the Health Commission sees itself as catering for those people who do not fit this description but who nevertheless live in the Health Commission Schedule V hospitals. However, the long-term implications are unclear, and many parents may fear that their sons and daughters will be dumped. It has already been stated in our region that no new client will be accepted into the Health Services who is considered outside the role of the Commission. Whether this is happening in practice is difficult to ascertain.

"The group considers that, while this is a correct decision, the problems faced by families and developmentally disabled people themselves who are not offered any alternate service by other government agencies will have to be recognised and met as a matter of urgency."

"The Group faces a dilemma in addressing itself to a submission regarding "health services" for people with developmental disabilities when it considers that the principal needs of this group of people are social and educational, and that there are particular health needs occurring at any time in the life of a developmentally-disabled person or the family, which should be met by the Health services."

"The group -itself faces the same dilemma in its activities at "grass roots" level in trying to gain better services."

"The historical fact that the Health Commission of N.s.w. has, by default, provided residential services for children and adults is recognised. In addition, it is recognised that clients presently in institutions are there because, at the time, it was considered an appropriate form of care. The group considers that, should history repeat itself, the Commission would provide different forms of services for developmentally disabled people and their families."

"In addition the difficulties faced by the Commission in relation to the training and education of people who have been institutionalised for many years are recognised."

"It is the view of the Action Group that the present situation is compounded by the recognition of the fact that not only should mildly or moderately handicapped people be given community-based options, but that those with severe and profound handicaps who, until very recently were considered unable to benefit from this form of service, should also have this option."

"The Health Commission therefore faces the added dilemma of having to plan different options for a great majority of its present institutional clients, and must now consider the future of the large institutions. They will certainly not be appropriate for the very small percentage of people who are assessed as requiring total medical supervision and care."

"Consideration has to be given to increasing the budget of another Government Department to enable a range of residential needs to be met while, at the same time, maintaining the Health Commission budget in its transition period from institutionally-based services to community-based services and to provide adequately for those people assessed as requiring total medical care."

(Extracts from 5313: Action for Handicapped Citizens a Northside Group) •

The second and related concern is that the policy document does not go far enough in the direction of "normalisation", and continues to place undue and inappropriate emphasis on medical/nursing care and hospital services for example, another group, Action for Intellectually Handicapped Citizens, in their response to the document, stated:

"We represent a group of parents and concerned citizens in the eastern and southern suburbs and many of the proposals of your draft policy strike a very sympathetic chord with people in our group, particularly in the aims of the services to be provided and in the recommendation for expanded residential facilities.

At a committee meeting to discuss the draft policy a number of points were raised which we would like to submit for your consideration before the final policy document is proposed:-

A major concern of the committee was the suggested size of the specialized hospitals intended to accommodate those who cannot be cared for adequately in the community residential units. It is difficult to see how the stated aim of the greatest degree of normalization possible could be achieved in a hospital of even 100 beds and we would question whether there would be any advantage in these specialised hospitals being larger than a community unit of a recommended maximum of 30 beds.

The design and staffing specifications of the community units also caused some concern. As represented in the diagram it does not conform to the expressed aims of normalization which is the theme of the policy. In particular we believe that the community team and the assessment and therapy staff should be geographically separate from the residence. The inclusion of a day care unit and therapy centre in the design of the community units also seemed a contradiction of this aim."

It has also been argued, as indicated above, that the "medical" or "illness" perspective so strongly permeates the health services that they cannot perform a broad educational/developmental role and therefore the role of the health services should be strictly defined to a narrow medical service.

Such a view of the role of health services for these groups has been presented by The New South Wales Advisory Council on the Handicapped which proposed redefinition of the "health" role within the context of the proposal to establish a Statutory Authority to be known as the Handicapped Persons Authority (which would perform multiple roles including advocacy, policy formulation and service delivery - see previous section) as follows:-

"(1) Community Services

Prevention - including immunisation, genetic counselling, etc.

Assessment - including medical and behavioural aspects as part of joint assessment processes.

Regional specialist medical teams.
(NOTE: Council proposes that non-medical staff of existing Health Developmental Disabilities teams would be absorbed in and form the basis of the Authority's new community service teams.)

"(2) Residential Services

- Health to be responsible for centres for people who require 24 hours, full-time nursing care."

". Authority to be responsible for all other residential services and contract with Health for specialised medical services for any resident who needs them."

"Council envisages that the new Authority would base its new community service systems on a new category of staff - "social trainers". Many displaced Health workers would be able to be retrained (in short courses) for this role. This could be interpreted positively to Unions."

(Extract from document presented by the New South Wales Advisory Council on the Handicapped.)

The Council made the following general points to the Inquiry about future directions for these services generally:-

"(a) Future Residential Services. That future residential services should be community-based thus ceasing the placement of developmentally disabled children and adults in large institutions.

Council is totally opposed to the concepts outlined in the draft policy document entitled "Health Services for the Developmentally Disabled".

"(b) Deinstitutionalisation. Council is most disturbed that the vital issue of deinstitutionalisation is not being pursued with sufficient vigor because present Government policy only allows for the disposal of assets provided the funds are returned to consolidated revenue. Unless this policy is changed the mistakes of the past cannot be rectified. Present residents will be confined to an institutionalised existence and, in addition, future generations of developmentally disabled people will be placed in institutions simply because they exist."

"It is therefore recommended that the Government move immediately to adopt a policy of deinstitutionalisation by the sale of present institutions. Implicit in such policy is that when"

"Government land or buildings are sold, the total sale price be used for the purchase of some suitable premises and appropriate support services for those previously resident in large institutions."

"(c) Staff Redeployment. Council, while recognising that many people are employed in institution settings nevertheless is of the opinion that there would be no reduction in employment caused by the shift of emphasis to community setting. The Council sees the need for the implementation of retraining and upgrading of the qualifications of some staff from which the community as a whole would benefit in the long term."

"(d) Shifts of Emphasis between Government Departments. In view of the principles Council is advocating that the Government should adopt a major implication would be a shift from Health Commission controlled services to allow the Department of Youth and Community Services, Education and Housing to increase their level of activity in direct service delivery to developmentally disabled people.

The transition from Health Commission to greater involvement of other relevant Departments needs a planned and orderly approach and in addition a commitment by the Government to provide a positive, co-ordinated plan of action."

"(e) Need for an Independent Statutory Authority.

Council is of the opinion that the only way to achieve positive co-ordinated services for the developmentally disabled is for the Government to establish an independent Statutory Authority."

(Extract from document presented by the N.s.w. Advisory Council on the Handicapped.)

The Inquiry does not support the argument that health services should have little or no role in the care of the developmentally disabled other than those who are physically or psychiatrically ill. This argument tends to deny the shift in health services towards a broader social perspective which is increasingly reflected in the provision of health services. Any movement towards a more narrow definition of health care would be, in the Inquiry's view, a backward step.

On the basis of its investigations, the Inquiry believes that the role of health services in this area should be defined as follows:

- (i) Development and implementation of preventive programmes:
 - (ii) Provision of comprehensive diagnostic/assessment and associated counselling:
- (These services should be available to all developmentally disabled children and their families):
- (iii) Provision of early intervention programmes (in consultation with the Education Department and the Department of Youth and Community Services to ensure a range of programmes are developed):
 - (iv) Provision of home support services (in consultation with the Department of Youth and Community Services. The Home-Care Service of N.S.W. and Local Government as appropriate):
 - (v) Development of small community residential units to rehouse residents from existing institutions:

- (vi) Development of small community residential units for the severely disabled, particularly the severely intellectually handicapped, and others with severe physical conditions, both children and adults, who are unable to continue living with their families
- (vii) Provision of respite and shared care arrangements within these units
- (viii) Provision of specialised therapeutic services as required,
- (ix) Access to general health services for the "routine" physical and mental health needs of the disabled.

This presupposes a strong commitment to progressively reduce the size and number of the existing institutions by decentralising, in the above manner, the services they provide. This process will be gradual and the institutions will continue to provide residential services, particularly for those who are unable to be maintained in the community with the present level of support services.

While there is evidence that increasing numbers of the less handicapped can be maintained in their own homes, if comprehensive assessment and adequate supports are available, the need for additional small community residential units for the adult disabled whose parents die or are physically frail is a growing problem.

Many of these people do not require the intensive staffing of a health-based service. This issue requires improved consultation between the relevant Departments, the Commonwealth and the non-government sector, to co-ordinate planning and funding for these services.

6. HOW ARE SERVICES BEST PROVIDED AND STRUCTURED TO MEET NEEDS?

6.1 Components of Service Delivery

There appear to be a series of critical stages in the life cycles of families of the developmentally disabled where critical service delivery issues emerge. These have been defined by McIntyre (1981) as:

- (a) at the time of the child's birth or when it is identified as being disabled:
- (b) at the time when the child is due to go to school for the first time:
- (c) at the time when the adolescent completes his education:
- (d) and finally, if the adult is still living at home, ... when the ... parent has to make a choice about his/her capacity to continue to care for the adult at home.

Increased advocacy for these clients through parent-based groups is placing greater emphasis on anticipating or planning for these stages rather than awaiting their occurrence. This is placing greater demands on government for the earlier provision of services to meet their need.

(i) Prevention

One outstanding achievement of modern technological health care is the development of procedures and knowledge which can assist in the ante-natal prevention and identification of some forms of severe disabling conditions. The availability of accessible high quality ante-natal care, genetic counselling and techniques such as amniocentesis are of major significance in

the lowering of risk and prevention of conditions which have permanent and life long impact on the individual and the family. It is important to make people more aware of these services and it is proposed that an amount of \$200,000 be allocated in 1983/84 from the Hospitals Health Promotion Programme for a public education programme on the importance of ante-natal care and the availability of screening and genetic counselling services.

(ii) Diagnostic, Assessment and Community Support Services

The Inquiry has been impressed by the degree of consensus on the importance of comprehensive assessment, early intervention and home based care in the care of the developmentally disabled. It has also been impressed by the quality and comprehensiveness of services that can be provided by an adequately staffed assessment service particularly when linked with other service providers such as general practitioners.

The Inquiry considers that high priority in the provision of developmental disability services should be the expansion or provision of adequately staffed assessment teams in each Region, and that these services should be expanded first in the Western Metropolitan, Hunter and Central West Regions.

Access to these services is of paramount importance. The Inquiry is concerned that many families may not receive appropriate support and advice following the birth of a handicapped child.

Accordingly, the Inquiry proposes that the Health Department develop a policy to be implemented in all public hospitals to ensure that parents of all handicapped children identified at or soon after birth are automatically given access to counselling and assessment and early intervention services.

The evidence clearly indicates that with early support and counselling families can be supported to accept the handicap, to deal with their own guilt and grief, and to continue to care for their child with the availability of appropriate back-up support and respite care. The evidence available on the positive benefit for both child and family of this approach and the negative effects of early institutional care on the child's subsequent development clearly point to the need for formal and comprehensive assessment as early as possible and certainly prior to admission to residential care.

The Inquiry therefore considers that as soon as community teams are adequately established in every Region, admission to all Health Department residential services and ultimately all government services be filtered through such an assessment service. Funding and where appropriate licensing of non-government residential care facilities and nursing homes specialising in the care of the developmentally disabled should be conditional on their acceptance of a pre-admission assessment process.

In order to ensure that most effective use is made of available residential care, each Region should establish a Residential Placement Committee, involving service providers, to determine priorities for community residential places.

(iii) Early Intervention and Early Childhood Services

The importance of these services and the problems currently associated with their delivery were best summarised to the Inquiry in the Submission from the Catholic Archdiocese Advisory Committee on Handicapped Persons:

"Recent research evidence has shown that early intervention programmes can greatly reduce the developmental and learning deficits of high risk and disabled children.

In Australia, the results of the Downs' Syndrome Programme carried out at Macquarie University have demonstrated that precise techniques and their early application raise previous expectations for Downs' children.

A significant point is that early intervention programmes give parents an opportunity to develop skills and confidence and allow them to receive support and hope. It is seen that the success of a programme is not measured only by the number of skills the child achieves but on the strengthening of the family unit.

In N.S.W. the Department of Health (Health Commission), the Education Department and the Department of Youth and Community Services have broad powers which enable them to provide services to young children with disabilities, but none has specific responsibility for an early intervention service. Historically the Health Commission through its Developmentally Disabled Team has the closest links with early intervention services for the developmentally disabled. However, its services - diagnosis, evaluation, treatment and support are unevenly distributed throughout the State - non-existent in some regions and adequate in none. Even where assessment is available, treatment services may be minimal."

"The demand for early intervention service far exceeds present provisions. In the Department of Health (Health Commission), present case loads for community nurses and therapists are heavy. Department of Youth and Community Services are unequally distributed. The Department of Education's provisions are insufficient - e.g. there is only one Special Education Consultant (pre school) to provide a special advisory service on a State wide basis, also, children can only enter Department of Education's regular pre-"

"school classes when they reach the chronological age of three years nine months by this time important needs could have been overlooked."

(Extracts from S 296: Catholic Archdiocese Advisory Committee on Handicapped Persons)

Similar problems exist in the provision of services for children of school age. As the above submission continued:

"Between the ages of four and five years when a child starts to attend school regularly, there is a need for continuing input from allied health professionals - occupational therapy, physiotherapy, speech therapy and nursing. As the Report Strategies and Initiatives for Special Education in N.S.W. states:

"It is claimed that only one-third of the children requiring therapy services are currently receiving it. This lack of services is said to be even worse in country regions. As an objective and accurate measure of the need for therapists is not available at this stage, it is felt that while there is certainly a considerable need for therapists in special schools and classes, an exact quantification of this need is not possible." (p. 165)

Several consequences follow from the lack of provision by the Health Commission of adequate therapy services:

- It means that some children are only at school part-time and are therefore denied full access to education.
- It may also mean that some children's mobility, independent living skills and communication skills are not being developed to their full potential."

(Extract from S296: Catholic Archdiocese Advisory Committee on Handicapped Persons).

The Commonwealth Government has also initiated some funding of these services, through a pilot project funded by the Department of Social Security, and the programme of special education for ~~dis-advantaged~~ children, funded through the Schools Commission.

The development of a co-ordinated programme for the phased expansion of these services has been beyond the scope of this Inquiry. The Inquiry considers that greater co-ordination of existing services and resources is required as a pre-requisite to the development of a specific coated plan. This issue should be addressed with some urgency by the co-ordinating mechanism discussed above.

In addition, the Inquiry anticipates that the decentralisation of residential care services and associated changes in staffing patterns will release some resources for the expansion of these services.

(iv) Residential Care Services

A primary focus of this Inquiry has been the appropriate and desirable mode of provision of residential care services for the developmentally disabled. On the basis of its investigations, and the submissions received, the Inquiry considers that there is widespread support for a movement towards care based in small, domestic-scale community residential units (housing between 5 and 10 people, usually in an ordinary house).

It is important to emphasise the other components of service delivery such as assessment and early intervention. However, much of the good work performed in these other areas will be nullified unless residential care services are improved and the emphasis changed from large-scale to small-scale accommodation, so that the most likely residential environment is no longer the large institution or the poor quality non-supportive private accommodation.

On the one hand, small-scale residential care has to be provided, on the other, as existing institutions are reduced in size and number, services within them have to be improved.

These issues are discussed in more detail below (see 6.2).

'(v) Activity and Work-Related Programmes

It has been strongly argued to the Inquiry that the Department of Health should upgrade and expand provisions for these services associated with the provision of community residential units. The main purposes of these facilities is defined by the Department of Social Security in its Activity Therapy Centre Handbook as •••"to develop the individual to the maximum of his potential, and in so doing assist in his greater independence and adjustment to living in the community."

Although the Health Department has provided various types of training and activity centres largely within Fifth Schedule hospitals the Inquiry as reservations about the continued provision of these services based on hospitals particularly as the focus of services changes to emphasis on community based provision of facilities. Further, the Department of Social Security through provision of funding to non government agencies and the administration of the Commonwealth Rehabilitation Service also has an important role to perform. There are a number of examples in Victoria and to a lesser extent New South Wales of joint Health and Social Security co-operation in this area and this should be more actively developed.

The normalisation process not only involves providing clients with community based residential services and supportive health and welfare back up but also access to day to day activities which enhance the individual's social skills by providing worthwhile activities from which personal satisfaction can be derived.

The Inquiry consider that there are a number of problems in the current arrangements:

There is insufficient diversity in the models available.

The traditional sheltered workshop is forced to be too product-oriented, rather than skill-development oriented:

There is insufficient liaison and co-ordination with the Department of Social Security on the co-operative development of these services and wider access to Commonwealth Rehabilitation Services.

It is inappropriate that work activities be located on the campus of hospitals - they should be community-based and accessible.

It is suggested that Regional and local management review the location of work oriented facilities and initiate their relocation to community-based premises: and further that the Department of Health consult with the Department of Social Security regarding the potential expansion of co-operative arrangements in this area.

6.2 Changing the Nature and Focus of Residential Care Services

(i) Community Residential Units

(a) Style of Provision

By their very nature, large hospitals are inappropriate venues for the care of this group. Even where the staff are actively seeking to implement an educational approach to care, the nature of the institution with its tendency to routine, and use of staff resources for daily living requirements such as

cooking and feeding, defeats them, and reinforces dependency. Although the Inquiry has been impressed at the level of staff commitment to a different approach, and the initiatives which several hospitals have taken to develop more "normal" living units within and outside the hospital campus, the Inquiry considers that the alternative model will only be realised through an active programme, resourced explicitly by government, and with active consultation with parents and staff.

Living in normal houses (community residential units) within the community facilitates the developmental/ educational approach to the care of clients, in three ways. Firstly the environment of a small house is itself a learning experience in that the residents are exposed to a more "normal" living environment. Secondly residents learn from involvement in the everyday routine of home life with all its associated risks and benefits, and opportunities to interact both positively and negatively with people in their own group and with other children and adults in the surrounding neighbourhood and to participate in the activities of daily living of washing, dressing, cleaning, etc. Thirdly, structured programmes for living skills can more readily be based on particular individual needs.

The conventional wisdom in this area has been that only those with less severe functional limitations could be successfully accommodated in small community-based settings in terms of both their ability to care for themselves and their acceptance by the community. However the experience of re-housing programmes in Nebraska, Queensland and Victoria, and in New South Wales, at Marsden, Peat Island, and Hornsby-Kuring-gai has demonstrated that provided adequate staff support is available (and in some cases this may be 24-hour staffing - as intensive as hospital care) many of the severely and profoundly handicapped can be supported in this style of unit. More

importantly, in the experience of these agencies, the functional ability of these very handicapped people improves (in some cases dramatically) in the more normal environment.

Another aspect of conventional thinking has been to develop a series of graded living places within the institution through which residents move as they are trained.

It is now recognised as preferable that the residents should move to the place in which they will live for some time and that the staff levels should be adjusted to their needs as these needs change. The result is that the residents learn in the environment where they will use the knowledge, and the slow process of developing neighbourhood contacts and support is not disrupted. The key elements in this process were described by Dr. Michael Connolly, Medical Superintendent of Peat Island Hospital, in a Newsletter to the Parents Association, as

- "1. Careful selection on a range of criteria.
2. As much preparation as possible before the event.
3. Selection of a suitable site- taking into account things like closeness of transport, shops, work and recreation places.
4. Compatible grouping of residents - as much as possible by their own choice.
5. Adequate staff supervision.
6. Establishment of support systems, especially medical and social.
7. The greatest degree of flexibility in all the above, and with the clear understanding that should the system fail or should any individual be unhappy or uncomfortable in it (beyond solution) that the central support service will provide a back up (accommodation) where the whole project may be reconsidered."

Both parents and staff have real fears about this trend. The primary concern is that residents will fail in community-based settings because of lack of appropriate levels of support. This reinforces the view that the residents themselves are unable to cope in the community and should be in institutions,

rather than an acknowledgement that the system itself has failed its clients and the community.

The Inquiry is also conscious that there are some clients whose additional physical handicaps may require intensive and specialised care. However the Inquiry is of the view that the care of these groups would be enhanced in small decentralised units, although more intensive staffing and more specialised support may be required.

As a matter of principle, therefore, the Inquiry considers that in the long-term all care of the developmentally disabled should be based in small decentralised units preferably in the form of individual houses (with varying levels of staffing depending on the level of disability).

In each Region a network of community residential units each accommodating 5-10 people should be established to provide both short (including respite) and long term residential care and social and living skills training for developmentally disabled people.

(b) Catering for Varying Levels of Disability

The need to provide an adequate supply of residential care units has two dimensions. Firstly, the Health Department must

accept responsibility to make appropriate arrangements for the continuing care of those who inappropriately and because of lack of other alternatives have been placed in health care institutions.

Secondly, there are a number of developmentally disabled children and adults currently living in their own homes who need either short-term or long-term placement. The age distribution of these clients also indicates the growing problem of the older handicapped person whose family have managed to maintain them and are now unable to continue due

to their own ageing. It seems likely that this pattern will continue and increase as increasing levels of support enable longer periods of home and family care.

The differing levels of need of clients within community residential services has been described by the Mental Retardation Division of the Health Commission of Victoria as follows:

"Children requiring maximum assistance.

Residents will be children up to the age of 16 years who are severely profoundly intellectually handicapped and/or severely physically disabled. Some of these children may also suffer from sensory impairments such as blindness or deafness. Most of these children will be non ambulant, although a few may be frail ambulant. These children will require total assistance from staff to identify and meet their needs. They will require extensive physical care and direct assistance with all activities of daily living. They will require intensive stimulation and assistance with their general development, with particular regard to motor, self help, social and emotional development. These children will attend day programmes that provide specialist services for multiply handicapped children."

"Children requiring moderate assistance.

Residents will be children up to the age of 16 years who are intellectually handicapped, but who do not suffer from severe physical or sensory disabilities. These children will require direction and assistance in all activities of daily living and they will be dependent upon staff to identify their individual learning needs and provide experiences which will enable each child to develop his physical, intellectual and social capabilities. These children will attend Day Centres or Special Developmental Schools and they will participate in all

domestic and family activities within their home. Participation will be dependent on staff skills as the children will generally have a low level of self-motivated activity. Some children may have behavioural disturbances requiring a high level of staff supervision."

"Children requiring minimal assistance.

Residents will be children up to the age of 16 years who are intellectually handicapped. The children will require direction and supervision in daily living activities. Generally, the children will be able to initiate play and participate in the household with supervision from staff rather than direct assistance. The children will be attending an educational facility during the day. Behavioural problems may require a high level of staff supervision."

"Adults requiring maximum assistance.

Residents will be adults who are severely or profoundly intellectually handicapped and who may be severely physically disabled. These residents will usually be non ambulant, although a few may have limited movement using some form of assistance. Standard and individually designed wheelchairs will be required for mobility, however some residents will be unable to sit and will require a trolley for movement between bedroom and bathroom. These adults will require total assistance from staff to identify and meet their needs. They will require extensive physical care with particular regard to maintenance of muscle tone and motor ability. They will require direct assistance with all activities of daily living and opportunities to develop social and emotional maturity and enjoy a personally satisfying life. These adults will attend day programmes that provide specialist services for multiply handicapped adults."

"Adults requiring moderate assistance.

Residents will be adults who are mildly or moderately intellectually handicapped and who may be physically disabled. These people will usually be able to move independently with the use of wheelchairs or other aids, however, a few may rely on staff for assistance. These residents will be independent or semi-independent in most self help skills. They will participate in domestic activities with assistance or direction with certain tasks. These adults will require some assistance with physical care, particularly with regard to maintenance of muscle tone and motor ability. They will attend adult activity programmes, with support from specialist services for physically disabled persons. Behaviourally disturbed residents will require a high level of staff supervision."

"Adults requiring minimal assistance.

Residents will be adults who are not physically handicapped: however, the degree of their intellectual disability limits their potential for independent living."

"These adults will be semi-independent in most self help skills. They will participate in all domestic activities, although direction and assistance may be required with certain tasks. They will be dependent upon staff to provide experiences that will enable each resident to develop skills in all aspects of daily living and to live a personally satisfying life. These people will attend adult activity programmes, with support from other services."

"Adults requiring minimal assistance.

Residents will be adults who are not physically handicapped: however, the degree of their intellectual disability limits their potential for independent living. These adults will be semi-

independent in most self help skills. They will participate in all domestic activities, although direction and assistance may be required with certain tasks. They will be dependent upon staff to provide experiences that will enable each resident to develop skills in all aspects of daily living and to live a personally satisfying life. These people will attend adult activity programmes, with support from other services."

"Adults requiring limited assistance.

Residents will be adults who have potential for living independently in the community, or with minimal assistance.

These adults will be competent or nearing competence in most routine aspects of daily living. However, they may require support or opportunities to further develop their skills in the most complex areas of daily life, such as, human relations, decision making and legal matters. These adults may work in sheltered or open employment or they may be unemployed."

(Extract from "Staffing Patterns for Community Residential Units", Health Commission of Victoria 1982).

It should be emphasised that community residential units are one model of community care.

The Inquiry considers that every effort should be made to develop a range of models of community residential services, for example, fostering and permanent part-time arrangements.

In addition, the Inquiry is aware that special residential arrangements will be needed to cater for clients with additional or special needs, for example, those with severe behavioural disturbance or specialised physical needs. One area of special need drawn to the Inquiry's attention is that of developmentally disabled women who have young children and require particular support to provide a stable and nurturing environment for themselves and their

children. The needs of this group were the subject of a submission from the "Women in Limbo" Group, which includes representatives of the Women's Refuges, and were reinforced by staff in community services.

In order to encourage development of innovative models of residential care and/or special services for groups with special needs, the Inquiry proposes that a fund be established for this purpose.

(c) Auspice and Funding

Community residential services for the developmentally disabled are currently provided by both government and non-government agencies. The Inquiry saw good examples of both, and considers that auspice in itself is irrelevant, provided that there is adequate accountability for standards, that there is effective involvement of residents and families in management, and that the residential care service is adequately linked to a network of other services.

Resources for the provision of residential services are currently provided by Commonwealth funding of non-government organisations and by State funding through hospital budgets. A major issue in this area is the appropriate role and co-ordination of Commonwealth and State funding.

The Department of Social Security provides subsidies to non-government organisations for capital (\$4 for \$1) and operating costs (50%) associated with residential facilities under the Handicapped Persons' Assistance Programmes. The capacity also exists for capital funding under the Aged and Disabled Persons' Homes Act (although funding under this programme has primarily been directed to the care of the aged).

The requirement to raise one-fifth of the capital and one-half of the operating costs places great pressure on the non-government organisations working in this field which tend to be small and less able than large charities to raise funds or carry costs (although operating costs are to some extent met by fees and the Handicapped Children's Benefit). In addition, the fact that the majority of the voluntary organisations are primarily composed of parents not only places an additional and many would argue unjust, financial burden on those who are already handicapped, but can also lead to restrictive and isolationist eligibility policies on the part of these agencies.

Several of the parent-based organisations commented to the Inquiry that they no longer saw it as socially appropriate for them to provide direct services. At the same time, there is some evidence that other (i.e. not parent-based) voluntary organisations are interested in expanding their work in this field, provided that a more adequate funding arrangement can be developed.

An example is the work of the Association for the Assistance of Intellectually and Socially Handicapped Persons. The Association is a charitable organisation operating in the western suburbs whose objectives are to provide community based accommodation for developmentally disabled adults. Over the last six years the Association has provided accommodation for 100 handicapped people, the majority of whom have moved on to totally independent living. This arrangement has primarily provided for the mildly handicapped clients who had been resident in Rydalmere Hospital and who could be accommodated without live-in supervision and with the provision of "drop in" support from the staff at Rydalmere. Towards the end of 1981 the Association in co-operation with the community services staff at Rydalmere started to develop a programme to provide

accommodation with more support which could cater for the moderately and severely handicapped adults. The Inquiry considers that this type of approach should be further facilitated.

In Victoria a programme has been established whereby the accommodation services are managed by community management committees under the "Community Residential Unit Programme" in which they are fully funded by the State Government for the capital and operating costs of providing community residential services for the developmentally disabled. The Victorian Government has established approximately 35 houses in this way.

Related to this arrangement, it is understood that the Department of Social Security in Victoria primarily directs funding under the Handicapped Persons• Assistance Programme to the provision of activity therapy centres and work programmes.

The Inquiry proposes that the Department of Health establish a fund for the provision of community residential services. These funds should be allocated to the high priority Regions as discussed below. The funds may be used for direct provision by the Department or in contract with an appropriate non-government agency.

The State government should also negotiate with the Commonwealth government regarding future arrangements for co-operative funding of these services.

Accordingly it is proposed to recommend:-

That from 1983/84, specific purpose funds (up to \$2 million) be allocated to Regions to assist in the development of community residential units to re-house residents currently resident in institutions and those at home urgently in need of placement.

Priority for the funding of such units should go to the Hunter, Western Metropolitan, Southern Metropolitan, and Northern Metropolitan Regions.

That initially these services be funded from the total hospital budget: and that from 1984/85 resources for this purpose be augmented from savings to be achieved through reductions in the size and number of existing institutions, as specified in Section 8.

Further, it is suggested that the Minister for Health, in consultation with the Minister for Youth and Community Services, negotiate with the Minister for Social Security to establish a mechanism to improve co-ordination of planning and service delivery and to develop proposals for joint Commonwealth/State funding of these services.

Another source of accommodation is the New South Wales Housing Commission which has in recent years amended and broadened its policies in relation to the housing of disabled people and has indicated that it now recognises that it is appropriate to provide some accommodation for this client group within new and existing housing estates. The Housing Commission has indicated that it would be prepared to provide accommodation for clients under certain conditions and this arrangement could be developed either directly between the two departments or with the co-operation of non-government community groups.

It is proposed that the Minister for Health negotiate an arrangement with the Minister for Housing whereby a proportion of welfare housing stock in existing and proposed developments is specifically made available as community residential units for developmentally disabled people.

(ii) Existing Institutions

It must be appreciated that the transition towards a fully decentralised community-based model of residential care will take some years to implement, and that initial expenditure will be required to develop some of the alternatives in order to reduce the size of the institutions and achieve savings which will enable further expansion of the alternatives. During this transition period, a proportion of those in need of residential care will continue to be placed in specialised hospitals.

The Inquiry considers that a number of management and service changes are essential to improve the quality of care in these facilities. The management changes are discussed below and include the separation of services for the developmentally disabled from the services for the psychiatrically ill.

The Inquiry is concerned that owing to staffing levels, the range of skills involved and the line management arrangements, the educational focus is not sufficiently strong within these facilities. As one submission from an individual staff member asked rhetorically:

"The category of "Programme Officers" was introduced to these hospitals to instil a programming and training emphasis for the clients.

"The Programme Officer position is one of responsibility for "programmes" but no authority for implementation.

1. Why pay someone \$21,000 p.a. if they cannot improve the quality of life for the client?
2. Why run a special Health Commission course of 8 months duration, when the Programme Officer has to come and convince a 1st Year Nurse to accept a programme for a resident?
3. Why run activities when the clients don't have the opportunity to attend because staff are not made accountable for the quality of care they provide."

(Extract from Submission S.91: Nurse)

The Inquiry considers that direct-care ward or unit-based staff should be made responsible to the programme personnel (Programme Officers, Psychologists etc.) for the implementation of educational programmes within the ward. It therefore proposes that within existing hospitals emphasis in client care be placed on implementation of independent living training programmes. These programmes should be developed and monitored by programme staff to whom staff in individual wards would be responsible for programme maintenance and achievement.

The Inquiry recognises that mental retardation nurses have a strong behavioural/educational component in their training, and that many of them are enthusiastic about this aspect of their work. However, as a result of perceived inadequacies in staffing levels, the day-to-day physical care of residents becomes paramount. As discussed below, the Inquiry recommends that the staff category of Mental Retardation Nurse be gradually replaced by a mixture of Residential Care Assistants (a new category of direct care worker) and Programme Officers (to provide the educational/programme component). The Inquiry also considers that the ratio of direct care staff in the care of severely handicapped and multiply handicapped residents at Stockton Hospital should be gradually increased as resident numbers decrease.

The Inquiry has also been concerned that some hospitals (particularly Stockton, Morisset, Kenmore and Bloomfield) are inadequately staffed with social workers, psychologists and occupational therapists. Not only are these perspectives essential in a comprehensive assessment process, but they are also vital to the implementation of a developmental, family-oriented programme approach with these residents. The Inquiry appreciates the recruitment difficulties of these hospitals, but considers that the Department could facilitate access to these skills through a formal contractual arrangement between hospitals and between Regions. The development of such arrangements should be expedited as a matter of urgency.

7. HOW ARE RESOURCES BEST STRUCTURED TO PROVIDE SERVICES

7.1 Staffing

As indicated above there is widespread agreement that the care of the developmentally disabled should be based on an educational and developmental approach which aims to maximise the independent living skills of the client. Health services have been and continue to be criticised for an approach which is seen to emphasise care and maintenance rather than education.

It is clear that the staff who are involved in the provision of services for children and adults who are developmentally disabled need to have a strong skill-development orientation - they need to see the clients as people who can learn and change and be prepared to structure their own behaviour to take every opportunity to teach the client the skill rather than to do things for the client. It has been argued that nurses are less likely to be able to take this approach because their orientation has traditionally been towards support, care and protection rather than education and risk taking.

On the other hand, the syllabus for mental retardation nursing does provide some opportunity for nurses to learn these skills and it can be argued that it is the environment of the institutions which limits and conditions the ability of staff to operate in this way because they are working with so many highly dependent individuals and do not have time or adequate staff support to adopt a different approach.

The Inquiry considers that, while the training of mental retardation nurses may have an educational/behavioural perspective, it is inappropriate per se, for the developmentally disabled, particularly those living in community residential units, to be cared for by a staff category identified as "nurses". The concept of nursing held

by the general community will continue (and appropriately so) to emphasise care, treatment and support rather than the desired developmental function.

The Inquiry considers that care of the developmentally disabled requires two distinct but related sets of skills.

The direct care both in community residential units and in hospital settings requires a high level of consistency and continuity with staff who have skills in:-

providing a physically and emotionally secure environment and promoting physical, emotional, social and intellectual development.

sharing the responsibility for life decisions with natural families and/or the adult resident.

assessing, with assistance, the need for skill development and maximizing naturally occurring opportunities in the home to develop these skills.

caring for the residents' normal health needs, providing basic first aid treatment in emergencies and providing home care in the case of influenza and such illnesses.

working in conjunction with other direct care staff and the multi-disciplinary regional team to assist in the planning, development and implementation of individual programme plans designed to develop the residents' skills in daily living.

As well as implementing specific skill programmes, the direct care staff will have a general "household management" function, which will require them to demonstrate and undertake normal household tasks in conjunction with the residents. These would not normally be classified as "nursing duties."

The Inquiry proposes that a new category of staff be developed for this purpose; an appropriate title would be "Residential Care Assistant". The advantages of such a position would be the ability to provide continuity of unit and ward-based staff, with an appropriate mix of nurturing and developmental functions.

To meet the different levels of care required by clients two shift patterns would be necessary within the category of Residential Care Assistant - a 24 hour shift (similar to the existing Houseparent category) and an 8 hour shift (similar to Child Care Workers or Enrolled Aides) •

The Inquiry considers that there are many currently unqualified staff in the existing hospitals who have the capacity to develop these skills with appropriate training.

The training of the Residential Care Assistant should be structured as an apprentice-type programme, with day release for course attendance. The training would be appropriately located in the Department of Technical and Further Education. The skills required have some elements in common with the existing Child Care Certificate course in T.A.F.E. and some elements of this programme could be incorporated, while recognising that the Residential Care Assistant will be expected to care for either children or adults.

Entry to this programme should be on the basis of either school certificate or mature-age entry. Mature age entry should be encouraged to attract staff in existing institutions who may not have educational prerequisites but have the desired personal skills and empathy.

The second level of skills required are in some aspects similar to those of current Programme Officers/Training Officers within the existing institutions. Within the current arrangements, these people are nurses who complete an in-service training programme.

The functions required to be performed at this more senior level are:

development of appropriate educational programmes for residents in consultation with direct care staff, and psychologists and occupational therapists on the regional team.

monitoring and evaluation of their implementation:

participation in multi-disciplinary assessment of new clients and their families, and the development of appropriate management programmes:

provision of supervision and support for direct care workers in community units and existing hospitals.

The Inquiry proposes that the employment of Programme Officers be expanded, as a major staff category in community developmental disability teams and in specialised hospitals. The salary should be the equivalent of the range for Charge ,er Senior Charge Nurse. It will be necessary to incorporate this classification into the Public Hospital awards.

However, the education of Programme Officers should be upgraded to increase the theoretical content and level of skill commensurate with the broad range of functions required.

This programme would appropriately be developed at C.A.E. level, either as an undergraduate or post-graduate programme, open to people from a range of disciplines. It is essential that the programme be structured in such a way to ensure access to the course for current mental retardation nurses, who will provide the major work-force in this area, and a.lready have a grounding in these skills.

Within the existing hospitals, these classifications of Residential Care Assistant and Programme Officers should be used in re-staffing hospitals during the transfer of nursing education to the education sector.

In the longer-term where nursing care is required for the developmentally disabled this should be provided by the comprehensively-trained single register nurse, whose training should include a strong behavioural/social perspective, a theoretical understanding of normal and delayed development, and an appreciation of the importance of an educational/developmental perspective in the care of the developmentally disabled.

7.2 Organisation and Management

The major organisational issue raised in submissions to the Inquiry was the need for increased co-ordination and advocacy at State government level, in the form of a central co-ordination mechanism. This has been discussed previously.

The Inquiry also considers that a number of parallel changes are required in the organisation and management of health-based resources for the developmentally disabled, to improve the advocacy for this group within the health services and to more effectively reflect the principles enunciated above.

The first and over-riding change proposed is the movement of services currently provided within State-run specialised hospitals and community health services away from direct management by the Department of Health to a decentralised form of management through community-based Boards of Directors. The rationale for this proposal is discussed in detail in Part 1 of the Report, but can be summarised here as:

The negative social and psychological effects on clients and staff of a separate, isolated, stigmatised, system of care:

The lack of community-based advocacy for these clients:

The inappropriateness of centralised constraints on this area of human services:

Problems in continuity of care in a fragmented system:

Inadequacies of staff training in an isolated system.

The objectives of such a proposal are to integrate services and increase management's ability to use resources flexibly between different service components, and to improve the opportunity for continuity of care and training opportunities.

In addition, the resources available for these services are very limited and will continue to be for some time. Consequently regional management is appropriate to ensure that resources are co-ordinated and effectively utilised. As services develop it may be appropriate to decentralise management to the local level through local hospitals boards.

The Inquiry does not consider that it is appropriate to establish separate Boards for the existing developmental disability hospitals, as this may create a climate which tends to reinforce the status quo, rather than actively seeks to redistribute the staff and resources into alternative community-based services.

The care of the developmentally disabled (unlike mental health services) is distinctly different from mainstream acute health services, in that the focus is life-long and educational. This distinction and the need for close collaboration with other agencies and departments can best be reflected in a distinct management structure with broad representation from the various interest groups.

It is therefore proposed that at the appropriate level (Regional or supra-Regional), a Board of Directors be established with the responsibility for the management of all services within the health administration for the developmentally disabled, both residential and non-residential. The Board would be community-based, including representatives of parent and voluntary groups, and should establish advisory mechanisms to include representatives of the other relevant government departments. These services would be managed by a Chief Executive Officer responsible to the Board.

The Inquiry is aware that in some areas of the State, the provision of developmental disability services has already been linked to existing general public hospital Boards. This has happened in Hornsby-Kuring-gai (where the Board has an area responsibility), Wollongong, Kogarah, Albury and Armidale. The Inquiry visited the Hornsby-Kuring-gai, Kogarah and Wollongong services and was impressed by them. Clearly, management arrangements need to be flexible to suit local needs and capabilities, and it may well be appropriate to expand such local arrangements, particularly as Area Boards are developed.

Priority should be given to the development of Regional Management Boards in the Regions serviced by existing institutions, that is, Southern Metropolitan, Western Metropolitan, Northern Metropolitan, Hunter, Central West and South-East Regions. It may also be appropriate to link some Regions together for this purpose.

Appropriate contractual arrangements will need to be negotiated between the Regional Board and general hospital boards providing these services within that Region, or Area Boards as they develop. Each Regional Board must be given detailed responsibilities and specific timetabled goals to be achieved. These would include:

development and implementation of a detailed programme for the re-housing of residents of the institutions:

development of staff training programmes:

liaison with other government Departments and agencies for additional community support services:

development of feasible proposals for the alternate use of institutional land and buildings:

full consultation with parents and staff on all these matters.

As new services are developed, and the existing institutions rationalised, priority must be given to the removal of residential developmental disability services from the campus of psychiatric hospitals. Throughout the Inquiry concern was expressed at the inappropriateness of this juxtaposition of services, and the negative effects of this for residents and their families, particularly through the association of the two conditions in the eyes of the general public.

In this transition period, which will clearly be of some years duration, steps should be taken to separate the services as much as possible, through the establishment of a separate management structure in hospitals, to be responsible to the Regional Chief Executive Officer and Board (discussed above) and by the physical separation of facilities as far as

possible. The developmental disability services in these hospitals should be degazetted in the terms of the Mental Health Act, when the new Act is introduced, and this should be clearly promulgated.

Accordingly, it is proposed that care of the developmentally disabled in specialised hospital settings should be separated from the care of the psychiatrically ill by the establishment of distinct management organisations, responsible to the Regional Boards and by the degazettal and physical separation of services.

The appointment of Regional Boards should provide a strong basis for improved advocacy at Regional level and an appropriate professional officer should act in an advisory capacity to the Board.

Within the Central Administration of the Department it is essential that some well-defined mechanism exists to represent the needs of this client group. The area in which current arrangements in the Central Administration is most deficient, in the view of the Inquiry, is the active involvement of client advocates in the budgetary process, both capital and operating.

It is suggested that the role of the Senior Specialist (Developmental Disability Services) in the Central Administration of the Health Department should be strengthened by involving him or her to a greater extent in budget decisions affecting provision of services.

7.3 Funding Priorities

The Inquiry's assessment of resources required in this area of service delivery has had regard to the following factors:

- (a) review of current expenditure (primarily in the Fifth Schedule Hospitals):
- (b) assessment of the size and nature of the demand for services:
- (c) assessment of the costs involved in providing an appropriate range of services:
- (d) determination of priorities:
- (e) assessment of the capacity for and potential pace of redistribution:
- (f) consideration of additional or alternative funding methods.

The principles on which the Inquiry believes services should be based, as discussed above, are:

that as far as possible all care should be provided in small units of 5-10 places, even for the severely and profoundly handicapped:

that as far as possible residents should not be moved from unit to unit as their needs change:
staffing levels should be adjusted appropriately.

The development of proposals for funding has been based on the following assumptions:

- (a) that services should be developed as a network, with strong organisational links between the various service components, rather than isolated units:

- (b) that Regional and sub-regional community developmental disability teams will have responsibilities for the assessment of new clients, family support and for programmes and activities for clients living at home and in residential care.
- (c) that staffing levels in residential units will range from minimal supervision to intensive 24-hour staffing:
- (d) that as far as possible school and day programmes should be separated from accommodation, in the interests of normalisation.

The Inquiry has argued that the two prime operational principles should be:

- (i) fund and/or provide services which maintain clients in their normal living environment: and
- (ii) progressively reduce the size and number of existing Fifth Schedule Hospitals by decentralising the services they provide.

The competing priorities in the care of the developmentally disabled would appear to be:

the improvement of the level of care within the existing hospitals, by increasing the ratio of direct care staff and programme staff to residents and upgrading physical facilities.

establishment of community teams and residential units:

the re-housing of existing residents:

the housing of clients on waiting lists.

In the current economic climate, with government's seeking to reduce expenditure in all areas, any new initiatives or programmes must be funded within existing resources, that is, by a re-organisation of priorities and redistribution from other service areas.

Within the framework of current health expenditure on the developmentally disabled there is clearly capacity for redistribution of existing resources, given the level of consensus that both residents and staff in Fifth Schedule Hospitals for the developmentally disabled would be more appropriately located in small decentralised community units. In some hospitals, a gradual programme of relocation of services into community settings is already underway.

The capacity for redistribution both within and between Regions is constrained however by the prior need to develop the alternatives which will make it possible to reduce the size of the institutions with minimal disruption to residents, families and staff. Genuine efforts to deinstitutionalise services must be preceded by the planning and development of community services and adequate links must exist not only within health services but also to other welfare services. The initial investment required for this development must be specifically allocated for this purpose and the Inquiry has recommended in Part 1 that an amount be drawn from the hospital system as a whole, including acute general hospitals and the Fifth Schedule Hospitals, for the "seeding" of these new services over the next three years.

The initial investment should be clearly targeted to services and facilities which will explicitly facilitate the reduction in the size of the existing institutions. Resources thus freed would provide the impetus for the on-going expansion of community-based services.

This will also mean that some priority must be given to the re-housing of residents currently in institutions, over the needs for placement of those on waiting lists, or newly-identified clients. Balance must be achieved between the two objectives. The provision of a proportion of respite care places within the residential units will assist to ease the burden on families. These decisions should be made on a local consultative basis by a Regional Placement Committee, as recommended.

The Inquiry's clear preference is for overall priority to be given to the development of alternative community based services. Within this objective, priority should be given to the development of services which can directly facilitate the reduction in the size of the institutions. In the short-term this will mean initial investment in the metropolitan and Hunter Regions. The urgently needed services in the country Regions must be financed out of savings achieved as the institutions are reduced.

The choices however are not always clear and the pace at which, for example, the process of re-housing can occur will be dependent on both the resources to establish the alternative services and the level of preparation of residents within the institutions. Therefore while it may be necessary to improve the level of programme staff (both programme officers and psychologists) in the existing hospitals, these staff should preferably be attached to a community service, to ensure that the clear orientation of their activities is toward the goal of deinstitutionalisation.

7.4 Legislation

The former Mental Health Act provided for protection and guardianship arrangements for developmentally disabled people who were unable to handle their own affairs and were without parents or guardians. It was rightly considered inappropriate for such people to be required to be declared "mentally ill" to receive this protection, and consequently this arrangement has been removed from the new Mental Health Bill.

A legal arrangement is now needed to provide for the protection and guardianship of such people, without stigma or institutional admission being required.

The Inquiry recommends that the Minister for Health consult with the Attorney-General regarding appropriate legislation for this purpose.

8. IMPLEMENTATION TIMETABLE

8.1 Development of Community Services

(a) Community Developmental Disability Team

The major priority component to be funded is the provision of community based multi disciplinary teams which will prevent unnecessary future admission to institutions by providing effective assessment and early intervention to facilitate the process of rehousing from the institutions by providing support services to the community residential units.

Incentive funding totalling \$1.5m per annum over the next three years is necessary to commence to stimulate provision of these teams (or to supplement existing teams). This will focus on regions with institutions with some provision for other regions with little or no existing services of this kind. In those regions with institutions, funding for additional services would be provided on a tapered grant basis with full funding in the first year and reduced funding in second and subsequent years as staff resources are transferred from the existing hospitals. After the third year services would be fully funded from savings from institutions.

Those regions without institutions would be funded during the first three years after which funding would come either from savings from institutional reductions in other regions or from savings in other services within the "non institutional" regions.

These multi-disciplinary teams operate at two levels. At Regional or sub-regional level (200,000- 250,000 population). The team has the functions of:

comprehensive assessment of all new clients.

provision of early intervention programmes

development of educational programmes for clients in residential care

responsibility for admission to all residential care and programmes

liaison with other Departments and non-government organisations.

To undertake this diversity of functions the following professional categories should either be included in or available to these teams:

- Psychologist
- Social Worker
- Programme Officer
- Medical Practitioner
- Occupational Therapist
- Physiotherapist
- Speech Pathologist

It may be efficient and appropriate to obtain the medical and physiotherapy skills on a sessional basis from hospitals or the private sector. When costed on the basis of equivalent full-time position (7 professional staff plus support staff) the estimated cost is \$220,000 per annum.

At local or area level (60,000- 80,000 population), the Inquiry supports the concept of two-person teams, located in community health centres, to provide individual client and family support, supervision and support of the residential care programme in that area, and liaison with other departments, and agencies. Appropriate composition would be a Programme Officer and a Social Worker.

The estimate cost of such a team is \$50,000 per ann. ••

Incentive Funding Priorities for the Resourcing of "Regional"
and "Local" Community Developmental Disability Teams

1983/84	Regions	Target Allocation <u>Numbers</u>	<u>Staff</u>
	Western Metropolitan Region		
	6 local teams	12	\$520,000
	1 sub-regional team	9.5	
	Hunter		
	6 local teams	12	\$520,000
	1 sub-regional team	9.5	
	South-East		
	1 regional team	9.5	\$220,000
	Central West		
	1 regional team	9.5	\$220,000
		62	\$1,480,000
<u>1984/85</u>	<u>Recurrent expenditure</u>		
	Western Metropolitan		
	1 sub-regional team	9.5	\$220,000
	Hunter		
	1 sub-regional team	9.5	\$220,000
	South-East		
	1 regional team	9.5	\$220,000
	Central West		
	1 regional team	9.5	\$220,000

1984/85	New Expenditure	Target	Allocation
	South-West	9.5	\$220,000
	Orana & Far West	9.5	\$220,000
			\$1,320,000
1985/86	Recurrent Expenditure		
	Western Metropolitan 1 sub-regional team	9.5	\$220,000
	Hunter 1 sub-regional team	9.5	\$220,000
	South-West	9.5	\$220,000
	Orana & Far West	9.5	\$220,000
	New Expenditure		
	North Coast Region	9.5	\$220,000
	New England Region	9.5	\$220,000
			\$1,320,000

(b) Residential Services

In order to obtain some indicative levels of costs the Inquiry has examined the components of service in a range of models operating in Victoria, South Australia and New South Wales providing residential services. The key variation in cost is the staffing factor which depends on the ultimate capacity of residents to live with varying degrees of resident supervision.

The broad range of levels of supervision and the associated costs of the model preferred by the Inquiry are listed on the next page. These are based on the Victorian Health Commission guidelines.

The costs only reflect expenses incurred in managing the community residential units and do not include the costs of support and programme staff which are provided for in the "local" community developmental disability teams. As the teams will undertake a variety of roles including assessment, family support it is not possible to apportion the costs of services to community residential units from the total costs of these teams.

The Inquiry considers that to stimulate the provision of community based services and to reduce the number of beds within the large institutions a feasible target would be to create around 500 "community placements" per annum (i.e. 100 community residential units each with 5 or 6 residents). This can be achieved by funding the equivalent cost of actually establishing and running these units (i.e. rental of houses, power, light, food etc.) with costs of staffing being largely met by transfer of staff or staff resources from the institutions. It is estimated that the cost of this programme to achieve 500 places per annum would be approximately \$2m per annum.

Indicative Gross operating costs Per Community Residential unit (per annum)

(To House 5 to 6 residents)

	Independent <u>Living</u> (No Live In Supervision)	Minimum Live In Supervision	Medium Live In Supervision	Maximum Live In Supervision	
		3.6 staff F.T.E.	4.8 staff F.T.E.	6.8 staff F.T.E.	5.1 F.T.E.
1. Staff COsts		\$57,400	\$76,000	\$106,900	\$ 00,100
2. Other Operating Costs		\$14,400	\$19,000	\$ 26,700	\$ X>,000
3. T0tal Gross Operating COsts*		\$71,800	\$95,000	\$133,600	\$100,000

* Gross operating costs will be reduced marginally by client contributions for "hotel" services

Note: Additional staffing of 0.33 F.T.E. per house is required as "contingency" for intensive care of behaviourally disturbed residents.

As indicated elsewhere, to facilitate the process of releasing staff resources from the institutions it will be necessary to give priority to those regions in which institutional services exist. Further as also already pointed out the full extent of savings from reductions in these institutions cannot be realised unless "whole units" are closed (for example proposed closure of Peat Island by 1984 and Gladesville - north side by 1986- see below). The desired approach therefore, is to achieve this end and proposals have been structured accordingly, while still attempting to meet needs in some of those regions where services are most deficient.

The proposals tabulated below provide for incentive funding of these services on the basis of achieving the target of around 500 new placements per annum.

The mechanism proposed is that for example, in the first year, in Western Metropolitan Region \$460,000 for equivalent non-salary operating costs would be allocated to establish 115 placements, with staff resources necessary to support these facilities being transferred from the institutions along with the clients so placed. In the second year the equivalent operating costs for the initial 115 placements would be met from savings in operating costs within the institutions and not from a special allocation. At the same time a further special earmarked allocation for an additional 125 placements would be made on the same basis as in the first year. A similar arrangement would occur in the third year. After the third year all services would be fully funded from savings achieved from reductions in institutional care.

In those Regions without institutions recurrent funding equivalent to both non-staff and staff operating costs will be necessary as they have no local potential to extract resources. It is envisaged that the regions with institutions will be expected to achieve additional savings to provide for growth

in demand in their own region and for services in other regions, commencing in 1984/85 when realised savings from the complete closure of Peat Island Hospital would contribute towards services in Illawarra, Orana and Far West and North Coast regions. The opportunity to apply savings across regions resulting from reductions in institutional care needs to be monitored as the process continues so that as savings are realised they can be translated immediately into alternative services in the regions where they are most needed.

It is estimated that the savings from the closure of Peat Island, after relocation of staff resources and operating costs necessary to rehouse existing residents, will be of the order of \$500,000 - \$900,000 per annum. This will be used in subsequent years to partially fund the development of community residential units in other Regions.

On the basis of the current staff: resident ratios in the specialised "mental retardation" hospitals, and average staff costs in these hospitals, in comparison with the proposed ratios in community residential units, and the reduced staff costs associated with the new category of staff, the Inquiry estimates that the transfer to community residential units will release additional resources for the expansion of community teams, as recommended below. This process will clearly require careful management to ensure that services within the hospitals are organised to maximise transfer of resources.

DEVELOPMENTAL DISABILITY INCENTIVE FUNDING PRIORITIES FOR
ESTABLISHMENT OF COMMUNITY RESIDENTIAL UNITS

<u>1983/84</u>	<u>Region</u>	<u>Target</u>	<u>Allocation</u>
1	Western Metropolitan Region (non-salary costs equivalent)	115 places	\$460,000
2	Hunter Region (non-salary costs equivalent)	115 places	\$460,000
3	Northern Metropolitan Region (non-salary costs equivalent)	150 places (and closure of Peat Island Hospital)	\$600,000
4	Southern Metropolitan Region (non-salary costs equivalent)	50 places	\$200,000
5	South-East Region (non-salary costs equivalent)	12 places	\$ 40,000
6	Central West Region (non-salary costs equivalent)	12 places	\$ 40,000
7	North Coast Region (full operating costs)	12 places	\$200,000
		_____	_____
		466 places	\$2,000,000
		_____	_____

1984/85	<u>New</u> Expenditure	Target	<u>Allocation</u>
1	Western Metropolitan Region (non-salary costs equivalent)	125 places	\$500,000
2	Hunter Region (non-salary costs equivalent)	125 places	\$500,000
3	Southern Metropolitan Region (non salary costs equivalent)	150 places	\$600,000
4	Orana and Far West Region (full operating costs)	12 places*	\$200,000
5	Illawarra Region (full operating costs)	12 places*	\$200,000
6	South-West Region (full operating costs)	12 places*	\$200,000
		436 places	\$2,200,000

Recurrent Expenditure	Target	Allocation
North Coast Region	12 places	\$200,000

* To be funded from savings from Peat Island closure, estimate \$600,000 per annum

1985/86	New Expenditure	Target	Allocation
1	Western Metropolitan Region (non-salary costs equivalent)	150 places	\$600,000
2	Hunter Region (non-salary costs equivalent)	150 places	\$600,000
3	Southern Metropolitan Region (non-salary costs equivalent)	100 places (and closure of services at Gladesville)	\$400,000
		400 places	\$1,600,000
1	Recurrent Expenditure Orana and Far West Region (full operating costs)	Target 12 places*	Allocation \$200,000
2	Illawarra Region (full operating costs)	12 places*	\$200,000
3	North Coast Region (full operating costs)	12 places*	\$200,000
4	South West Region (full operating costs)	12 places	\$200,000

* Funded from savings Peat Island Hospital.

It is envisaged that by 1986/87, the metropolitan and Hunter Regions will have achieved adequate savings to fund their own services and to augment funds for other Regions. In Central West and South-East Regions, an additional 88 places in each region will be funded from within existing regional resources.

8.2 Rationalisation of Existing Institutions

Subject to the provision of alternative community services targets can be set for the reduction of existing institutional services including the complete closure of Peat Island Hospital and the north side of Gladesville and substantial reduction of the size of some other hospitals such as Stockton. The targets listed below represent the Inquiry's evaluation of reductions that can be achieved through the provision of alternative community services and as argued repeatedly the critical factor is the provision of adequate funds for this purpose.

In setting targets regard has also been had to factors such as - standard of physical stock, isolation of facilities, continuity and potential to close "whole units", potential for eventual alternative use of sites and the need to remove developmental disability services from psychiatric hospitals (other than those clients with clearly defined psychiatric illnesses).

Western Metropolitan Region (Currently 871 Developmental disability hospital places)

To achieve the desired objective of separation of psychiatric and developmental disability services, and to maximise potential savings by the closure by "whole services" (as recommended by the Parliamentary Accounts Committee) it is proposed that by 1985-86 Rydalmere Hospital operate solely as a developmental disability service by removing existing psychiatric services from the southern side of the hospital (see Part 3 for proposals concerning the psychiatric services) •

With the planned provision of community services over the next three years, it will be possible to close residential services at Marsden Rehabilitation Centre, by relocation of residents either to community units or to Rydalmere. The total number of places in hospitals will be reduced by 150 approximately in this process.

In addition Rydalmere and Marsden will be reduced to approximately 570 beds with progressive further reductions as community services develop.

Subject to the "heritage" considerations associated with the Marsden Rehabilitation Centre site alternative uses should be examined including possible disposal. Ultimately the rehabilitation facilities (workshop etc.) may have to be relocated.

Southern Metropolitan Region (Currently 276 developmental disability hospital places)

The rationalisation of Gladesville and Rozelle Hospitals as a specialised psychiatric service is proposed in Part 3. At the same time the opportunity exists to completely decentralise by 1986-87 developmental disability services from Rozelle and Gladesville (currently 190 places) into the community in view of the planned provision of community services previously outlined for this region.

This would completely separate these services from psychiatric services and provide an excellent model for a totally community based service in a region formerly dependent on care in a large institution. Scope would then exist to consider the north side of Gladesville Hospital for possible disposal and the planned closure would achieve the important objective of closing a "whole service" which would ensure resources can be fully transferred to community based services.

Grosvenor Hospital currently provides both residential and community services (including assessment) and it is proposed to reduce the number of residential places from 86 to 32 by 1986-87. This will provide an appropriate scale of residential care more in keeping with the physical capacity of the hospital.

At the same time the Inquiry is aware that regional management has proposed the relocation of the Grosvenor assessment service and this is endorsed as a way of providing more locally accessible services for the region by linking assessment services with general hospitals.

Northern Metropolitan Region (Currently 316 developmental disability hospital places}

The main hospital facility is Peat Island Hospital (174 places} which is an extremely isolated facility largely consisting of old barrack style buildings reflecting its original purpose as an isolation facility.

Physically the hospital is an anachronism and typifies the isolationist and segregationist philosophies which underpinned the provision of these "services" in the past. The facility has no place in a modern service but fortunately due to progressive management the hospital is well advanced in the process of placing clients in a planned way in the community. Therefore, the opportunity exists to facilitate this process by adequate funding of community services and to close the hospital by 1984 and utilise the savings achieved to fund services not only in this Region but as indicated before in others. The other facilities in the region are Collaroy (54 places} and Macquarie Hospital (88 places}. It is not proposed to reduce places at Collaroy and the facilities at Macquarie (a specialist psychiatric hospital} are largely used by disturbed developmentally disabled clients and this arrangement should continue for the present.

Hunter Region (Currently 1052 developmental disability hospital places)

Morisset Hospital is an isolated facility which currently provides 208 places for the developmentally disabled as well as 481 for psychiatric services. In accordance with the Inquiry's principles of service delivery all developmental disability places should be moved from Morisset by 1985 to either Stockton Hospital or to community residential units.

Stockton Hospital has some locational disadvantages but its major difficulty is its scale (844 places) which must be reduced to enable the progressive policies pursued by the hospital administration to become fully effective.

The ability to reduce the size of Stockton is also constrained by the need to move the above places from Morisset and accordingly a target of 670 places by 1986 has been set which accords with the provision of community services outlined above.

South East Region

Currently 200 places are provided at Kenmore Hospital and with the provision of community services over the next two years it is proposed to reduce this number to 100. Although it would not be feasible to physically separate these facilities totally from psychiatric services the management arrangements proposed in this Report will create a separate identity for these services until the services are completely relocated in the community.

Central West Region

Bloomfield Hospital currently contains 198 places and on a similar basis to Kenmore a target of 98 places by 1985-86 has been set. Once again total physical separation from psychiatric is not possible, however, separate management arrangements are proposed by the Region and this Report.



INQUIRY INTO HEALTH SERVICES FOR THE PSYCHIATRICALLY ILL AND DEVELOPMENTALLY DISABLED

PART3

MENTAL HEALTH SERVICES
AND SERVICES FOR
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1. INTRODUCTION

Part 3 of the Report of the Inquiry into Health Services for the Psychiatrically Ill and the Developmentally Disabled examines mental health services and services for the mentally ill and sets out to:-

- (i) identify preferred patterns of service delivery in the light of the general values and principles outlined in Part 1 and the special needs of these clients.
- (ii) translate these into specific proposals to meet needs using minimum resource costs.
- (iii) develop plans to achieve and implement these proposals.

While the Inquiry has dealt primarily with those clients adjudged to have a defined "mental illness", this represents the extreme end of a continuum of problems experienced by people. These problems are an outcome of a complex interplay of often indeterminate social, psychological, physical and cultural factors.

By concentrating on these "extreme" needs the Inquiry has had to face up to the problems of these clients and thereby gain an insight into the total process by which some thousands of socially and economically disadvantaged people are provided with services. This has highlighted the deficiencies in current provisions particularly in the light of the service delivery principles and values outlined in Part 1. Some of the services recommended as a result of this process are also equally relevant to people who face a wide range of emotional problems without necessarily being regarded as mentally ill (e.g. expanded community based multi-disciplinary assessment, psychiatric consultancy services in general hospitals, 24 hour crisis services etc.) Such services may be classified as early intervention or "secondary prevention".

An alternative approach which conceivably could be adopted and would probably be seen as more "preventative" and "universal" is to structure services to give priority to the needs of those potentially at risk of becoming ill. The Inquiry supports preventative programmes which are highly structured but in view of the large inadequately serviced and from the seriously ill considers this latter group must be given priority.

This Part of the Report is written in the context of public discussion of the new Mental Health Bill, which with its greater emphasis on civil liberties will place new constraints on involuntary admissions to psychiatric hospitals. Clearly, this legislation must go hand in hand with a commitment to increase the provision of alternative, community based services in order to maintain people outside hospital. Without this commitment, the new Mental Health Act could be portrayed as an exercise designed to reduce the level of resources available to this disadvantaged population.

2. RECOMMENDATIONS

The following recommendations arise from Part 3:-

1. That as a matter of policy the highest priority in mental health services be the community-based care and rehabilitation of the seriously mentally ill. (refer to Section 3.1)
2. That these services be provided in an integrated manner for each defined catchment area, through the appointment of one person with joint clinical responsibility for the inpatient and community services servicing that catchment area. (3.2)
3. That the Health Department implement a policy that all admissions to public sector psychiatric services be dependent on prior assessment by a community-based assessment team. (3.2)
4. That each Region develop a preventative programme which is tightly defined and targeted at specific client groups or needs. (4.1)
5. That the highest priority in the funding of mental health services be given to the development of adequately staffed community-based assessment, crisis-care and treatment services. (4.1)
6. That from the specific allocation referred to in Part 1 (approximately \$9 million per annum for the next three years), an amount of \$5 million per annum be allocated to mental health services. (5.3 : 6)
7. That from 1983/84 a specific fund be established (\$1.2 million initially) from these funds for the funding of non-government non-profit organisations to provide supportive and therapeutic hostel and group-home accommodation for the mentally ill, and services for special needs groups. (4)

- a. That guidelines be developed to ensure adequate accountability of organisations allocated funding. These guidelines should be developed in consultation with the Department of Youth and Community Services and the Commonwealth Department of Social Security. (4.1)
9. That within this non-government fund an amount of \$400,000 be "earmarked" in 1983/84 for the support of innovative programmes to meet special needs, such as Louisa Lawson House and the Kings Cross youth Refuge assessment service. (4.1)
10. That the Minister for Health, in consultation with the Minister for Youth and Community Services, negotiate with the Minister for Social Security to improve co-ordination of planning and service delivery and to develop proposals for joint Commonwealth/State funding of these services. (4.1)
11. That the Minister for Health negotiate an arrangement with the Minister for Housing whereby a proportion of welfare housing stock in existing and proposed developments is specifically made available as hostel and group home accommodation for mentally ill people. (4.1)
12. That the Minister for Health explore with the Ministers for Planning and Environment, Housing and Youth and Community Services, potential for implementation of a programme of subsidies to private boarding-houses for housing of people with long-term psychological disabilities. (4.2)
13. That as a matter of policy all acute psychiatric admission services be located in general public hospitals: existing acute admission units and staff in state psychiatric hospitals should be relocated or administratively attached to general public hospitals. (4.1)

14. That all acute psychiatric units in general hospitals be authorised for admissions under the Mental Health Act. (4.1)
15. That in association with Recommendation 13 above, services currently provided in general public hospitals for people with acute psychiatric diagnoses be upgraded through the employment of psychiatric nurses and sessional psychiatrists to provide direct services and a formal consultancy service in accident and emergency departments and in general hospital wards. (4.1)
16. That as psychiatric services in general public hospitals are upgraded these hospitals be authorised for admissions under the Mental Health Act. (4.1)
17. That use of Enrolled Nursing Aides be expanded in the staffing of specialised psychiatric hospitals. (4.1: 5.1)
18. That the Health Department and the Nurses• Registration Board urgently review the curriculum and length of Nursing Aide training with a view to upgrading the psychiatric component • (4•1)
19. That Regional Directors negotiate expansion of arrangements for purchase of social work, psychology, and occupational therapy services between hospitals and regions. (4.1)
20. That services in psychiatric hospitals be made more specialised on the basis of diagnostic groupings and programmes. (4.1)
21. That in staffing to meet clinical needs within available resources, more use be made of sessional arrangements for use of private practitioners. (5.1)

22. That Regional Directors negotiate arrangements for greater use of authorised private psychiatric hospitals for the provision of services for public patients. (4.1)
23. That within hospitals emphasis be placed on rehabilitation programmes developed and monitored by programme staff. Direct care ward staff be responsible to the programme staff for programme maintenance and achievement. (5.1)
24. That the Department of Health approach the College of Nursing to develop a training programme to facilitate the transfer of nurses to community care services. (5.1)
25. That services for children and adolescents (located in community health centres, child health centres or in hospitals) be administered as a specialised network at regional or sub-regional level. (5.2)
26. That Advisory Committees on Child, Adolescent and Family Mental Health be established at regional and state level, including representatives of the Departments of Youth and Community Services and Education. (5.2)
27. That from the specific allocation (\$5 million per annum) referred to in Recommendation 6, an amount of \$3.8 million be allocated to Regions to develop community mental health assessment crisis-care and treatment services necessary to facilitate reduction in the utilisation and size of the existing specialised psychiatric hospitals. Priority to be given to the Western Metropolitan, Hunter, Southern Metropolitan and Illawarra Regions. (5.3)
28. That the existing psychiatric services in the following hospitals be responsible to the Boards of the following hospitals:

Rozelle and Gladesville Hospitals - Royal Prince Alfred Hospital Board (with widened membership to represent psychiatric services)

Parramatta Psychiatric Centre (and services at Rydalmere Hospital until 1985/6) - Parramatta Hospitals Board (with widened membership to represent psychiatric services)

Macquarie Hospital - Royal North Shore Hospital Board (with widened membership to represent psychiatric services)

Newcastle Psychiatric Centre and Morisset Hospital - Regional Psychiatric Board (with teaching hospital representation)

Kenmore Hospital - Area Board for Goulburn

Bloomfield Hospital - Area Board for Orange

29. That the following targets be adopted for the expansion of community services and the relocation of acute admission services, and the reduction in size of specialised psychiatric hospitals:

Region	PSYCHIATRIC HOSPITALS			Target Beds	Target	Target Communi- ty Mental Health Positions
	Current Beds	Proposed Reduction Hostels	Proposed Transfer			
Western Metropolitan	803	100	100	603	n o t s p e c i f i c a l l y a l l o c a t e d	56
Southern Metropolitan	1155	305	100	750		20
Northern Metropolitan	286		40	246		
Hunter	591	241	100	250		29
South-East	396	106	40	250		10
Central West	467	245	60	162		10
Illawarra						15
South-West						29
Orana & Far West						29
North Coast						29
New England						29
	3698	997	440	2261	500	256

30. That in each specialised psychiatric hospital a migrant health advocate be designated from among the existing staff. (7.1)

3. HOW ARE CLIENT NEEDS BEST SERVED?

3.1 What are client needs?

In each area of its investigations, the Inquiry has endeavoured to take as its starting-point the identification of client needs. The expression of needs is constrained by other factors and the structure of service provision is inevitably the outcome of compromises between -

community demands for control and protection:

professional preferences for different modes of service, selected on the basis of skill, experience and assumptions about need:

expressions of consumer/client need:

community values about the care of the disadvantaged.

In a health care system where choice is largely reliant on income, health insurance status, and geography, it is difficult to assess consumer preferences for particular forms of service.

The emergence in recent years of a small but growing number of self-help and consumer groups including for example, GROW, the Association of Relatives and Friends of the Mentally Ill (AFAFMI), the Manic-Depressive Self-Help Group, and the Alzheimer's Disease and Related Disorders Society represents a gradual shift, in community attitudes towards a more open acknowledgement of mental illness. The growth of consumer based advocacy groups, although often one-dimensional in focus, has the potential to provide valuable feedback to providers and planners.

The Inquiry has endeavoured, through the process of submissions discussions with individuals, forums and a "Phone-in" (conducted by the Mental Health Co-ordinating Council in November, 1982) to gather information about client needs. This process has indicated that both consumers and relatives are concerned about the quality of care provided, lack of continuity of care and the range of services available and has highlighted the following needs:-

comprehensive multi-disciplinary assessment, including physical, psychological and social components.

increased individual attention and treatment and less reliance on medication.

increased involvement of family and friends.

increased information about the problem, treatment and likely outcomes, both positive and negative.

clearly identified and available support mechanisms.

The following extracts from the Interim Report of the Phone-in Survey on Psychiatric Services conducted at the Inquiry's suggestion by the Mental Health Co-ordinating Council of N.s.w. in November 1982 illustrates these needs:-

"The largest category of recommendations made by past and present inpatients concerned improving existing services which included such comments as improving hospital services, providing "better" public hospitals and the need for better contact between services.

The second largest category of recommendations concerned improving the quality and type of care provided in psychiatric services. This category included comments such as placing more emphasis on self-help groups and self responsibility, less emphasis on drugs, more emphasis on prevention and more privacy with doctors."

"The third category of recommendations concerned improving staffing and training with such comments as staff needing to have more caring attitudes and communicating better with patients.

The final category and recommendations concerned developing more and better community support services and comments included providing more community services, including follow-up care, crisis counselling and family support, providing accommodation and therapeutic community services and making better use of family and home resources and the response from relatives and friends indicated a similar pattern of concerns.

Respondents were asked in what ways existing services for patients should be changed and what new services were needed. Apart from requests for intangibles like the removal of the stigma of mental illness, most relatives referred to the improvement of treatment programmes. By far the largest number emphasised the importance of understanding and caring staff. Better staff training, more individual therapy, and physical/biochemical allergy tests came next, along with the need for smaller institutions. Research into the causes of illness and into medication and its alternatives was also mentioned, together with more active hospital programmes and occupational therapy."

Many callers wanted more information to be available about mental illness, alternative services, employment, legal and financial problems. In terms of community support services the largest number requested more home visits and community based services which understood the relatives' needs. Self-help groups for patients and relatives and a 24 hour crisis service was also considered very important."

"Relatives saw the most valuable follow-up care as day or drop-in centres and accommodation in half-way houses. There was some interest in more group therapy, "fewer psychiatrists and more counsellors", and more services for chronic patients."

(Extracts from Interim Report - Phone-in Survey on Psychiatric Services - Mental Health Co-ordinating Council of N.S.W., December, 1982)•

A number of submissions to the Inquiry expressed concern about the level of unmet need in the community and stressed the need to provide adequate resources outside the hospitals as deinstitutionalisation proceeds:-

"Movements within the mental health system have led to an increasing enthusiasm for the "negative" rights that guarantee the integrity of the individual against state interference and coercion, and relatively less enthusiasm on the part of the State for the "positive" rights of an adequate level of resources to meet needs."

"The new Mental Health Act includes provisions for a patient advocacy service and a strengthened civil liberties component."

"The result of this new shift away from medical/psychiatric paternalism towards civil liberties protection will mean it will be more difficult to involuntarily detain a person in a psychiatric hospital. It is likely that it will also be used to cut down on the utilisation of psychiatric beds. If no increase in community-based mental health services coincides with this shift, then many people who now get inappropriate (and unwanted) hospital treatment, may find themselves with no treatment at all."

(Extracts from Submission 139: PALA Society)

This has been a well documented concern overseas. Evidence from welfare agencies and the Inquiry's own research and field work has shown that the reduction of numbers of patients in psychiatric hospitals in N.S.W. over the last decade or so has placed some of these people in community settings where they live impoverished lives. This is particularly the case in regard to those who possess other disadvantages, for example those with low income, the unemployed or the homeless.

"The two major changes over the past 20 years are the implementation of the policy of managing mentally incapacitated people in the community and the public funding of the medical aspects of their disorder through health funds and state and federal assistance. This has resulted in overcrowded boarding houses and nursing homes, to maximise financial returns and an over reliance on medication to achieve behavioural control. "The back ward institutionalizing" process has been shifted out of sight into the community.

Although medication is an important aspect of management, the fact that it is the only aspect of treatment with access to unlimited funds has resulted in a gross imbalance in treatment and a deteriorating standard of care. This process will inevitably continue if the responsibility of care is left to doctors working on a "fee-for-service" basis with a captive boarding house community."

(Extract from individual submission S 173: Psychiatrist)

and as expressed by the Salvation Army:

"It is fair to say that not one of our services is exempt from the effect of the changes to the Mental Health Services in recent years. Some types of service have been effected more than others. This state of affairs may be seen from one point of view to be acceptable. From the Salvation Army's point of view, it is unacceptable as:

1. Staff have had to try to handle clients for whom training has not been appropriate.
2. Staffing ratios of necessity have to be higher when the psychiatrically disturbed are accommodated and our staffing structures, and consequently funding, are related to what is conceived as the basic service which excludes this complexity."

and

"The service areas that have been effected by the changes in services to the psychiatrically ill over recent years are:

1. Emergency accommodation homeless persons
2. Rehabilitation programme for drug and alcohol dependants
3. Senior citizens services.

How these have been effected is as follows:

1. Persons have been hospitalised because of some psychiatric disorder. Stabilization has been achieved through treatment and the establishment of an effective medication regimen. Such persons are then assessed as being able to manage their own affairs and discharged to independent living. However, once discharged, many have consistently displayed an inability to manage their medication, have become unstable and have then become too difficult for the staff of our homes for the homeless to handle.

The point of acute aggravation has arrived when the persons have not been accepted for care and further treatment by those institutions best able to provide it. The end experience for these persons then, is squalor, dirt, cold, loneliness, violence, and the staff of our homes continue to be frustrated in providing a modicum of care and security."

2. Persons present at our rehabilitation units with an addiction problem but are also under medication for a psychiatric illness. Without the complications after presentation, there are those that relate to the potential overdose, violence and death. After admission to the programme and failing an established point of reference for the discussion of the psychiatric illness, there is the danger of inaccurate diagnosis and/or the cessation of very important medication with resulting confusion and complications."
3. Senior citizens services can be effected by the organisation accepting a person for care who ultimately displays an incapacity to handle consistently well, their medication. If such persons are to continue in residence, then they must allow some responsible persons to handle their medication. Where they refuse to allow this to happen, then there very often is no alternative but discharge ... but to where?

Or take the case where a person in a nursing home comes to the place of needing psychiatric treatment but is refused admission by an appropriate Government Hospital unless we accept one of the hospital's other patients. Such approaches can soon remove the 'home' aspect from the whole concept for all concerned, and could well relegate the nursing home to simply being another hospital in the chain of institutions."

(Extracts from Submission 209 : The Salvation Army

This concern was given added emphasis even by those concerned to promote alternatives to hospitalisation:-

"There is local evidence at the early stages of decarceration that inadequate community facilities exist to support people out of hospital. About one half the people who contact the mental health system do not seek further contact except in emergencies and the most common form of 'treatment' after hospitalisation is a mixture of medication and entertainment.

"The prospects for change in this situation are not optimistic. People primarily get in contact with the mental health system when an emergency develops, yet the number of crisis-oriented services is relatively small, with the only options after hours or on weekends being hospitals. Crises don't confine themselves to business hours and neither should services.

As the option of hospital becomes more inaccessible, the police will be used more and more, as will voluntary agencies who deal with the poor and homeless.

The more general problem with a lack of emergency accommodation is exacerbated in relation to people in emotional distress. The various refuges have their hands full with providing material aid and often emotional support is a scarce resource. At the same time community services are run down as a result of continuous public service staff freezes to the point where some services have had to close completely."

(Extracts from Submission 139: PALA Society)

Initiatives are needed to minimise the possibility of these problems continuing through the provision of continuous community based treatment and rehabilitation and adequate accommodation services. Vulnerable people will always be "at risk" in society and while reasonable provision of services will assist to offset this they cannot eliminate the problem. The fact that people are "at risk" should not be used as an argument to perpetuate inappropriate custodial care. Those people who suffer from serious mental illness often require supportive accommodation and occupational activities, but they do not necessarily require hospital treatment or custodial care.

The other major concern is the question of priorities.

One family in five in New South Wales can expect to experience mental illness in at least one of its members during the life span of the family. Furthermore, mental illness is a major cause of disability in the elderly and the increasing numbers of aged persons in our society will inevitably increase the burden of mental illness in the future.

"Mental illness touches all socio-economic groups in Australia, and there is growing evidence that its morbidity is greatest in the most productive working years when family responsibilities are also at their peak.

The following figures give some indication of the extent of the problem:

Australian studies agree that about 1.5 percent of the population have some serious mental illness and an additional 18-23 percent suffer some significant psychological disorder. About half of these are still troubled six months later.

9.5 percent of all general practitioners' contacts in 1974 were for mental disorders. A 1979 study suggests that one in four of all general practitioners' contacts are for emotional, not physical illness, and that one third of these patients are still chronically troubled six months later. Of these about half (six percent) see themselves as in need of treatment."

The 1977/78 Australian Bureau of Statistics Health Survey showed that in the population surveyed, 4.6 percent of all conditions for which a doctor (not a general practitioner) was consulted were coded as mental disorders. The same survey showed that an additional 30 percent of all contacts with doctors were coded to conditions for which there is good evidence that they relate to underlying psychological and life stress."

"One in three of all patients attending an outpatient clinic for the first time did so for a primary psychiatric disorder."

(Royal Australian and New Zealand College of Psychiatrists: "Discrimination against the Mentally Ill" (July 1980)).

The size of the problem and the diffuseness of its boundaries, is exacerbated by the ideology of health service provision that intervention is or should be unlimited. It has also been forcefully argued to the Inquiry that the needs of special groups such as the homeless, women with children, and migrants, have not been adequately recognised in the past.

Particular concern was expressed to the Inquiry regarding the needs of troubled and disturbed children and adolescents and their families.

"Adequate information on the incidence and prevalence of child and adolescent psychiatric disorder in the general population of New South Wales is not available. However, studies in Great Britain (Rutter et al 1970), and in Victoria (Krupinski et al 1967) indicate a prevalence of approximately 10%; a more recent study of Queensland schoolchildren (Connell et al 1982) suggests an overall prevalence rate of 14%, rising in metropolitan schoolchildren to 18%. With the severity of psychosocial stressors on children and young families today in Australian society, it is unlikely that the above figures and the need for appropriate and high quality services will diminish. We view the target area for the delivery of mental health services for children and adolescents to encompass the age range from birth to 18 year olds and to include their families. Planning and development of such a service should then provide for an integrated appreciation of the overall developmental needs of this segment of the population, the at-risk factors operating for the vulnerable, and areas of major psychopathology requiring"

'intervention. Resources already available within the professional medical and paramedical personnel should be supported and consolidated and new services developed to meet the needs identified.

It is appreciated that severe emotional disorder in childhood and adolescence, if untreated, may be long lasting and have deleterious effects on individual development leading in some to learning difficulties and severe educational deficits, to social dependence, recurrent psychiatric illness, substance abuse and dependence, serious conduct disorder leading in some to vandalism and crime. This experience invariably involves other family members. Appropriate and adequate management requires expertise and is costly and time consuming in the short term; however, it has major implications for the ongoing health and psychosocial adjustment of the young person involved, as well as for prevention in other family members and in the next generation. In the long term it is cost effective."

(Extract from Sl41: Royal Australian and New Zealand College of Psychiatrists)

"The needs of emotionally disturbed adolescents differ greatly from those of the population at large. A significant proportion of youth residing in crisis accommodation are emotionally disturbed, thus highlighting the need for accurate assessment measures. The current assessment facilities are not appropriate for an accurate and timely outcome. This is exemplified by the fact that emotionally disturbed adolescents are still being processed through the judicial system and come under the control of the Department of youth and Community Services, either in wardship or in training schools. The reason for this is that their behaviour is often termed as 'uncontrollable' and youth refuges neither have the staff, nor the facilities, to cope effectively with these adolescents."

(Extracts from S 208: Wayside Chapel - Committee on Emotionally Disturbed Adolescents).

Officers of the Department of Youth and Community Services have also expressed concern about the needs of children who are identified as being "at risk" as a result of their parent's mental illness, and the need for mental health services to remain actively involved in the care of these families and accept and maintain responsibility beyond the act of notification to the Department. These families will, in the Inquiry's view, be more appropriately cared for by specialist child and family mental health personnel.

Resources for the provision of these services will continue to be limited and therefore the determination of priorities will be a primary task at all levels and existing resources must be more effectively utilised. The Inquiry considers that the highest priority should be given to the community based care and rehabilitation of the severely mentally ill. A reasonable balance needs to be struck between direct and indirect services. But the major emphasis should be on direct services for those in greatest need of psychiatric services.

"Another problem which has developed is that the Schedule V hospitals have had to maintain high levels of staffing to provide acute care to the individuals who are constantly breaking down in the community. The rise in readmission rates is largely due to the failure of medical management to adjust the individual to the conditions they will meet in the community. People are rehabilitated to a hospital standard of care which is not available on discharge."

(Extract from individual Submission Sl73: Psychiatrist)

"Because the costs of chronic mental illness - in human, social and monetary terms - are enormous, the prevention of chronicity should be one of the most important goals of health and community services. Hospital treatment has been

found to encourage further hospitalisation and hospitalisation is now widely viewed as promoting chronicity. The prevention of the first psychiatric admission - by means of community treatment - can therefore be seen as an important step in the prevention of chronicity and as being of considerable importance to the future of those patients and the community as a whole."

(Reynolds, I. and Hoult, J.: "Preventing first Psychiatric Admissions and Supporting the Chronically Ill in the Community")

In the context of redistributing existing institutional resources, this emphasis must inevitably be on the adult population, who constitute the bulk of admissions. Although recognising above the special and important needs of children and adolescents, the Inquiry believes that the highest priority must be given to changing the primary focus of care away from the institutions. The Inquiry however, proposes some organisational changes in this area, as discussed below, and recommends that child, adolescent and family mental health services be given priority in staffing of community health services as resources become available.

3.2 Principles of service delivery

1. Integration

In one sense, mental health services represent the "human", "psychosocial" side of health care, and greater integration of these services into the mainstream of health care can have desirable outcomes for the recognition of psychosocial issues in the care of physical conditions, or better intervention where such psychosocial issues are paramount. On the other hand, concern is expressed that integration will mean that the mental health area is overshadowed by the powerful forces of technological and biological medicine.

At the same time it is widely recognised that there are significant dangers in maintaining an isolated, segregated system of care. Not only may patients not be adequately diagnosed, or physical symptoms or causes overlooked, and a false dichotomy between mind and body perpetuated, but the isolation of such a disadvantaged group leaves these services vulnerable to economic pressures because of the lack of community based advocacy.

As discussed in Part I of this Report, mental health services are provided by a number of government auspices. The fragmentation of state psychiatric hospitals, general public hospitals and community health services inhibits opportunities for improved service delivery and co-ordination.

To some extent the decline in utilisation of state psychiatric hospital services in recent years, has been offset by the increased utilisation of general hospitals (10 percent of patients with psychiatric diagnoses in 1980) both with and without psychiatric units. Whether this reflects consumer preferences, medical referral patterns or both, it highlights the need for effective specialist consultative arrangements and appropriate links to follow-up services.

The major objective of a more integrated service delivery system at local or area level is to promote appropriate and high quality care, early intervention and avoidance of unnecessary and costly hospital utilisation.

The Inquiry considers that integration of mental health services can best be achieved at area or sub-regional level, through the appointment of one person with clinical responsibility for the inpatient and community services serving that catchment area. The community mental health services should also be integrated with the other community health services in that area. This would be further facilitated by the employment of all community services staff by an Area Board or, until they develop, the Board of a general public hospital. The composition of these Boards may need to be reviewed should such a change occur.

2. Decentralisation

The provision of comprehensive mental health services, which focus on the social and psychological environment of the client, is only possible if services are highly decentralised, and located as near as possible to where people live and work.

The maldistribution of services, particularly of hospital beds, would appear to lead to inappropriate reliance on hospital care in some areas and lack of access in other areas. The Inquiry does not however advocate only the redistribution of hospital facilities, but the redistribution of resources for the provision of a co-ordinated network of care.

While there is a need for an increase in the number of psychiatric units in general hospitals to provide local, accessible acute care, the prior need is to develop services which can effectively intervene and assess in the client's normal living environment, with the objective of avoiding hospitalisation wherever possible.

3. Comprehensive assessment

Managers and service providers have emphasised the importance of the assessment process as a prerequisite to appropriate and individualised care. The quality of assessment is a key management issue as it determines the nature and level of resources to be made available to individual clients and their families. The importance of assessment as a major determinant of resource allocation is often not understood by the staff who are exercising discretion in this area.

There is, of course, general agreement on the need for assessment to be multi-faceted and multi-disciplinary, and it is clear that greater priority should be given to make such an approach a reality.

The more contentious issue is where and when assessment should take place, and the extent to which those involved in the assessment should have some control over the allocation of scarce resources such as home support services, hospital services and residential care. It has been strongly argued and the Inquiry considers that the assessment process should take place, as far as possible, while the client is still living in the normal home environment, prior to admission to an institution, as assessment within any inpatient service is influenced by the process of admission itself.

This is not, of course, to imply that admission will not continue to be needed by some clients in order for an effective assessment to be carried out. It is rather to imply a different orientation and a rearrangement of priorities.

The other major component of assessment is the need for reassessment and review of the objectives of intervention with any particular client or family. This activity also appears to the Inquiry to be generally undervalued.

d) Continuity and comprehensiveness

A major concern expressed to the Inquiry about the current system of mental health care is that it is largely episodic, that is, services are organised to respond to episodes of illness, rather than provide continuity of care. This concern was particularly related to hospitals.

For example,

"For 150 years or more, hospitalization has been considered the standard method of treatment for the mentally ill, although there has never been any research which showed that hospitalization was either effective or necessary. Nevertheless, the hospital is now the focus of most of our treatment efforts.

Mostly, hospitals deal only with episodes of illness. Patients are admitted for treatment only when their disorder has progressed to such an extent that their environment can no longer cope. On discharge, patients and relatives are left mostly to their own devices and are completely unsupported after normal office hours. That is, pre-care and after-care services are either lacking or poorly funded and insufficient. Yet many patients have ongoing symptoms and problems.

Research studies show that no matter how good a hospital program is, 6 months after discharge patients are relapsing at the same rate as patients who did not have such a program. The only exception is when there is a good program of continuing care."

(Extract from individual submission S.219 Psychiatrist)

The problem with continuity of care was also highlighted by the "Phone-in", although it was clear that this is less of a problem on discharge from a State psychiatric hospital than from a private or general hospital.

The need for continuity and a comprehensive approach was described most graphically in the submission from the Lower North Shore Mental Health Services.

'The long term psychiatrically disabled are people who, for a variety of psychosocial reasons, are unable to conduct their lives at a maintained functional level without continuing professional, institutional or other extra care.

Psychiatric diagnostic classifications alone are unhelpful in defining this disability. Firstly, one or more diagnoses may be involved. Secondly, their long term disability is often a result of perpetual interplay between psychiatric disorder, functional impairment, and inadequate community response to their needs.

Their functional impairment involves a lack of specific skills and perceptions which enable most of us to cope with life:

- i) lack of a continuing sense of competence and mastery over their own lives, so that they may not believe that their actions can lead to any improvement in their lives.
- ii) lack of attention to their own self-care, nutrition, clothing, shelter etc.
- iii) impaired ability to make and keep social relationships, leading to isolation, a lack of social role and supporting social network.
- iv) impaired ability to be productive in the use of time, whether by work or leisure activity.
- v) impaired ability to acquire sufficient material resources, whether by working or by knowing how to gain their due entitlements.
- vi) impaired ability to withstand any new threat to their present circumstances, leading to vulnerability to change and exploitation."

They are therefore readily stressed, often passive and their motivation to remain involved in life in the community becomes easily eroded. They often remain pathologically dependent on their families and/or institutions all their lives. A pathologically dependent relationship mutually encourages maladaptive behaviours, and often induces feelings of panic in all involved when its loss is threatened.

Community response to their needs and incapacities has been generally inadequate:

- i) lack of appropriate support and facilities in the community for rehabilitation.

- ii) lack of opportunity to work and have a role in the life of the community.
- iii) lack of appropriate accommodation in the community.
- iv) falling back on psychiatric hospitals and patients' usually crisis prone families to provide total care almost in rotation, thus deepening pathological dependency.

There is strong evidence that the social conditions in which these people live determine the severity of their disablement."

and continuity of care is defined as:

- "i) continuity of follow-up: the gains made by intensive initial efforts to re-establish a foothold in the community for the longterm disabled, will be reversed without longterm regular professional follow-up. Lifelong support may be required to ensure that gains are maintained and built upon.
- ii) 'continuity between health agencies: Mental health workers should co-ordinate continuity of care between treatment and helping agencies around the person, rather than assume that he will successfully negotiate the often difficult pathways from one agency to another on his own."

(Extract from S 212: Lower North Shore Mental Health Services).

e) Shared care

In order to provide the broadest focus for service delivery and provide for a variety of needs and modes of delivering services, responsibility for the provision of these services needs to be shared across a wide range of professional skills. Emphasis on clients needs and flexibility of services is more likely to occur where no one professional skill has a monopoly on the delivery of services.

At the same time there is a wider notion of shared responsibility which places emphasis on the community "bearing" shared responsibility of services not just in the traditional sense of paying tax and getting some kind of service. This requires an approach to "helping" from the point of first contact and assessment which sees the client's immediate family and social network as the most important agents of help and support, and the professional and institutional role as support and education of these agents. This involves operating in the wider context of the client's immediate social and family framework and trying to encourage community based provision of services. It also has the potential of involving the client or client "proxy" in the resource decisions and attempting to encourage as supportive a normal community framework as possible.

More scope needs to be found for involvement of voluntary agents in negotiated arrangements to help provide these services. Greater involvement by community based groups reinforces the principle of normalisation and enables better use to be made of the scarce resources of health professionals.

4. HOW ARE SERVICES BEST STRUCTURED TO MEET NEEDS?

4.1 Components of service

(i) Prevention

The concept of prevention, particularly primary prevention, in the area of mental health, has been the subject of much debate in recent years, and a number of programmes have been developed, particularly within the community health services with the stated objective of primary prevention of mental or emotional disorders.

While such programmes undoubtedly have socially beneficial effects for those who participate in them, it is extremely difficult to demonstrate that they are actually preventing or reducing the incidence of mental ill-health. The problems associated with the prevention of psychiatric disorder have been described by Professor Beverley Raphael in the Australian and New Zealand Journal of Psychiatry (1980) as

"i) Aetiology: The aetiology of much disorder is uncertain, both in terms of the necessary and contributing conditions, as well as the processes involved in the appearance of psychiatric problems. Few would disagree that multiple parameters are involved ..."

"ii) Outcome: What is to be prevented? Good epidemiological morbidity studies are few, and those that exist may be open to many interpretations... It may be difficult to demonstrate an effect on events which are themselves relatively infrequent, such as suicides. A further difficulty arises when taking into account the many variables of personal functioning that may or may not be affected by psychiatric illness. Outcomes involving these measures may be more dictated by the pre-intervention state of these factors themselves than by effects of disease or preventive

interventions,, e.g., schizophrenia and premorbid interpersonal and work functioning. "

"iii) Techniques and processes have often been poorly defined, perhaps because aetiological processes are also unclear . . ."

"iv) Methodological problems arise from the factors outlined above There is the difficulty of demonstrating an effect when diffuse factors are subjected to diffuse interventions with possibly diffuse outcome effects".

The Inquiry considers that a rigorous evaluative approach is necessary with preventative programmes. However because of the extent of the need for direct services the Inquiry is reluctant to give the area as high a priority as some advocates would argue. However, specific preventative programmes should be developed to focus on particular needs as specific interventions directed towards high risk populations (for example, the bereaved) to achieve specific prevention goals have shown that primary prevention may be effective in some areas.

(ii) Network of community-based assessment, treatment and support services

Arguments about the question of deinstitutionalisation of mental health services have raged in recent years perhaps even more vigorously than the debate over prevention. The debate has become, perhaps inevitably, polarised around the question of the need for and the future role of institutions and hospital services. The underlying issues in this debate are as follows:

the nature and extent of community services which are required for adequate care of the acutely and chronically ill.

the appropriate venue and style of facility required to provide "asylum" care.

The capacity of the "mainstream" general health system to provide acute care of the mentally ill.

arrangements for continuity of care between different service components.

While the Inquiry accepts that hospital services are and will continue to be essential for the acute and long-term care of some mentally ill people, as discussed in more detail below, many of the services provided in the current institutions could be provided in a more acceptable, personal and continuous manner as part of a network of community services. Unfortunately, the lack of adequate funding of community services, the lack of clear policy direction about the priority to be given to the seriously mentally ill or the future role of the institutions, have all combined to reinforce the views of hospital staff that the institutions are the only place where the seriously mentally ill will be cared for, and that these facilities and services must be maintained at all costs. For example:-

"It seemed to be the hope of planners and administrators that many patients who in the past required long-term care in psychiatric hospital, could be better housed and managed in the community. Much was made of the alleged effects of "institutionalisation" and discharging such patients from hospital wards and subsequently abandoning the tradition of asylum in hospital, held out the hope that such long-stay wards would not be necessary except for the mentally retarded and the demented. These hopes do not appear to have been realised: patients previously housed in hospital wards are now housed in community boarding houses and nursing homes, sometimes in appalling conditions.

Recent studies in the United Kingdom show that the effects of institutionalisation have been over-estimated in the past, and

that the majority of patients suffering from chronic psychotic illnesses develop the same disabilities and limitations outside hospital as do those kept in long-stay wards, and that such functional handicaps are largely the result of the patient's illness rather than of being "institutionalised".

(Extract from Submission S.28 : Banks House, Bankstown Hospital).

While the Inquiry understands these views, the fact that the seriously mentally ill need intensive support is not in itself a justification for their treatment in hospitals.

The Inquiry's preference is for a system of care which gives greater priority to the "normalisation" of the mentally ill, through support and intervention which as far as possible maintains the individual in their home environment, or provides a "home-like" alternative. That this is therapeutically desirable has been pointed out by a number of writers, for example:

"A series of research projects on psychiatric patients and their families which I had undertaken in the 1960s had shown that a psychiatric diagnosis, especially if accompanied by admission, was associated with a peculiar rift between the patient and others in his world, and that this rift had serious consequences from which they might never recover, however well the patient himself subsequently became. I term this rift "closure" (Scott and Ashworth, 1967: Scott, 1973, 1975). In the build-up to a crisis, there is increasing pain and stress in interpersonal relations, especially between those who are most dependent on each other in daily living. At a critical point the stress and the pain become intolerable, and the subjects close, just as any of us closes off in face of a situation which has become beyond endurance and from which there appears to be no other immediately available means of escape. But what our family members are closing are relationships - relationships which contain the most sensitive feelings and bonds with each other. In closing these

"bonds the members do not, as a rule, abandon each other in the ordinary sense - they dehumanize each other.- It is at this point that the person, or family, forces professionals to intervene to reassert cultural norms. In this context the professional sanctioned by society is the doctor. He is required to give his official confirmation as to who is ill, and in doing so he will almost inevitably confirm, and thereby perpetuate the rift of dehumanization."

(R.D. Scott, "A. family-oriented psychiatric service to the London Borough of Barnet" Health Trends, 12, (1980)).

and as put to the Inquiry in one submission:-

"None of the modes of service delivery which we use were ever instituted on the basis of any research. Mental hospitals were built in the 19th Century initially because reformers and doctors promised that hospitals would cure mental illness. They failed spectacularly. However, they continued to be built because they provided a culturally legitimate way for people to shed the intolerable burden of caring for mentally-ill relatives in the urbanizing, industrializing, economically unstable and poverty-ridden Victorian society. In spite of regularly occurring scandals in the hospitals, few cared.

Our change-over to psychiatric units in general hospitals has similarly been made on the basis of changes in social values. To my knowledge, after searching the literature, there is only one study comparing outcomes for patients in such a unit with patients in a mental hospital. There was no difference between the 2 groups; however the relatives said they liked the general hospital unit better.

Similarly, the community mental health centres were set up on the basis of a new wave of reformism and new social values. No pilot studies were done to evaluate in advance. It is not surprising that they have attempted many things and succeeded with few."

"Only in the past 20 years has some research been done into methods of delivery of psychiatric care. Consistent trends emerge. Firstly, short hospital care is as effective as lengthy hospital care. Secondly, programs which provide alternatives to hospital care are as effective as hospital care. Thirdly, programs of alternative care which provide comprehensive and continuous services have a better outcome than hospital care and standard after-care. Fourthly, patients relapse when the comprehensive services are withdrawn."

(Extract from Individual submission S.219: Psychiatrist)

It is clear that community services must be adequately staffed and resourced and given clear operating objectives against which they can be evaluated. Reduction in the size of the institutions and decentralisation of their staff and services will only be possible if the alternative services are adequately established and have a role in the assessment of patients who are referred by agencies in their area for admission to inpatient care.

The components of such a comprehensive community care service were described coherently in several submissions to the Inquiry, for example, the N.S.W. Association for Mental Health identified the following elements:-

- "1. Area-based teams of rehabilitation (and habilitation) professionals should be specifically trained and staffed to ensure that the needs of the long-term psychologically and/or socially **disabled** in the community are met. Staff should be mobile, spending most of their working time where their patients live, rather than in the office, clinic or hospital, and should be rostered in day and evening shifts seven days a week. The functions of such teams would include:

- "(i) Ensuring that basic needs are met
(i.e. practical help with food,
clothing, shelter, etc.)
 - (ii) Providing or facilitating the use of
individually tailored training in
community living programs (carried out
where people are actually living)
aimed at improving basic living skills
(e.g. the use of public transport,
personal hygiene, etc.).
 - (iii) Assisting patients to arrange social,
residential and work rehabilitation
programs.
 - (iv) Ensuring or providing family support
and counselling (which is crucial if
the family is to cope with, benefit
from, and not undermine the gains made
with this program).
 - (v) Encouraging every long-term patient to
choose a general practitioner doctor
and establishing regular liaison with
the general practitioner to provide
him with whatever support and advice
he needs to manage the patient's
medication and any other aspects of
the patient's management program with
which he is involved, including
education of the patient in the
appropriate use and limits of
medication.
 - (vi) Assisting in providing or supporting
both area-based 24-hour crisis
services (discussed in detail in the
Association's Position Paper on
Services for People in Crisis) and
other primary care services, so that
crises and exacerbations of
psychiatric disturbance can be dealt
with quickly (and the need for
medication or hospital treatment
thereby minimized) and so that access
to psychiatric admission facilities
and other services can be
facilitated.
2. Continuit of communit care should be
ensured so that these people do not
'get lost in the system') by the
provision of (i) ongoing rather than
time-limited services, (i) personal
case-managers, liaising with general"

"practitioners and encouraging and co-ordinating involvement of other local services, (iii) assertive follow-up of the provision of services, and (iv) a system of records that ensures that review occurs regularly and that any transfer takes place efficiently.

3. Accommodation. There should be a range of small-scale accommodation facilities in each area. Such accommodation would vary from supervised to unsupervised.

(i) foster home schemes - placement with a carefully selected family, with professional support

(ii) group homes - houses or units

(iii) residential living skills training hostels

(iv) long-stay hostels, boarding houses and nursing homes.

It is desirable that hostels, boarding houses and nursing homes for long term placement of the psychologically and/or socially disabled should be small and operated under licensing legislation that (1) provides positive incentives in the form of subsidies and professional support of management, and (2) ensures humane living conditions, appropriate clinical care and access to occupational programs.

4. Social rehabilitation programs. A living skills day centre in a home-like setting is needed in each area with adequate staffing to provide informal drop-in facilities, assessment and group learning programs in both the practical tasks of independent living (e.g. cooking, budgeting, etc.) and developing competence in adult social roles (e.g. social skills, self assertion, communication skills, leisure and recreation). Evening centres should be provided. Centres should be easily accessible by public transport."

"Volunteers can be very helpful as role models in living skills training. Such volunteers require considerable support, and supervision from the area-based team, and provision for payment of expenses.

5. Work rehabilitation programs. There should be a range of work facilities at different levels of supervision on an area to regional basis: vocational assessment services: sheltered workshops providing both training and maintenance, developing along the lines of normal industry: and" specific work retraining programs.
6. Self-help groups. Self-help and mutual support groups of people with long-term disorders, their families and other interested persons should be supported through adequate funding and consultation.
7. Long-term in-patient facilities. If the services described above were available the need for long-term in-patient facilities (i.e. hospital-type facilities) would be minimal. Such facilities as are needed should be provided on a regional basis and should be small scale and well-staffed, conforming as far as possible to concepts of normalization and small group living.
8. commitment regarding the continuing viability of services in the community for the long-term psychologically and/or socially disabled should be made by government at every level. This would ensure the lifelong support often required, and assure families that their disabled member would be cared for, when they are no longer able to do so."

(Extract from Submission S 213: N.S.W. Association for Mental Health).

The Inquiry considers that the priority services within this network are the adequate staffing of community - based assessment, crisis care and treatment services.

The advantages of an after hours crisis service are:-

It is called in at earlier stage of illness or relapse. Clients, relatives and general practitioners are usually unwilling to send patients to hospital until the situation is quite intolerable.

It enables the client to stay in his own environment, usually preferred by the client and his relatives.

It is much more likely to see the whole family so it can make a better assessment, and give immediate advice and support to the relatives.

It gives great security to clients and relatives. - knowing there is someone readily available is more likely to make the family more willing to continue caring for the client, and to assist the client to overcome the crisis.

Comprehensive community services for the mentally ill should give first priority to caring for the seriously mentally ill. A policy statement emphasising first priority for the seriously mentally ill should be made by the Health Department.

The accommodation facilities (hostels and group homes) should be developed in consultation with the non-government agencies who have considerable expertise in this area, particularly the After-Care Association, the Richmond Fellowship and the Psychiatric Rehabilitation Association. For some services, these agencies currently receive some Commonwealth funding under the Handicapped Persons' Assistance Programme.

The Commonwealth government has been understandably concerned to avoid funding services which would enable the States to transfer the cost of care of the mentally ill, which has been

entirely a State responsibility, from the State to the Commonwealth. However, the Handicapped Persons' Assistance Programme acknowledges a national responsibility for the care of the handicapped. In view of the complexity of these issues, the Inquiry considers that the State should initiate discussions with the Minister for Social Security regarding the possibility of greater co-operation and joint funding of services in this area.

In the initial stages of the development of these services, the State government should provide some funds for the expansion of non-government services in priority areas of the State.

The Inquiry proposes that a specific purpose fund be established by the Department of Health and that guidelines be developed to ensure adequate accountability of organisations allocated funding. These guidelines should be developed in consultation with the Department of Youth and Community Services and the Commonwealth Department of Social Security.

Within this fund a specific allocation should be earmarked to encourage the development of innovative service and accommodation programmes to meet special needs, such as the Louisa Lawson House proposal for disturbed women and the Kings' Cross Youth Refuge assessment team.

A number of submissions also suggested that the State should initiate a programme as has been developed in South Australia, for payment of a small per capita subsidy to the proprietors of boarding-houses who agree to care for the severely mentally ill. Such an arrangement would clearly have to be linked to legislated licensing provisions, to ensure that adequate standards are maintained. In South Australia, the Minister for Health has the power to license and subsidise boarding-houses as psychiatric rehabilitation hostels, under the Mental Health Act. In New South Wales, the licensing of boarding-houses and hostels rests with the Minister for Youth and Community Services under the Community Welfare Bill.

The advantages of such a proposal are that it would provide an incentive for the improvement of quality of accommodation and care, which is often grossly sub-standard, for the many psychiatrically and socially disabled who are currently housed in boarding-houses. It seems unlikely however that a subsidy as low as that paid in South Australia, even converted to New South Wales' costs, would be sufficient to help maintain an adequate stock of boarding-houses in the much tighter New South Wales' housing market.

The potential for implementation of such a programme should however be the subject of discussions between the Minister for Health, the Minister for Planning and Environment, the Minister for Youth and Community Services and the Minister for Housing.

In New South Wales, the State Housing Commission has in recent years widened its eligibility criteria and now aims to increase access to housing, both as individual applicants and through the auspice of other Departments and community groups, for group housing for clients with long term psychological disabilities. The Inquiry recommends that a formal arrangement for increased use of welfare housing stock for this purpose be negotiated.

(iii) Hospital Services

(a) General Acute Services

"Psychiatric illness, in its broadest terms, is not significantly different from physical illness and the two frequently co-exist. e.g. Psychological reaction to injury: chronic pain causing depression. Therefore, psychiatric patients should not be discriminated against in terms of treatment availability and resources, or in socio-economic ways. The management of psychiatric in-patients needs the siting of acute admission units close to where people live, attached to General"

"Hospitals, so that their relatives and friends can be easily involved and so that the mystery, fears and stigma of psychiatric illness can be approached, and hopefully dispelled, by increasing contact and education of the community."

(Extract from submission s.201, Psychiatrist)

Facilities for short-term acute psychiatric care should be provided as part of the network of community care described above, with one person having the responsibility for both inpatient and community services. Consequently these services should be highly decentralised through general public hospital facilities. The experience of specialised psychiatric units or wards in general hospitals to date, has been very encouraging, even though, in some situations either because of lack of support from management or because of inadequate accommodation, some problems have arisen. They are capable of providing service to meet a wide range of needs, however, there is always likely to be some clients whose problems cannot be effectively contained for any lengthy period in this environment. Care for these clients should be provided in the specialised psychiatric facilities.

The acute admission services in the State psychiatric hospitals should therefore be relocated, with their staff if possible, to a location within the catchment area they service. The acute admission units in State psychiatric hospitals which serve their surrounding catchment area should be attached for administrative purposes to an appropriate general public hospital, although the unit itself may not necessarily need to be relocated.

The Inquiry considers that the most cogent reason for the integration of acute psychiatric units with general public hospitals, is that it thus places these patients on the same clinical and financial basis as people with acute physical conditions. These patients would then be eligible for payment of Commonwealth Medical Benefits for their period of hospitalisation, unless they are pensioners or "disadvantaged" in which case they will receive free care.

All acute psychiatric units in general hospitals (including those in teaching hospitals) should be authorised for admissions under the Mental Health Act, and their services linked as described above, to an area community care service to formalise their responsibility for a defined catchment area.

The relocation of acute admission units on the site of general public hospitals will require significant capital expenditure. The Inquiry considers that except where capital resources have already been approved by the government (as is the case for Campbelltown Hospital), planning for the physical relocation of services should be delayed until adequate community care services have been established, as the implementation of an effective community care programme may affect the location of and bed requirements for such facilities.

At the same time, the Inquiry considers that there is insufficient recognition of the extent to which general public hospitals (without formal psychiatric units) provide acute psychiatric services. In 1980 approximately 10 per cent of hospital separations for psychiatric diagnosis were from general public hospitals.

"It is recognised that a substantial proportion of the psychological and emotional problems when recognised can be managed by the primary health care staff in surgical and medical wards if psychiatric consultation and support are available to them. A large proportion of the work carried out by psychiatrists in this setting involves consultation with staff regarding the emotional problems they are aware of in their patients and guidance to them as to the management of these problems. In offering, through consultation, the insight and expertise of the psychiatrist many more patients can benefit by the use of the primary care personnel than if long periods of time are spent by the specialist with the individual patient."

"The psychiatrist using this consultation technique treats many more patients indirectly using the abilities of the nurse, social worker and ward doctor, with whom he discusses the patient's problems as experienced by them. This consultation care works very effectively and makes the best use of the psychiatrist."

(Extract from submission 141 - N.S.W. Branch Royal Australian and New Zealand College of Psychiatrists)

It is essential that arrangements for the care of patients with psychiatric conditions in general hospitals be improved and that this level of care be more formally recognised and integrated into the mental health services. It is appropriate to use general hospitals for the care of psychiatric patients if the hospital has a formal policy of employing some double-certificated nurses and if a formal psychiatric consultation/ liaison service is established. This service should be developed in close consultation with the social work service of the hospital where these exist, to ensure that a multi-disciplinary service is provided. The staff involved in providing these services should be considered part of the area mental health service, for the purposes of professional responsibility, referrals and staff consultation and training. Expansion of these services should occur in association with the relocation of acute admission services, and should be met within existing resources.

Submissions to the Inquiry have articulated the potential value of this approach and in the New England Region, a "Psychiatric Resource Nursing Model" is being tested in country base hospitals to achieve:-

- "i) Provision of a psychiatric nursing service within the hospital in both a practical and a consultative capacity.
- ii) Provision of a nursing liaison and education programme.

- iii) Provision of a community follow-up and outpatient counselling service.
- iv) Liaison between this hospital, the psychiatric admission centres, and community agencies, and
- v) Implementation of, and participation in health promotional programmes."

(Extract from 8.298 : Armidale and New England Hospital Nursing Administration)

Another submission, from an individual psychiatrist, discussed the usefulness of a similar model employing psychiatric nurses (backed up by the services of a part-time psychiatrist) in casualty settings in general hospitals and described the role thus:

"Clinical/consultative service

This aspect of the service has two useful functions:- providing assessments for 'difficult' psychiatric problems with which casualty find difficulty coping. Secondly it provides a vehicle for inservice training

In service training

Most nurses working in casualty have no psychiatric training and their knowledge is sketchy. In practice new interns are in a similar position because, though they have some theoretical knowledge, their experience is limited and, because of this, they lack confidence.

A further problem, perhaps associated with lack of understanding, is a negative attitude to some psychiatric patients, especially young suicide attempters and alcohol or drug dependent patients.

It is a massive problem, not easily remedied. However it is argued that improving the understanding of and familiarising interns as well as nurses with psychiatric problems would improve skills, increase confidence and possibly change attitudes.

Liaison

This is considered an important aspect of the service. Psychiatric patients, like other people, have other medical problems, the management of which lie with others, i.e. G.P.'s, physicians, surgeons, etc. Indeed, because they are often poor historians they tend to drift around. Without good liaison disasters may occur.

Of particular importance is liaison with community health. Indeed the service can be seen as an outpost of community health."

(Extract from submission S 162 - Psychiatrist)

Provided these services are linked with hospital and community social work and welfare services, these models have the following advantages:

- (i) it improves screening functions in the hospital as people admitted with physical conditions are often identified as having a secondary but significant emotional disorder, and can be appropriately referred.
- (ii) medical practitioners and other professionals become more aware of the value of psychiatric services and utilise them more effectively.
- (iii) the knowledge of certainty of ready access to such a service facilitates maintenance of clients in the community who might otherwise experience repeated crisis admissions to hospital.

- (iv) the knowledge that psychiatric consultancy services are readily available and the experience and education gained from contact with this service encourages general nursing staff to try to resolve the problem at the local level rather than refer the client away from their local environment to a psychiatric admission centre.
- (v) community follow-up is facilitated and co-ordinated if problems are being resolved at the local level.

These services should also be locally accessible to people who require involuntary admission under the Mental Health Act, and for this reason the Inquiry proposes that ultimately, as psychiatric services are upgraded, general public hospitals be authorised for admissions under the Mental Health Act.

(b) Specialised Hospital Services

The State psychiatric hospitals currently provide a range of services, to a range of client groups with differing needs which include the following components:

"Acute Care: Treatment and management procedures designed to promote a rapid return to previous level of functioning.

Rehabilitation: An active programme to redevelop lost skills in daily living.

Habilitation: An active programme to develop "normal" daily living skills in persons who have previously not acquired same, e.g. some severely intellectually impaired patients.

Extended Care: Long-term care given to reasonably physically fit patients who have failed to respond to management programmes and who are likely to remain permanently psychologically disabled.

Total Care: Long-term care of patients requiring both management of their mental illness per se and nursing care for concomitant physical illness and/or general debility.

Maintenance: Programmes either in hospital or the community designed to maintain the higher level of functioning achieved through adequate management programmes."

(Extract from Inquiry Working Paper No. 11)

For those patients who cannot operate in the community environment even with the supports outlined above, and for those who have become totally dependent on the refuge or asylum which the hospitals have provided, some form of specialised hospital care will continue to be necessary.

The number of beds required in such facilities should reduce over time as adequate alternative community facilities are developed.

A number of concerns were expressed to the Inquiry both by staff and by other agencies and consumer groups, about the quality of care within the existing hospitals. The first concern expressed was that the level of staffing is generally inadequate, and that staff are thereby forced to return to a custodial care approach, with limited time for active habilitation and rehabilitation programmes. It was constantly argued by both staff and Union representatives that care would continue to be inadequate unless the 1979 Staff Review proposals were implemented. Although there has been a continuing gradual decline in the utilisation of the hospitals, the Unions argue that the actual numbers of staff proposed in the staff review are needed to effectively staff the services, as in their view, a decline in utilisation does not dramatically effect the ward staff requirements in these physically scattered facilities.

This issue is discussed in Part 1 and given the current economic climate and the operating objectives endorsed by the Inquiry, the Inquiry does not propose any overall increase in the staff budgets of these hospitals. Rather it proposes that the opportunity be taken to improve the level of staffing in the hospitals by use of the Enrolled Nursing Aide category.

As the proposed transfer of nursing education to Colleges of Advanced Education is implemented, hospitals should be re-staffed with a ratio of Enrolled Nursing Aides and Registered Nurses on an appropriate replacement basis.

The Inquiry has noted the recommendations of the Task Force on the Enrolled Nursing Aide regarding the relevance of this staffing category to this area of health care. Enrolled Nursing Aides have not been widely introduced into the State psychiatric hospitals (other than in the Nursing Homes) because of Union opposition to the potential loss of nursing positions, and concern that use of less qualified staff for some aspects of the physical care of patients would result in less consistent staff-patient contact and a less "therapeutic" or "educational" approach.) the more menial aspects of patient care.

The Inquiry recognises and appreciates these concerns, however believes that the se objections could be overcome with careful attention to staffing/team arrangements and appropriate supervisory arrangements . On the other hand, it can be argued that Enrolled Nursing Aides can potentially provide more consistency and reinforcement for patients as they are ward-based and not rotated through a number of wards. Concern has however also been expressed about the adequacy of Enrolled Nursing Aide training, and the lack of any psychiatric theoretical or practical content. The Inquiry shares this Concern and recommends that the Health Department and the Nurses ' Registration Board urgently review the curriculum and length of Aide training, with this perspective in mind.

The other related concern about quality of care in hospitals is the lack of specialisation and programme implementation . While this is an outcome of the overall staff level, it is also an outcome of the range of skills employed in the hospitals, and the lines of accountability for implementation and evaluation of rehabilitation activities. The number of psychologists, occupational therapists and social workers employed in the hospitals, is seriously deficient. The Inquiry considers that management at hospital and Regional level should give urgent consideration to the possibility of formal arrangements for purchasing these services from other hospitals or from other Regions.

The Inquiry considers that services in these hospitals should become more specialised on the basis of diagnostic groupings and programmes which emphasise habilitation and rehabilitation.

These specialised rehabilitation and extended care services will continue to meet regional and supra-regional needs. As such they will provide "back-up" to general public hospitals at local level, and will be the resource for the education of all disciplines in psychiatric rehabilitation. For integration of services to be fully effective it is essential that these hospitals be linked to their general hospital counterparts. In the metropolitan Regions, the Inquiry proposes that these hospitals be linked to regional specialist teaching hospitals.

Role of Private Facilities

The Inquiry is aware of the level of public concern about the clinical standards and lack of accountability of private psychiatric facilities, demonstrated at the extreme by recent publicity and legal action about one particular facility. It is anticipated that recent government action to amend the Private Hospitals and Nursing Homes Act will provide mechanisms to increase the accountability of private facilities.

At the same time, in the current economic climate, it is essential that optimal use be made of existing private facilities, and that they be adequately linked to the network of community care services proposed above. As indicated above, the "Phone-in" conducted by the Mental Health Co-ordinating Council in November, 1982, identified that patients and relatives were generally satisfied with the level of care and the amount of clinical contact received in private hospitals, however very few were referred to any other service on

discharge (presumably remaining in the care of their private psychiatrists) • This may be the case for a number of reasons - lack of local follow-up services, lack of knowledge or trust of such services on the part of the psychiatrists involved, "ownership" of the patient by the psychiatrist. Whatever the reason, greater efforts should be made to overcome the isolation of these facilities.

These services are of course not generally accessible to the socially and economically disadvantaged who do not have health insurance cover. However in some areas it may be more appropriate and cost-effective to negotiate an arrangement to subsidise the private sector to care for such patients than to develop a duplicate facility within a local public hospital. Such arrangements could also be used to encourage the private sector to provide more care for long-term patients than is currently available. The Inquiry is aware that an arrangement for such a subsidy and contract agreement has been proposed in one Region and it is proposed that the Department should determine appropriate subsidy levels, and encourage Regional Directors to negotiate such arrangements with appropriately located private facilities. These facilities would need to be authorised under the Mental Health Act if full responsibility for a defined catchment area were proposed.

5. HOW ARE RESOURCES BEST STRUCTURED TO PROVIDE THESE SERVICES

5.1 Staffing

(a) Increased Clinical Expertise

It is fundamental to the provision of an adequate mental health service that the service is based on high quality clinical care. This will require increased clinical use of psychiatrists, either as salaried specialists or as consultants, and a greater emphasis on a multi-disciplinary approach. The Inquiry has been concerned at the evidence from its own and earlier investigations, that adequate clinical care is not readily available in many settings, and that many psychiatrists in the State psychiatric hospitals are more involved in administrative than clinical work.

The Inquiry is aware of and appreciates the difficulties involved in the recruitment of salaried psychiatrists to positions in the State psychiatric hospitals and community health centres, a problem which also exists (although to a lesser extent) in general public hospitals. However, there is a widespread reluctance to buy services from the private sector, although the mechanism exists for sessional payments.

The Inquiry recommends that in staffing to meet clinical and staff supervision/training needs, within available resources, sessional arrangements for use of private practitioners be expanded, both within psychiatric hospitals and in community mental health services.

The potential to use the resources of the private sector more effectively applies not only to the purchase of psychiatric services, but also to other medical and non-medical services.

Particularly in community centres it may be more efficient to purchase these services on a sessional basis than to seek to fill full-time salaried positions. It is hoped that the reluctance of management to work in this way will be overcome under the different management structure proposed in this Report.

(b) Greater Emphasis on a Multi-disciplinary Approach

As discussed above, the Inquiry considers it essential that care of the mentally ill be made more goal-directed, with a stronger emphasis on the development of daily living skills and maintenance or development of social supports which will facilitate the patients' return to a 'normal' living environment. The Inquiry has been impressed by the efforts which are being made to implement such a 'programme' approach in some of the hospitals, but considers improvements are necessary.

The Inquiry appreciates that many hospitals particularly those in country areas, have had difficulty in recruiting professional staff such as psychologists, social workers and occupational therapists. Some of these difficulties may be overcome through the development of arrangements for purchase of these skills between hospitals and between Regions.

Within the hospitals, however, other changes are considered necessary to encourage patient care to relate more to "normalisation" in the community. Most particularly, it is necessary that programme and community-oriented staff be given greater authority to implement programmes within the ward environment. This will require that ward-based staff be made responsible to the programme staff for the implementation of programmes and accountable to them for this aspect of their work. Consequently the line management structure of the hospital should be based less on professional categories and more on service categories involving a variety of skills.

(c) Better Use Of Qualified Staff

The development of a stronger programme orientation within the hospitals will require that more effective use is made of the skills of trained psychiatric nurses.

Throughout the course of the Inquiry, nursing staff have consistently argued that they are being used inappropriately in a situation which requires them to spend a large proportion of their time in the physical care of patients. While this aspect of care can and should be provided in a therapeutic manner as part of the rehabilitation programme, there is little evidence that it requires the skills of a qualified nurse, or that it is the most appropriate use of their time. With the transfer of nursing education to the education sector, the re-staffing of hospitals to compensate for loss of student positions will provide an appropriate opportunity to expand the numbers of enrolled nursing aide positions. Aides will be appropriately used in the care of those patients who require physical care and reinforcement of daily living skills through consistent attention. It is not proposed that Aides should be used in the care of the acutely ill who do not need physical care.

(d) Staffing of New Services and Facilities

The expansion of community care services as proposed above, and detailed in the Section on Implementation will provide opportunities for existing nurses, to work in this setting. As these programmes are developed, management should actively seek to recruit nursing staff from within the hospitals to work in these new roles. As community work requires some different skills, the College of Nursing should be approached to develop an appropriate transition programme.

The development of supportive accommodation in the form of hostels and group homes, will also create some additional positions. The Inquiry proposes that these services be developed in co-operation with non-government agencies which have some experience and expertise in this area, particularly the After-Care Association, the Richmond Fellowship, and the Psychiatric Rehabilitation Association. In these settings, recruitment is based appropriately on personality and personal skills and less emphasis is given to professional qualifications. The contractual arrangement to be developed between these agencies, the Department of Health and the Department of Youth and Community Services (which has a licensing responsibility) must emphasise the government's requirements in terms of physical and clinical standards, and the agencies' accountability for the services provided.

5.2 Organisation and Management

In Part 1 of this Report, the Inquiry has discussed and recommended a major change in the management structure of psychiatric services in New South Wales. The main thrust of these recommendations is the development of a more integrated health system, with the existing three components, general hospitals, psychiatric hospitals and community health service, managed as an integrated entity, by Boards of Directors and a Chief Executive Officer.

The integration of services includes two elements. Firstly, it is clear that acute psychiatric services should be as decentralised as possible, to be more accessible to the population they serve. The Inquiry has proposed that all acute admission units should be located in, or attached to general public hospitals, where patients are eligible for Commonwealth Medical Benefits.

Secondly, there will always be a need for specialised psychiatric rehabilitation and long-term care facilities. The preferred option is that services be managed through attachment to an existing Board of a Second or Third Schedule hospital.

The linking of the management of general and psychiatric hospitals is the desirable goal if effective integration of health services is to be achieved. It offers the best chance of making psychiatric services available on the basis of the Inquiry's preferred principles of service delivery, and providing high quality clinical care to clients, particularly if the link is made to regional teaching facilities.

A change of this nature does raise some concerns:

The possibility of psychiatric services being "swamped" by general hospital service priorities;

The management difficulties of integrating large facilities;

The issue of restructuring existing Boards or creating new Boards to reflect the wide range of interests involved.

The additional reluctance of staff to not only the transfer to the Second Schedule but also management by a general hospital.

An alternative would be to create separate Boards for the psychiatric hospitals, however with the gradual removal of acute services from these hospitals, it is considered that such an approach would only further isolate these services.

The ultimate objective on which there is a wide consensus is the integration of all health services on an Area Board basis. The Inquiry endorses this approach.

It could be argued that if this is the desired goal, then integration of services should await the establishment of Area Boards. On the other hand, the Inquiry considers that change in the management structure of psychiatric services and their integration with general services is urgently required as a pre-condition of improved service delivery.

Consequently, the Inquiry proposes a more gradual process of evolution towards area management, by linking these services to existing Boards, with widened membership to represent the interests of psychiatric services.

In addition, it is imperative that the importance of psychiatric services is reflected in the senior management structure, with the person responsible for psychiatric services reporting directly to the Chief Executive Officer, and having similar salary and status as the person responsible for general clinical services.

In the Hunter Region, the less satisfactory model of a separate Board is proposed, in view of the particular stage of planning of teaching and psychiatric services in the Region.

In the South-East and Central West Regions, which do not have large teaching hospitals with the management capacity to support another facility, it is recommended that Area Boards for Goulburn and Orange be formed immediately, as there are not the legal and administrative impediments to this change which exist in the metropolitan area.

In the area of child and family mental health, several submissions drew the Inquiry's attention to the Report of the Working Party on Child and Family Mental Health services prepared as part of the Mental Health Services Planning and Review Committee in 1978. This Report recommended arrangements for more effective use of professional expertise working in child health and community health centres, by linking them to a specialist child, adolescent and family mental health service for supervision and professional support.

The Inquiry supports the concept of a specialised child, adolescent and family mental health service, which operates as a clearly defined network of services across a region or sub-region. Staff may be located in general community health centres, child health centres or in specialised units in hospitals, however, the professional and supervisory links between the various components must be clearly articulated, and incorporated in the management structure of services. The location of staff in general community health centres has the advantage of increased access for clients. The Inquiry proposes that staff wherever they are located should be formally responsible to, and where appropriate employed by, a regional or sub-regional specialist service. In the metropolitan Regions such a service is located in the teaching hospitals. The Inquiry also considers that it would be useful to increase advocacy and co-ordination for these services by the establishment at regional and state level of Advisory Committees on Child, Adolescent and Family Mental Health. Such Committees should include representation of the Department of Youth and Community Services and the Department of Education.

5.3 Funding Priorities

The Inquiry recognises that there are substantial deficits in the provision of an adequate network of community care services in many areas of the State. However in the current economic climate, where new services must essentially be funded from within existing resources, it would be irresponsible for the Inquiry to recommend additional funding unless real potential exists for redistribution of resource. In the short-term therefore, the Inquiry recommends that priority be given to the development of comprehensive community care services in those areas where there is a high concentration of existing State psychiatric institutions, with the clear objective of reducing the utilisation of these facilities within a specified time-frame. Priority should therefore go to the Western

Metropolitan Region, the Hunter Region and the Southern Metropolitan Region. Some additional resources should also go to the Illawarra Region as an area of significant undersupply of psychiatric resources.

The services to be established in Hunter, Western Metropolitan and Southern Metropolitan Regions should have the following features:

There should be one person, responsible for all aspects of the mental health care for each area . i.e. for both in-patient and community services and for both acute and extended care clients.

A comprehensive range of services should be provided in these areas. This range would include work and social activity programmes and a variety of accommodation settings.

In these areas, any client in crisis or who is considered to need admission would be seen first at the client's home. No client would be admitted to the in-patient facility without prior community assessment.

These services should have an orientation towards community care and family support, and have as a , priority the care of the seriously mentally ill.

6. IMPLEMENTATION TIMETABLE

6.1 Development of Community Services

To provide improved mental health services and at the same time gradually reduce the scale of existing institutions an expansion of community based services is the first priority for funding. In order to stimulate a process of releasing resources from the existing hospitals priority must be given to establishing adequate community services in those Regions in which large institutions are concentrated.

At the same time the Inquiry recognises that there are broad deficiencies in community based services in the Western Metropolitan (which has substantial institutional resources) and Illawarra Regions and this has been taken into consideration in proposals.

On this basis priority is to be given to Western Metropolitan Hunter, Illawarra and Southern Metropolitan Regions. The Inquiry's assessment is that the following additional staff would be necessary to provide more adequate community based assessment and treatment services.

The proposals below have been developed on the basis that the staff required for an adequate community mental health service for a catchment area of approximately 250,000 population is the equivalent of 29 staff positions. This is required for the provision of a crisis-service, community treatment services, an activity/rehabilitation programme and community staff support for accommodation facilities. The team would include:

4 Psychiatrists (including trainees/registrars)
 10 Nurses
 5 Social Workers
 4 Psychologists
 3 Occupational Therapists
 3 Clerical Assistants/Typists

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When costed on the basis of equivalent full-time positions the estimated cost of such a team (including other operating costs) is \$820,000 per annum.

The Inquiry proposes that an allocation of \$3.8 m per annum be made to the Regions, from the specific funds for this area, for the next three years.

By 1985/86, it is proposed that Western Metropolitan Region close psychiatric services at Rydalmere Hospital. It is estimated that savings of the order of \$5 m will then be available for investment in this area. This should be used for recurrent funding of services in the Western Metropolitan Region and partial funding of services in other deficit Regions (Orana and Far West, South-West). Similarly as community services are consolidated in the Hunter, savings should be achieved and resources transferred from the psychiatric hospitals.

	Region	Target <u>No. of Staff</u>	Allocation
1983/84	Western Metropolitan	56 positions	\$1,500,000
and	Hunter Region	29 positions	\$ 820,000
1984/85	Southern Metropolitan	20 positions	\$ 550,000
	Illawarra Region	15 positions	\$ 425,000
	Central West Region	10 positions	\$ 250,000
	South-East Region	10 positions	\$ 250,000
		140 positions	\$3,795,000

		Target <u>No. of Staff</u>	Allocation
	Recurrent expenditure		
1985/86	Illawarra Region	15 positions	\$ 425,000
	New expenditure		
	South-West Region	29 positions	\$ 820,000
	North Coast Region	29 positions	\$ 820,000
	Orana & Far West	29 positions	\$ 820,000
	New England Region	29 positions	\$ 820,000
		116 new positions	\$3,705,000

These community based services would form a part of a network of service delivery in these regions providing direct health services such as assessment, after hours crisis care and rehabilitation programmes co-ordinated with other service providers particularly non government agencies providing accommodation services.

It is proposed that staff from these services would act as catalysts in encouraging the non-government sector to apply for funding and/or accommodation from the Department of Health and other sources such as the Department of Social Security and the Housing Commission. In order to support the establishment of a network of accommodation services so that alternative accommodation is available for clients in need it is proposed that a specific fund be established to finance the establishment of these services by voluntary agencies in the priority regions mentioned above.

An allocation of \$1.2 million per annum is proposed from 1983/84, to fund the non-government sector to provide "after-care" facilities, and special need services. Proposals for such services should be developed by Regional Directors and the non-government agencies. It is envisaged that a range of staffing levels would be required, varying from minimal support to intensive therapeutic settings.

The special fund of \$1.2 million per annum should be supplemented by the Department of Health by redirection of some current health funding of non-government agencies. From 1986, be to establish as a minimum approximately 500 community after-the special funds would be substantially met from savings from the rationalisation of the institutions. The objective should care placements over the next three years. Priority in the development of these facilities should be given to the Regions with institutions and their catchment areas.

The Inquiry has recommended that the Department of Health consult with the Department of Social Security, and the Housing Commission regarding the potential expansion of resources in this area. In particular this may facilitate the provision of capital resources or housing stock.

6.2 Rationalisation of existing institutions

The utilisation of the existing psychiatric hospitals has been declining in recent years for a variety of reasons - availability of alternative services, use of drugs to maintain people outside of hospitals, changing social attitudes to mental illness, and constraints on funding and staffing.

In Part 1, the Inquiry has argued that the level of institutional care should be reduced and rationalised, provided adequate community services are available and in any case, the capacity to provide these services is linked with the scope for redistribution of resources from the existing institutions. At the same time, these services should be integrated with the general health system and this is proposed through management links to general public hospitals.

The current supply of psychiatric beds in the specialised state psychiatric hospitals is 3,700 approximately, or 0.71 beds per thousand population. This includes acute admissions, short-stay and rehabilitation facilities.

The Inquiry proposes the transfer of acute admission services to general public hospitals, and the establishment over a three year period of approximately 500 after-care placements in the community. In association with these developments, and the expansion of community mental health teams, the Inquiry proposes a reduction in the number of beds in the institutions of 1400 approximately over the three year period. It should be emphasised that on the basis of current utilisation, there is significant difference between the number of "available" beds and the number currently used and staffed.

(i) Western Metropolitan Region

In order to achieve the desired objectives of separation of psychiatric and developmental disability services, and to maximise potential savings by the closure of "whole services" it is proposed that psychiatric services be removed from Rydalmere Hospital (southern side) and Rydalmere operate as a developmental disability service by 1985-86.

The specialised psychiatric hospital services in the Region should be consolidated at Parramatta Psychiatric Centre, which should be managed by the Parramatta Hospitals' Board. The number of specialised psychiatric beds in the Region should be reduced from 803 beds to 603 beds by 1986-87.

(ii) Southern Metropolitan Region

While there are some disadvantages associated with the maintenance of two campuses for psychiatric services in the Region, the Gladesville Hospital rehabilitation services have a particular specialised and supra-regional role, which will justify their continued location on this site until these services can be decentralised to locations in the community. At the same time, the services at Gladesville and Roselle should be rationalised to

facilitate the development of more specialised programmes for rehabilitation and elderly patients and linked to the management of Royal Prince Alfred Hospital.

As proposed in Part 2 all developmental disability places would be closed at Rozelle/Gladesville by 1986.

The number of available psychiatric beds in Roselle and Gladesville should be reduced from 1155 to 750 by 1986-87.

The target for Rozelle Hospital includes the Veterans Affairs Beds which will continue to be funded by the Commonwealth.

(iii) Northern Metropolitan

Specialised psychiatric hospital services in the Northern Metropolitan Region are provided at Macquarie Hospital (286 beds). The relocation of acute admission services will enable some rationalisation of services. However as services in the Southern Metropolitan Region are rationalised, it may be appropriate for Macquarie Hospital to provide additional support to the peripheral areas.

(iv) Hunter Region

Specialised psychiatric hospital services in the Hunter Region are provided at Morisset Hospital and Newcastle Psychiatric Centre (total 591 beds).

In Part 2 of the Report, the Inquiry has proposed that developmental disability services be removed from Morisset Hospital. The isolation of Morisset Hospital constrains the development of "normalising" programmes, however the potential to develop more specialised rehabilitation programmes will be facilitated by the reduction and

rationalisation of services on the Morisset and Newcastle sites. With the expansion of community services recommended above, the Inquiry considers that the objective should be to reduce the number of available beds to 250 in total by 1986-87.

In addition, Tomaree Lodge, located in Hunter Region, is a smaller facility traditionally used for holiday respite for patients from other Fifth Schedule Hospitals, but in fact, utilised largely for a permanent population. It is considered appropriate to use this facility as part of the regional network of developmental disability services.

(v) South-East Region

Specialised psychiatric services in South-East Region are located in Kenmore Hospital at Goulburn.

Kenmore Hospital is the only psychiatric and adult developmental disability facility in southern New South Wales apart from small acute psychiatric units at the Wagga Wagga and Albury Base Hospitals respectively, and hostel style accommodation for 12 developmentally disabled adults at the Woodstock facility in Albury. Further, under a long standing agreement between the State and the Commonwealth, the psychiatric service needs of the population of the A.C.T. are satisfied almost exclusively by the Kenmore Hospital, though this is likely to change early in 1983 with the passing of already proposed legislation to allow A.C.T. authorities to deal with involuntary psychiatric patients locally.

The Inquiry proposes that the number of beds at Kenmore Hospital be reduced from 396 to 250 by 1986-87, as alternative community services are provided.

(vi) Central West Region

Similarly, Bloomfield Hospital has responsibility for provision of services to both Central West and Orana and Far West Regions.

The Inquiry's proposals and Regional plans are designed to facilitate the gradual relocation and reduction of services at Bloomfield, as community services are developed. It is proposed that the number of beds be reduced by 467 to 162 by 1986-87.

7. ADVOCACY FOR PARTICULAR NEEDS

Various submissions to the Inquiry highlighted the needs of particular groups within the general population and this section summarises the issues raised and identifies matters for more detailed consideration in future service delivery arrangements. In some instances where more intensive investigation has been undertaken by the Inquiry specific recommendations are proposed.

In respect to the needs of aborigines a separate review of health services is currently being undertaken and the Inquiry has not attempted to duplicate this activity but does comment on specific issues drawn to attention during its deliberations.

7.1 Major Population Group With Particular Needs

(a) Aboriginal Australians

There are a number of groups serving the health needs of Aboriginal Australians:-

An Aboriginal Health Programme is run by the Aboriginal Health Unit of N.S.W. Department of Health and is staffed by approximately 90 Aboriginal health workers and nurses throughout the State with some specialist back-up.

This service is supplemented by six male Aboriginal counsellors working with Aboriginals with drink problems throughout the State and utilising a number of half-way houses.

A number of general hospital units cater for the needs of Aboriginal Australians.

Specialised inpatient services for Aboriginal Australians are provided at the Prince Henry Hospital Psychiatric Unit.

-The Boards of the Royal Prince Alfred Hospital and King George V complex as well as the Royal Alexandra Hospital for Children employ Aboriginal Australians as Aboriginal health workers in these hospitals.

A third system of primary health care is provided by the Aboriginal Medical Services Limited who utilise general medical practitioners and Aboriginal health workers. Their major service provision is based at the Redfern Medical Service which provides general practitioner services for its clients and a specialist psychiatric and follow-up counselling service. The Redfern Medical Service has developed a special relationship with the Royal Prince Alfred Hospital with respect to alcohol services and to Rozelle Hospital with respect to general psychiatric services.

The A.M.S. Limited has six facilities in New South Wales (four of these in country areas) responsible to a Board elected from Aboriginal people in the community.

The Inquiry have received a number of suggestions about the organisation of services for Aboriginal Australians ranging from having a central directorate in the N.s.w. Health Department with access to the highest level of policy and planning, etc., to handing over the whole responsibility to Aboriginal Australians who would be assisted by Federal funding and who would be able to call upon experts on a contractual basis. All of these go well beyond the Inquiry's Terms of Reference however, in the areas it has examined the following issues require consideration in any general proposals for improved services for aboriginal Australians:-

- incentives to encourage aborigines to train in the health professions •
- improved training in mental health needs for aboriginal health and welfare workers.

- improved "cross cultural" training for general health professionals to develop a better understanding of aboriginal needs •
- upgrading of community assessment and treatment services (in conjunction with general health assessment services} in areas of large aboriginal populations •
- greater representation by Aboriginal Australians on boards controlling services etc.

(b) Migrants

The demography of the migrant population of New South Wales shows marked differences between different ethnic groups and the socio economic characteristics of migrants are diverse. However, some problems of access to and responsiveness of services have been drawn to the Inquiry's attention:

- lack of awareness among service providers of access difficulties posed by language and cultural differences.
- lack of understanding of different cultural expressions of emotional problems and mental illness •
- inadequate use by mainstream health services of the Health Interpreter Service •
- the adequacy of Health Interpreter and other interpreter services in particular regions •
- the adequacy of co-ordination and liaison of health services (particularly psychiatric hospitals} with government and voluntary ethnic services.

the shortage of bilingual professional and non professional health service staff•

- inadequacy of basic and continuing education for health services personnel in cross cultural issues.
- lack of knowledge of some ethnic people of the availability of services •
- special problems of aged migrants particularly sole persons, with inadequate command of English.

These concerns were particularly drawn to the Inquiry's attention by the Ethnic Affairs Commission of N.s.w. through discussions and a formal submission (s.308).

It has been recommended by the Migrant Health Unit of the New South Wales Department of Health that a migrant health advocate be designated from among the staff of each psychiatric hospital. The efforts of such a designated staff member could improve migrant access to service, make health professionals more aware of migrant needs, increase appropriate use of Health Interpreter Services and ethnic facilities in the community, and lead to more satisfactory liaison with ethnic agencies in the community.

There is also much to be said for the employment of appropriate bilingual staff (both professional and non-professional roles) where public contact with significant numbers of migrants is involved. A specific need has been expressed for bilingual health workers in Developmental Disability Assessment Units.

The Inquiry endorses the implementation of the Migrant Health Unit's guidelines to improve migrant access to services. It would be appropriate for ethnic communities to be represented where practicable on all advisory committees and boards of management.

While Health Care Interpreters provide a most valuable service it has been pointed out in a submission by the Ethnic Affairs Commission of New South Wales that they are poorly utilised in psychiatric hospitals.

To develop appropriate skills in Health Care Interpreters and Ethnic Health Workers for work in psychiatric facilities, the New South Wales Institute of Psychiatry has provided a part-time course and to date 83 Health Care Interpreters and Ethnic Health Workers have completed this course. This type of initiative is worthy of encouragement and support as is the concept of the Institute's proposed Course in Counselling for Ethnic Health Workers.

The vast majority of health professionals, currently employed in the health care system, have not received adequate training at tertiary institutions in cross-cultural issues and the Ethnic Affairs Commission of New South Wales made the following recommendation in its submission to the Inquiry:

"All tertiary institutions providing health related courses should be required to introduce cross-cultural studies as an integral part of the curriculum. These courses should not be grafted on to the core curriculum as an optional extra, but should be an integrated and examinable part of every course."

The Inquiry would endorse this principle although its relevance goes well beyond the services the Inquiry is examining.

7.2. Other needs

(a) Drug and Alcohol Services

There are currently a number of facilities within 5th Schedule psychiatric hospitals which provide drug and alcohol services including detoxification programmes. At the same time a significant proportion of admissions have a drug or alcohol related aspect associated with the psychiatric problem of the client. There is however, an important distinction between the actual taking of drugs, including alcohol, and the physiological, biochemical or psychological effects of drug taking. A person who takes drugs is not necessarily mentally ill and requires different assistance to one who is affected by drugs in a manner which manifests itself as mental illness.

It has been argued to the Inquiry that because of this distinction drug and alcohol services as such should not be provided in specialised psychiatric hospital services. However, such hospitals could continue to provide specialised services to deal with the longer term effects of drug and alcohol intake such as the management and rehabilitation of brain damaged persons.

The Inquiry has not undertaken any extensive investigations in this area but does agree in principle that drug detoxification programmes including those for acute alcoholic states should be phased out of specialised psychiatric hospital services and provided for in general hospital and in appropriate community based services.

The Inquiry is also aware of the diversity of public, private and voluntary groups involved in this field and consequently of the importance of co-ordination of resources and effort both within and outside the health area. Within health services it is considered that drug abuse programmes should be integrated with other health care activities within hospitals and community health programmes. These in turn should be linked at local level with a network of services involving other service providers outside the health system.

(b) Persons with Brain Damage

The major causes of chronic brain damage in adults are:-

age related brain damage (senile dementia) with maximum incidence over the age of 75 years;

- stroke with maximum incidence between 45 and 70 plus years;
- alcohol related brain damage with maximum incidence between 30 and 60 years;

traumatic brain damage occurring most commonly between the ages of 15 and 30 years.

Taken together this group of conditions is probably the most important cause of disability in Australia.

Services for the elderly with chronic brain damage have been discussed in detail in Part 4 of this Report.

The needs of younger patients, particularly those whose brain damage is the result of traumatic head injury, are discussed in this Section.

The only population based longitudinal study of severe head injury in Australia was carried out from Lidcombe Hospital in

1974. Based on the results of a follow-up of 60 victims of severe head injury some 12-18 months after the event the following estimations were made:-

In New South Wales with a population of 5.5 million about 800 people sustain a severe head injury likely to lead to permanent damage each year. Of these, 80 per cent are males and 50 per cent are under 30 years of age. Approximately 20 survivors per annum are dependent on an other for basic activities of daily living (bathing, feeding, dressing and toileting) and 80 survivors per annum are dependent for higher level activities

(cooking, housework and shopping). Approximately 330 survivors per annum have residual psychosocial problems at 18 months post trauma and in 145 survivors these are disabling. Forty survivors per annum require long-term hospitalisation or institutionalisation. Based on these figures and a relatively long survival of this group of people the prevalence of traumatic brain damage in the community may be as high as that of stroke (i.e. 500 per 100,000 population based on overseas figures).

In general, good motor-sensory recovery follows severe head injury, but mental, psychiatric, emotional or behavioural outcomes cause more frequent and more severe disability and more distress to relatives than physical impairment.

Assessment, defining, and researching the behavioural outcomes of severe head injury has lagged behind research into other areas of deficit caused by severe head injury. The Inquiry is aware of the role which has been developed by Lidcombe Hospital in research and rehabilitation related to this group and considers that these specialised activities should be maintained. The major teaching and referral hospitals are also developing their role in this area, and it is important that patients be adequately assessed by these services before any decision regarding long-term placement is made.

(c) Prisoners with Psychiatric Problems

With respect to mental health services for prisoners the Inquiry has noted the role of the Prison Medical Service Steering Committee and is aware of discussions regarding the establishment of a 120-bed psychiatric hospital for prisoners. In the mean time a new building to replace the Long Bay Observation Section (which was the subject of previous criticism) is under construction.

The Inquiry also understands that women prisoners with psychiatric problems are now cared for in a facility set aside at Mulawa, rather than in facilities at Rydalmere Hospital. The concept of developing half-way facilities in which previously psychiatrically disturbed prisoners may spend time before returning to the prison itself is also being developed.

The Inquiry has not reviewed services for prisoners in any great depth however it visited the services provided for male prisoners at Morisset Hospital and is aware that there are differing opinions as to the continued appropriateness of nursing staff providing security. It has also been argued that Morisset Hospital is an inappropriate location being so far from the majority of larger prisons in the State.

In the Inquiry's view it is inappropriate for nurses to have primary responsibility for criminal security; the responsibility for the care of these patients should be shared equally with the Department of Corrective Services. Further, in the longer term these facilities should be relocated to the Sydney metropolitan area.

(d) The Homeless

It has been claimed that around 30% of males and 40% of females who become either homeless or destitute have had at least one admission to a psychiatric hospital but cannot obtain continuity of care once they are discharged. To some extent this situation has resulted from moves to reduce long term stays in hospitals without adequate planning and funding of community support and accommodation services:-

"Admission to psychiatric hospitals is becoming more difficult and psychiatrists and psychiatric nurses are less willing to manage problems of psychiatric disability and of alcohol and drug dependence. This reluctance arises out of the sociological reaction to the social control implications of the diagnosis of mental illness and to a desire by psychiatrists to be involved in treatable illnesses, and not with intractable problems. But this leaves many people without care. Somehow this care function, and the need for it, has to be balanced against the over-reaction to the diagnosis of mental illness and intellectual handicap. In other words, services have to respond to real and immediate needs rather than be lost in the polemics of the legal definition of madness. For we have found that amongst the rootless wanderers of this city there are many people with disordered minds who are unable to care for themselves. They eke out a miserable existence in the city's night shelters. Humanity has deserted them."

(Extract from s.45 -Medical Practitioner working with the homeless)

The need to increase the amount of alternative community "after care" accommodation is discussed elsewhere in this Report, along with the need to co-ordinate services, and to provide community mental health teams. Some of these people could be accommodated in appropriately funded accommodation as outlined elsewhere in this Report.

A particular problem is the need for suitable long term supervised community accommodation available for emotionally disturbed women including those with children. Existing women's refuges are not established or equipped to handle the specific needs of this group of women (it is estimated that at least 18% of the women staying in refuges have some form of chronic psychiatric illness.)

"During their stay at a Refuge, great strain is placed upon the other residents and their children, who are forced to share their bedrooms, and their household tasks, with women whose behaviour can be frightening, threatening, dangerous, infantile, unhygienic, and bizarre. Bearing in mind that all the residents and their children are already in crisis situations and finding it difficult to cope with their own emotional problems, it is quite unreasonable to expect them to bear the added burden of the two categories of women with which this submission is concerned. Women's Refuges are simply not established, nor equipped, for the specific needs of these two special groups of women."

(Extract from S.2 - "Women in Limbo")

In dealing with the special needs of these women and their children it is important that the Department of Health consult with other Departments in particular the Department of Youth and Community Services and the Housing Commission, with a view to establishing long term community based accommodation for emotionally disturbed women.

Another concern drawn to the Inquiry's attention was the need for assessment and care of disturbed adolescents in Youth Refuges, (S•208)

Specific proposals seeking funding were put to the Inquiry (one has since been partially funded) from the "Women.in Limbo" group and Louisa Lawson House and the Wayside Chapel and it is considered that these types of services to meet special needs should be funded by the Department of Health to provide both long term supportive accommodation and/or 24 hour crisis services.

(e) Surgical Needs of Clients Within Hospitals

Currently a separate surgical unit is maintained at Macquarie Psychiatric Hospital to provide for surgery for patients in Fifth Schedule Hospitals and surgery facilities are also provided at Lidcombe Hospital.

The general philosophy however of the Department of Health is that general hospitals should be encouraged to care for all patients who require surgical care. For some patients however it is claimed general hospital care is inappropriate particularly because of the impact on other patients and their potential to disrupt normal activities. Examples have been given to the Inquiry of cases where general hospitals have refused treatment. Sometimes this has been resolved by negotiations between the services concerned.

It has been argued to the Inquiry that facilities and services at Macquarie are inadequate and make it difficult to maintain high quality services. Further uncertainty about the continued future of the unit is a concern of staff.

The dilemma is that to put additional resources into a special surgical unit may defeat the general desirability of treating these patients like everyone else. Realistically however, for some patients definite problems do exist in attempting to provide services in a general hospital setting and a facility like that at Macquarie will continue to be needed.

In the light of the Inquiry's proposal to integrate Macquarie Hospital with the Royal North Shore Hospital this issue should continue to be reviewed in the light of demand for surgical services and the capacity of general hospitals to provide for these needs.

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED

PART4

SERVICES FOR THE DISTURBED
AND CONFUSED ELDERLY
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MARCH 1983

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1. INTRODUCTION

The care of the aged in general is currently the subject of other reviews at State and Federal level. Part 4 of the Report of the Inquiry, however, addresses itself to the needs of the aged in two respects:-

the needs of elderly people who develop psychiatric symptoms (both functional and organic) and require appropriate care. Many of these people are currently cared for in the State psychiatric hospitals;

the role and organisation of the State nursing homes (Garrawarra, Allandale, Strickland and Lidcombe) needs to be considered in conjunction with the broader recommendations of the Inquiry.

Neither of these aspects can be considered separately from wider planning for the development of integrated health and welfare services for the elderly. These services attract significant Commonwealth government resources directed largely to the private non-profit and profit sectors.

In this part of the Report, the Inquiry seeks to:

- (i) identify the needs of the aged who become disturbed or confused.
- (ii) outline some preferred strategies for provision of services for these elderly people.

(iii) suggest issues for consideration in the context of existing Commonwealth - State arrangements for the care of the aged.

(iv) identify appropriate roles for psychiatric hospitals and State nursing homes.

One issue which needs to be stressed at the outset is the inappropriateness of the label "psychogeriatric" used to identify confused or disturbed elderly people. Such a label adds further stigma and may reinforce inappropriate care.

2. RECOMMENDATIONS

The following recommendations arise from Part 4:-

1. That the primary focus of services for the disturbed and confused elderly be based on a multi-disciplinary community oriented geriatric assessment service (refer to Sections 3.2, 4.1).
2. That these services be provided in an integrated manner through linkages to appropriate area or regional acute health services (including psychiatric services), day hospital facilities and a range of supportive accommodation facilities (4.1).
3. That the Health Department implement a policy that all admissions of elderly people to public sector psychiatric or nursing home facilities be dependent on prior assessment by a community based geriatric assessment service (4.1).
4. That the Department of Health in conjunction with the relevant educational authorities and professional bodies review the adequacy of training of professionals involved in caring for the disturbed and confused elderly with a view to improving knowledge and understanding of their special needs. (4.2)
5. That the following issues be raised by the Minister for Health with the Commonwealth Ministers for both Health and Social Security:-
 - (i) the need for Commonwealth funding of geriatric assessment services to ensure more appropriate care is provided to confused and disturbed elderly people and to minimise inappropriate private nursing home placements;

(ii) the need to eliminate administrative impediments to the adequate provision of "extensive care" benefits under the National Health Act for those elderly people who require intensive nursing care for non-physical reasons.

(iii) the need to foster the development of alternatives to nursing home accommodation through appropriate Commonwealth funding arrangements (5.2).

6. That in granting approvals for the establishment and/or extension of nursing homes the Department of Health give priority to proposals which provide facilities and programmes for the confused elderly and consider introduction of a requirement of this kind as a condition of licensing. (5.2)
7. That services for the elderly in specialised psychiatric hospital facilities be linked to acute geriatric and psychiatric services provided within the general hospitals to which these specialised facilities will be linked in future and/or to regional geriatric services. (6.1)
8. That existing Fifth Schedule Nursing Homes be transferred to the Second Schedule of the Public Hospital Act and linked to regional or area geriatric services as follows:

Allandale Hospital - initially a separate Board with representation from the Cessnock, Kurri Kurri and Maitland Hospital Boards (subsequently to become part of a regional geriatric service).

Lidcombe Hospital - separate Board.

Garrawarra Hospital- transfer to management of the Board of St. George Hospital.

Strickland House - transfer to management of the Prince Henry/Prince of Wales Board.

9. That the Boards responsible for the management of these services be given the clear responsibility to decentralise and rationalise the accommodation facilities, through the development of smaller community based accommodation, expanded day hospital facilities and improved home care. (6.2)
10. That use of the term "psychogeriatric" to describe the confused or disturbed elderly be discontinued. (1)
11. That the role of David Berry Hospital in geriatric, rehabilitation and long-term care be expanded, and the hospital be linked for management purposes to other health services in the Shoalhaven area, and transferred to the Second Schedule of the Public Hospitals Act. (6.2)

3. HOW ARE CLIENT NEEDS BEST SERVED?

3.1 What are client needs?

Although the classification has its inadequacies the Inquiry has followed the accepted practice of regarding as aged those people 65 years and over.

"During the next ten years there will probably be an additional 75,000 people in New South Wales over the age of 65, an increase of about 15%. This rate of increase is then expected to slow, but by the year 2000 it is expected that there will be a 20% increase in the aged population as compared to 1981. These increases need to be compared with the much slower rate of growth of the total population which is expected only to rise by approximately 6.5% between 1981 and 1991.

Elderly persons are high users of health and welfare services. Persons over the age of 65 years occupy one third of all general hospital beds, consume one third of prescribed medication and are responsible for a quarter of general practitioner consultations, yet they represent only a tenth of the total population of New South Wales."

("Planning Health Services in the 1980's": Health Commission of N.S.W., 1981)

Like many aspects of care of the aged, the care of those who develop symptoms of disturbed mental functioning has been characterised by myths and stereotypes. Several submissions to the Inquiry commented on the inappropriateness of care provided and the lack of understanding of their needs.

For example,

"The over 65 population is perhaps the greatest victim in our society of the dualistic mind-body attitude. The result is that many elderly patients are "dumped" on the psychiatric services because of disturbed behaviour or impaired intellectual function, despite the fact that this is often a result of physical illness or medication. Other cases without overt disturbance may be erroneously labelled "senile" when they have a depressive illness and continue to suffer with a treatable illness. The geriatric population most clearly shows the complex interplay between mind, body and environment, and the need for a comprehensive approach to treatment."

(Extract from 828: Banks House, Bankstown Hospital).

and

"A large number of old people are still being referred to the State psychiatric hospital system where they are usually treated in special wards designated as "psychogeriatric" wards.

These referrals are often inappropriate and many occur simply because there are no adequate alternative facilities available in the community.

Admission to a psychiatric hospital can be very damaging both psychologically and socially to old people and to their families. The negative effects of hospitalization should never be underestimated.

Once old people have been admitted to a psychiatric hospital they are often detained for longer periods than necessary. Nursing homes, for example, are often reluctant to take old people who have been in a psychiatric hospital, however inappropriate their initial admission may have been"

(Extract from 8213; N.S.W. Association for Mental Health)

and

"The myths that "senility" is a normal part of ageing and that one has to be old to become demented are very prevalent in the community. There is widespread avoidance of the problems of mental illness and of the aged in the community as people generally deny things which they do not understand or are afraid of. As a consequence dementia receives little publicity, is shunned by the media and by the public in general. Contrast this with public attitudes to Multiple Sclerosis which is fourteen times less common than Alzheimer's Disease. The community needs to be made aware of the facts about dementia and about what can be done. Families need to be told about diagnostic services and about help that they can receive in their homes and with placement."

(Extract from SL42: Alzheimer's Disease and Related Disorders' Society)

Elderly people may suffer from any form of defined mental illness, and to any degree, as is the case with the rest of the population. In addition it is estimated approximately five per cent of those over 65 years suffer from moderate to severe dementia, and twelve per cent suffer from mild to moderate dementia.

"Dementia is a chronic organic brain syndrome characterised by relentless progression of loss of memory, deterioration in intellect and deterioration in personality. It is commonly called "senility" but as has been demonstrated one does not have to be old to become demented, nor is dementia a normal part of ageing. There are many causes of dementia, the commonest of which is Alzheimer's Disease, a degenerative process of the brain."

(Extract from SL42: Alzheimer's Disease and Related Disorders' Society)

Because "senility" and "dementia" are assumed to be an inevitable part of ageing, not only do they often go untreated, but also other psychiatric conditions in the elderly may be unrecognised or assumed to be "dementia". Despite much evidence of the prevalence of psychiatric problems, most services emphasise physical care, and mental health services for the elderly have not been given much attention.

The dominant theme of submissions to the Inquiry was the importance of comprehensive physical, social and psychological assessment of the elderly person prior to decisions being made about treatment or placement. There is evidence that some of the psychiatric symptomatology in elderly patients is reversible providing full assessment and appropriate care is available.

Submissions highlighted the following major problems:

- (1) Inadequate and inappropriate accommodation - maldistribution of and insufficient nursing homes in some areas; lack of facilities including appropriately designed nursing homes for the containment with dignity of the wandering or behaviourally disturbed patient; and lack of hospital accommodation including appropriate assessment units in general hospitals.
- (2) Lack of skilled staff trained in assessing and treating the psychiatric disorders of old age.
- (3) Lack of support services for families who are the major "therapists" for demented people.
- (4) Lack of services such as laundry, home help, handyman, temporary care facilities, etc., the provision of which could obviate inappropriate nursing home placements.
- (5) Lack of other community services which would assist in reducing social isolation.

In addition, the New South Wales Council on the Ageing (S.292) stressed the need for appropriate services for the migrant aged referring particularly to language and cultural barriers and to the needs of those without families.

Many of these problems have resulted from the fragmented and uncoordinated nature of services for the aged by all levels of government, the private sector and voluntary agencies. For example, the lack of good general medical care in psychiatric hospitals, and the lack of sophisticated psychological care in some general hospitals.

3.2 Principles of Service Delivery

(i) Integration

Perhaps in no other area of health care is the principle of integration so important as it is in the care of the aged:

"Psychogeriatric treatment and care requires a high standard of medical care in association with a high standard of psychiatric care. The old often suffer from multiple disorders, each of which contributes to the others and the management of each may contribute to the worsening or alleviation of the others."

(Extract from SL41: Royal Australian and New Zealand College of Psychiatrists)

Because of the complex inter-reaction between organic and psychiatric factors in elderly disturbed patients the only rational approach is one based on joint responsibility of geriatric and psychiatric personnel and the primary focus of their care should be in the multi-disciplinary setting of a geriatric assessment service.

Subsequently if it is apparent that an elderly person has a functional psychiatric illness, such as depression, then, in the Inquiry's view, they should have access to the same range of services and facilities as any other person with the same illness (as discussed in Part 3 of this Report).

(ii) Health-Welfare Coordination

The care of the elderly requires a high level of coordination between the various components of health and welfare services and a primary goal is the maintenance of the elderly person in his or her own home, for as long as it is desired and feasible. This is particularly important for the elderly person who has a chronic brain syndrome, and who is likely to be confused, as their confusion will usually be more contained while they are in familiar surroundings.

4. HOW ARE SERVICES AND RESOURCES BEST STRUCTURED TO MEET NEEDS?

4.1 Components of Service

(a) Comprehensive assessment

The primary health care provider in the care of the aged is and will continue to be the general practitioner. Consequently the general practitioner must be actively involved in the assessment and ongoing care of the client and his or her family.

The importance of comprehensive physical, social and psychological assessment in the care of the aged was stressed in submissions to the Inquiry. In particular, it was emphasised that as far as possible such assessment should take place in the clients' own home, for example,

¹¹Assessment and screening services for people who require, for reasons of ageing, psychosocial and welfare services, should be incorporated into a community-based total care service for old people (which should include staff trained in mental health)¹¹.

¹¹Assessment should take place in a person's home or place of residence at the time of referral¹¹.

¹¹After the initial assessment at home, short-term in-patient assessment may be considered necessary (for special tests etc.). Such assessment should not be carried out in a psychiatric unit¹¹.

¹¹Where, at the time of assessment, it is determined that the person has a functional psychiatric illness, such as depression, they should be treated through the same network of services and facilities as any younger person with the same illness¹¹.

"Where it is determined, at the time of assessment, that the person has a chronic brain syndrome, then specific additional services should be available within the community to enable that person to be maintained at home in an environment with which they are familiar."

(Extracts from S213: N.s.w. Association for Mental Health)

The essential point is that assessment should be based on a geriatric service, with the availability of psychiatric consultation as required. In 1980, the Adviser in Geriatric and Rehabilitation Services, to the then Health Commission Dr. L. Mykyta, pointed out:

"Up to 40% of elderly patients admitted to hospital for any reason are likely to become seriously confused. In most instances the confusional state is due to an underlying physical disorder. Despite this large numbers of acutely confused elderly people are admitted to psychiatric hospitals or nursing homes that do not have the skills or facilities to diagnose, investigate and adequately treat the problem because the disturbed behaviour rather than the reason for it has determined the patient's destination".

"Full clinical assessment is of crucial importance. Most assessment clinics find that between 15 and 20% of referrals have a reversible cause. Nor is the plight of the remainder necessarily hopeless. There are many aspects of brain failure that are to some degree treatable such as the disturbed behaviour, depression, loss of ADL skills etc. Aggressive treatment programmes may enable an individual to maintain a higher level of functioning and live in a less supportive environment than would otherwise be possible".

"Initial assessment should ideally be carried out by a multidisciplinary joint unit i.e. the caring team should comprise of specialists in Geriatric Medicine, Psychiatry and the allied health professions".

"The unit should be established within the Geriatric Medicine Department of a major Regional teaching hospital. While administratively the responsibility of the Geriatric Services, the Unit must provide equal access to and demand equal responsibility from a consultant psychiatrist and his back-up team, where possible, from the Psychogeriatric Unit of a Regional psychiatric hospital".

"The unit should be the point of entry of acutely ill and disturbed elderly patients. Where possible, assessments should be carried out on a domiciliary basis deploying the personnel of the inpatient team".

"The reason for siting the unit in the Geriatric Department is that the psychogeriatric patient is commonly physically ill at the time of admission and requires medical care and nursing. The yield of organic pathology is high and most investigational and treatment services are sited at the General rather than the Psychiatric hospital. Geriatric services are on the whole more integrated with community support organisations than are psychiatric services and are more able to deploy these on the patient's behalf".

"After acute assessment and treatment patients can be streamed into the next appropriate service. It must be emphasised that units operating in this way return a large percentage of their patients to the community after stays that average from 2 to 6 weeks."

The need for assessment to be routinely provided prior to admission to nursing home care has been canvassed in many reports. Such an arrangement has been implemented in relation to admission to some State nursing homes and this should be extended to all State nursing homes and "psychogeriatric" wards in psychiatric hospitals. The possible extension of assessment procedures as a pre-requisite to admission to private and deficit-financed nursing homes, clearly requires additional funding for assessment teams and is linked to the general issue of Commonwealth - State funding which is discussed below.

(b) Day Care

It has been demonstrated in a number of centres in Australia and overseas that the Day Hospital concept, widely utilised in Geriatric services, is able to achieve the same advantages for the psychiatrically ill elderly as for the physically disabled.

Day Hospital-based assessment can be used as an alternative to admission for many patients, and it can permit earlier discharge of in-patients. Living at home confers many benefits that cannot be attained in an institutional setting. Day hospital attenders remain in the community longer than non-attenders as the respite afforded to families enables them to cope more effectively. Day care is considerably cheaper to provide than inpatient care and limited resources can be more fully utilised for greater numbers of patients than would be possible on an institutional basis.

(c) Residential Care

Several submissions to the Inquiry highlighted problems in the provision of residential care for the disturbed or confused elderly including the following:

- lack of short-term, respite care arrangements, the availability of which would assist families to maintain their elderly relative at home for longer periods;

- lack of alternatives to nursing home accommodation, in the form of supervised group homes or hostels;

- lack of appropriate nursing home facilities to care for the confused elderly who do need physical care;

- inappropriate placement in "psychogeriatric" wards in State psychiatric hospitals.

The need for more specialised services and the development of alternatives was emphasised by the N.S.W. Association for Mental Health:

"If, for various reasons, it is not possible for an aged person to be maintained in their own home, then the next best alternative is living in a simulated domestic atmosphere provided by a small residential home. Ideally these homes should be small units located in the community and preferably outside the hospital environment. The smaller the number of residents in the home, the greater is the possibility of the creation of an intimate and homely atmosphere. Wherever possible such homes should be in the districts where the aged persons have lived to enable contact to be maintained, and visits made, by relatives and friends."

"Over recent years there has been a gradual build up of nursing homes which could be styled 'psychiatric nursing homes'⁷ that is nursing homes where all or nearly all the residents suffer from the effects of chronic brain syndromes, have psychiatric illnesses and/or are behaviourally disturbed. If the Government elects to continue to support the private entrepreneurial nursing home system of accommodation for the aged, it should recognise the special nature of the 'psychiatric nursing homes' and establish control over them so as to ensure that they are adequately and appropriately staffed so that psychological and social care as well as physical care is provided, and that they are not of a large size".

"Even if all the above services were available, there would still be a small group of patients who, for the time being, will require accommodation and care in facilities provided by the State. They are mainly patients with chronic brain syndromes who are unable to be placed elsewhere because of a combination of noisy, aggressive or violent behaviour, severe disorientation leading to wandering and/or chronic or severe functional psychiatric illness. Admission to such

services should be carefully controlled to ensure that inappropriate admission does not occur. Such services should also be adequately staffed and programmed so as to provide a model of care for such people in relatively small units."

(Extract from S213: N.S.W. Association for Mental Health)

These problems were discussed in some detail in the recent Report from the House of Representative Standing Committee on Expenditure which concluded:

"Information available on nursing home patients indicate that between 30 and 50 per cent have some degree of senile brain disorder. Care of these patients is a major problem facing staff in nursing homes. A nursing home designed for physically frail and sick elderly people in a typical four-bed ward situation is not necessarily an appropriate place to care for somebody who is physically well and ambulant, but is suffering from brain failure or senile dementia. There have however been few attempts to investigate what the appropriate forms of care might be.

The potential for developing special programs within non-segregated nursing homes and hostels depends on the availability of staff for diversional activity programs and suitable architectural settings. The modification of existing facilities is a preferable, and necessary, means of providing for this group as new construction of purpose built facilities would only ever cater for a small proportion of these patients. To complement developments in institutional settings, the introduction of community-based psychogeriatric services must be seen as a high priority as many families bear an enormous responsibility in caring for these patients at home. If community services in general are lacking, those for psycho-geriatric patients are non-existent".

"It was put very strongly to the Committee that attention to the needs of the ambulant demented patient is urgently required. Existing nursing homes do not have the required skills. A large part of care in nursing homes involves attempting to restrict these patients to a limited area rather than providing diversional therapy and activities. One of the problems is that while staffing levels are required to be fairly intensive only nursing staff are included in setting staff ratios. Many nursing homes find that their existing facilities and staff levels can no longer cope with the problem.

Care of the confused elderly was the single problem that was most repeatedly brought to the Committee's attention. The conclusion reached is that the problem will not be solved simply by the construction of special nursing homes but that action is needed to stimulate a diversity of provision in small units in existing nursing homes, and in a range of community psycho-geriatric services, such as relative support groups, relief sitting and admissions, and day-care. Fundamental to all these developments is the provision of proper diagnostic and assessment services."

(Extracts from "In a Home or At Home": Accommodation and Home Care for the Aged: Report from the House of Representatives Standing Committee on Expenditure- October 1982).

The Inquiry endorses the conclusions of the House of Representatives Standing Committee for the need for diversity in these services. This will require review of the role of both the public sector and the private sector, and encouragement of appropriate services through the existing financing mechanisms.

Some alternatives already exist and the Inquiry considers, for example, that the work of the Uniting Church in establishing supervised group homes, provides a useful model for further development. The principles outlined in the Uniting Church evaluation of their programme could usefully be adopted as principles by all the agencies providing residential care for this group and these are summarised in an abridged form below:-

- (i) The ideal form of care is a warm, stable, supportive domestic type of environment in which the dementing old person can feel at home and take part in stimulating activities. Any necessary restrictions on wandering should be as unobtrusive as possible.
- (ii) To make them feel more secure and more at home, residents should be encouraged to keep old photographs or treasured possessions in their rooms.
- (iii) The environment should be kept simple and stable so that the residents can become familiar with it.
- (iv) Residents are basically elderly people with an additional disability. They experience pleasure and pain, and until a late stage they respond fairly appropriately to social inter-actions.
- (v) Residents should be treated with the patience and courtesy normally extended to respected elders.
- (vi) Staff should spend time with residents and should talk to them slowly, clearly, and simply. They should learn to know as much as possible of their background, interests, families and achievements and their likes and dislikes.

- (vii) Self-esteem and well-being are increased if they're encouraged to do all they can for themselves and each other, and to help staff, even in minor ways - no matter how slowly this is done.
- (viii) Self-esteem and well-being are also enhanced when staff take particular interest in each resident's appearance, assisting them, when necessary, to maintain a high standard.
- (ix) Active rather than passive participation in simple household chores, movements to music, craft work, discussions and outings helps them develop and make best use of their remaining faculties, and gain the maximum enjoyment from their lives.
- (x) Residents require normal, regular medical examinations to treat physical illnesses that are likely to occur in the elderly. Any sudden deterioration or change in behaviour requires prompt investigation.

(Sourced from "Forgetting but not Forgotten" - Community Services Division - Uniting Church in Australia, Melbourne 1982)

4.2 Staffing

In this, as in the other areas of the Inquiry's investigations, the emphasis in staffing must be on a multi-disciplinary approach. This is essential in the assessment and care of the elderly person whose physical, emotional and social needs are so interwoven. However, it has been argued to the Inquiry that the training of all health professionals is inadequate in the area of the care of the elderly with psychiatric problems, for example:

"Many general practitioners do not realise that a number of the dementias are treatable and reversible and that some conditions, the "pseudo-dementias" can mimic dementia and unless the cause of this pseudo-dementia, usually a depression, is treated then a person can languish for years in a "senile" state. Many doctors who are aware of the diagnostic difficulties with dementia are unaware of management strategies once the diagnosis is made. This is particularly true with Alzheimer's Disease patients for whom there is no specific treatment but there is much that can be done to improve the person's lot and that of his or her family."

(Extract from Sl42: Alzheimer's Disease and Related Disorders Society)

It was also proposed that the training of all disciplines in this area be upgraded, and that specific training posts be established in geriatric psychiatry, as follows:

"That specific attention is urgently given to the training of health professionals generally in aspects of geriatric psychiatry (e.g. the State government could, through its Higher Education Board encourage universities and colleges of advanced education to give greater emphasis to geriatric psychiatry, especially dementia and its management).

That attractive training posts for health professionals be established to encourage the selection of geriatric psychiatry as a career, (e.g. training posts for "2nd part" M.R.A.N.Z.C.P. candidates and/or post diploma fellowships at the N.s.w. Institute of Psychiatry could be established specifically in psychogeriatrics) ."

(Extract from Sl41: Royal Australian and New Zealand College of Psychiatrists)

5. IMPLICATIONS FOR COMMONWEALTH - STATE COORDINATION

5.1 Funding

Financial and organisational arrangements for the provision of services for the care of the aged have been the subject of intense investigation and inquiry by both Federal and State governments over the last ten years. This is one of the most complex areas of all intergovernment relations. The need for a joint Commonwealth/State policy on the care of the aged has been argued in many of these Reports, and it is particularly important as the bulk of resources for the care of the aged are directed to institutional care (the most important being Commonwealth payment of Nursing Home Benefits - \$550 million approximately per annum) while there is growing recognition of the need for a wider range of home-based services (currently the direct responsibility of State governments).

Unlike the other areas examined by the Inquiry most of the resources involved in care of the aged are interlinked with specific purpose Commonwealth funding directed largely to the private profit and nonprofit sectors. Proposals for redistribution of resources cannot be solely developed at State level and therefore specific funding recommendations have not been developed by the Inquiry.

The most recent Inquiry in this area (The Report from the House of Representatives Standing Committee on Expenditure - cited above), recommends a restructuring of Commonwealth resources and eventual transfer of all funding to the States, which would then have the complete responsibility for aged care services and their funding. The Inquiry does not consider it appropriate or possible to discuss these issues in detail. The following matters however, are particularly relevant to the Inquiry's areas of concern.

5.2 Specific Issues

Firstly, the funding of assessment services is of crucial importance to the development of appropriate services for the confused and disturbed elderly. The Inquiry supports the comment of the House of Representatives Standing Committee on Expenditure:

"It is acknowledged that the establishment of assessment teams operating at the State and regional level would require additional funding. It would be difficult to build in an incentive for the States to pay for them and use them if the Commonwealth were still paying all nursing home benefits. There is a limited number of nursing home beds. The assessment teams could achieve better use of these beds being an appropriate rationing device."

and their recommendation that this funding be accepted as a Commonwealth responsibility.

The Inquiry is aware that there have been earlier approaches to the Commonwealth on this issue, however, it would be appropriate, in the light of the abovementioned Report, for this matter to be considered further by the next conference of Australian Health Ministers. It is therefore proposed that the Minister for Health raise the funding of geriatric assessment teams as an agenda item for the next Health Ministers' Conference.

Secondly, the Inquiry considers that the State government should take a more active role in seeking to ensure that the special needs of the confused elderly are met within the current organisational and funding arrangements. The Department of Health has the control of approvals for new nursing homes and extensions to existing homes. The Department has recently issued a document on "Guidelines for New Nursing

Home Accommodation for the Aged", (December 1982) which refers to the need for nursing homes to be prepared to care for and develop active programmes for the confused elderly. The Inquiry recommends that the Department of Health give more regard in future approvals of nursing homes to the care of the confused elderly, and consider the introduction of a requirement of this kind as a condition of licensing.

Thirdly, concern has been expressed to the Inquiry that extensive care benefits (the additional Commonwealth benefit for those who require more intensive nursing care) are not readily available for the care of the confused elderly, who may not need intensive physical care. The Auditor General's Report (Efficiency Audit of Commonwealth Administration of Nursing Home Programmes -1981) also pointed out that New South Wales has the lowest percentage of all States of nursing home patients receiving the extensive care benefit (35.3% compared to the Australian total of 51.3%).

Extensive care is defined in the National Health Act as nursing home care required by a person -

"who is bedridden or virtually bedridden
and is wholly or substantially dependent
on nursing care; or

who is undergoing treatment for any
illness, disease, incapacity or
disability and, for the purposes of that
treatment, is wholly or substantially
dependent on nursing care. (S.40
AF(5)) •"

Although this definition can be interpreted to include those patients who do not have major physical needs for intensive care, the problem appears to lie in the NH5 form, which is completed by doctors seeking admission of a patient to a nursing home. The information sought on this form would seem to place the emphasis on the patient's physical needs.

In view of the intensity of care and supervision required by the confused elderly, irrespective of their physical needs, the Inquiry recommends that this issue be raised with the Commonwealth Department of Health to facilitate greater use of extensive care benefits for this group of patients.

Fourthly, as discussed above, it is important that action is taken to encourage a range of accommodation facilities as alternatives to nursing home accommodation for this client group. The primary source of capital funding for hostels and other alternative arrangements is the Aged and Disabled Persons' Homes Programme. The Department of Social Security has recently established a Committee with State government representatives, to co-ordinate planning for these services and to assist in the determination of priorities within the programme. The Inquiry has also proposed that the Minister for Health negotiate with the Minister for Social Security to improve co-ordination in relation to the needs of all the client groups it has examined. The special needs of the confused elderly should be recognised, and appropriate organisations encouraged to develop proposals to meet these needs.

6. SERVICES IN PSYCHIATRIC HOSPITALS AND STATE NURSING HOMES

6.1 Psychiatric Hospitals

The Inquiry has proposed that the psychiatric services in existing Fifth Schedule Hospitals be transferred to the management of existing Boards of general hospitals (and in the metropolitan Regions, hospitals which have regional specialist and teaching functions). This management change will obviously include the services provided for the aged in these hospitals within "psychogeriatric" wards. Within the new management arrangements these services for the aged should clearly be linked to acute geriatric and psychiatric services within the hospitals to which they are attached. (In the Hunter Region a different arrangement is proposed and special consideration of the link to geriatric services will be needed).

Services for the disturbed or confused elderly should be organised as part of a geriatric service, preferably at area level, with appropriate psychiatric consultation. The primary objective should be the development of domiciliary assessment services and day care facilities which can assist in the maintenance of the elderly person at home, and the appropriate use of inpatient and residential facilities.

Consequently, formal links should be developed between Regional or area geriatric and rehabilitation services and the geriatric services in existing psychiatric hospitals and State Nursing homes. These organisational arrangements should be considered in the context of the Inquiry's recommendations about particular hospitals in Part 3 of this Report.

All admissions of aged people to psychiatric hospitals should be controlled by a joint assessment service as discussed above. Pending the establishment of fully-staffed geriatric assessment teams, and acute assessment units, small assessment teams should be established by gradual redeployment of some of the existing staff of "psychogeriatric" services within the existing institutions.

"The admission of an old person to hospital should always be viewed as a serious step and never advised without careful consideration of the total situation that has led to the request for inpatient care. There is a real risk of long stay patients being treated as second or third rate citizens, interesting neither as medical or nursing cases but treated as social rejects. Legitimate reasons for admission can be considered under three headings:

- . the need for treatment that is not possible on a domiciliary, out-patient or day patient basis:
- . the impossibility of containing the patient in the community because of his behaviour or of inadequacies of community care:
- . the need to give relatives and friends a period of rest and relief to enable them to continue helping the patient to live in the community."

{Extract from S280: Southern Metropolitan Region, Health Department) .

6.2 State Nursing Homes

In New South Wales, the State is involved in the provision of nursing home care both directly and indirectly - directly through the administration of geriatric hospitals and nursing homes under the Fifth Schedule of the Public Hospitals Act, and indirectly through funding of nursing homes administered by the Boards of public hospitals {under the Second Schedule of the Act) or by charitable organisations {under the Third Schedule of the Act). The State Government also acts as the licensing authority for all nursing homes.

Although State government nursing homes represent only a small proportion of the total stock of nursing home beds (12% in New South Wales) they could potentially play a role in providing for special needs which are not catered for by the non-government sector.

There are four Fifth Schedule Nursing Homes in New South Wales:

- (i) Allandale Hospital (Hunter Region): 536 beds
- (ii) Lidcornbe (non-recognised beds) (Western-Metropolitan Region): 310 beds.
- (iii) Garrawarra Hospital (Southern Metropolitan Region): 331 beds.
- (iv) Strickland House (Southern Metropolitan Region): 108 beds.

These facilities are approved under the National Health Act for payment of Commonwealth nursing home benefits. Private insurance benefits are not payable in respect of patients in these nursing homes. The main source of revenue (apart from nursing home benefits) is direct State government funding.

Public sector nursing home facilities should provide services complementary to those provided in the private sector, and have the potential to provide more specialised or intensive care for groups with special needs, including:

confused and disturbed aged persons, particularly those whose behaviour is disruptive to others, or who need intensive individual care;

frail elderly for whom the private sector nursing homes are unable to care, for example, very heavy patients.

Public sector facilities are able to offer a more comprehensive range of services, through the employment of ancillary health personnel, and can be integrated with rehabilitation and extended care assessment services. They have the potential to provide services such as respite care which can relieve the pressure on families and enable them to care for their aged or disabled relative for much longer periods than would otherwise be the case.

As indicated above, the majority of public sector nursing home beds are provided in the large Fifth Schedule Nursing Homes. There are a number of problems in this arrangement:

These services tend to be isolated geographically, making it difficult for relatives to maintain contact with patients, difficult to establish formal and informal links with "normal" community activities, and difficult to recruit an appropriate range of staff skills.

These services are also isolated organisationally and professionally, with the result that they are not linked to a comprehensive programme of care for the aged and disabled, and they are less likely to provide appropriate and on-going assessment, structured rehabilitation programmes, and continuity of care.

The Inquiry was impressed by the efforts being made, particularly at Garrawarra, to provide a more specialised and goal-directed service and to develop links with other services and the local community. However, the Inquiry considers that this process would be facilitated by changes to the management structure of these services and gradual decentralisation of these services. In Part 1 of the Report the Inquiry has argued the need for a more integrated health system, to provide more appropriate services for clients and improved opportunities for staff. As discussed above, integration is particularly important in the care of the frail aged, where the fundamental component of the service system is the provision of comprehensive multi-disciplinary assessment.

Consequently, the Inquiry proposes that each of the existing Fifth Schedule Nursing Homes be transferred to the Second Schedule of the Public Hospital Act and linked to regional or area geriatric services as proposed below:

- (i) Allandale Hospital:- In the short term, in view of the isolation of the Hospital from existing geriatric services in the Region, a new Second Schedule Board should be created for Allandale Hospital, including representatives of the Board of the general hospitals in the same area, namely Cessnock Hospital, Kurri Kurri Hospital and Maitland Hospital.
In the longer-term, it would be appropriate to link Allandale to the future development of geriatric services in the Region.
- (ii) Lidcombe Hospital:- Lidcombe Hospital is a Fifth Schedule Hospital which has undergone a significant change of role in recent years, with the introduction of general acute hospital services to the hospital campus. The Hospital's role in care of the aged and disabled has been and continues to be significant. It provides nursing home facilities, a geriatric rehabilitation service and other specialised treatment and rehabilitation services for the disabled, of all ages. These services include those for traumatic brain damage and back injury patients and a group of physically disabled patients who have proven virtually unmanageable in other environments. It would be appropriate for Lidcombe to operate as an integrated hospital, managed by its own Board as a Second Schedule Hospital.
- (iii) Garrawarra Hospital - Garrawarra is the most geographically isolated of the Fifth Schedule Nursing Homes. The Hospital, in consultation with the Regional Director of the Department of Health, has however taken a number of initiatives to develop closer links to other geriatric services. Although the Hospital services both

the Southern Metropolitan and Illawarra Regions, the Inquiry proposes that, for management purposes, the hospital be linked to general acute geriatric services in the Southern Metropolitan Region and be managed by the Board of the teaching hospital St. George Hospital, Kogarah. The Hospital should also maintain its close links to Sutherland Hospital and community services.

- (iv) Strickland House: This facility should be linked to geriatric services as they develop at Prince of Wales Hospital, and be managed by the Prince Henry/Prince of Wales Hospitals Board.

The Boards responsible for the management of these services should be given a clear responsibility to rationalise and decentralise nursing home services through the development of smaller community based accommodation, expanded day hospital facilities and improved home care.

The Inquiry's attention has also been drawn to the potential of the David Berry Hospital (a Fifth Schedule hospital providing acute general health services - located near Berry) to be linked into regional services by broadening its current role to include geriatric, rehabilitation and developmental disability services. This may require amendments to the hospital's own incorporation legislation. The desirable way of proceeding is to transfer the hospital to the Second Schedule of the Public Hospitals Act and link its management to other health services in the Shoalhaven area.

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**INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED**

PART 5

APPENDICES

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MARCH 1983

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

PART 5

APPENDICES

March, 1983



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LIST OF STAFF AND CONSULTANTS

staff

Mr P. Primrose	Research Officer
Mr I. Dempsey	Administrative Officer
Ms J. Marston	Stenographer

Part-time Consultants

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Dr J. Dey	Senior Specialist, Developmental Disability Services, Department of Health, NSW
Ms K. O'Connor	Senior Manpower Policy Analyst, Planning and Research, Department of Health
Dr P. Shea	Medical Superintendent, Rozelle Hospital
Dr N. Shiraev	Senior Planner, Planning and Research, Department of Health
Ms L. Solomons	Director of Nursing, Gladesville Hospital
Mr J. Taylor	Senior Industrial Officer, Department of Health
Mr H. Wirth	Assistant Director, Management Division, Public Service Board of NSW

MEDIA RELEASE

ISSUED FROM THE OFFICE OF THE MINISTER FOR HEALTH
LAURIE BRERETON, M.P.

217.5844

The Minister for Health, Mr Laurie Brereton, today announced an enquiry into health care services provided for the psychiatrically ill and the intellectually handicapped.

Mr Brereton said the enquiry would be chaired by Mr David Richmond, a member of the Public Service Board and a senior administrator of many years' experience.

The enquiry will include one assessor from the unions involved in the 5th Schedule (psychiatric) hospital system, to be nominated by the Labor Council, and one assessor from the Health Commission.

Mr Brereton said the enquiry would examine the present range of services provided for the psychiatrically ill and the intellectually handicapped, both in institutions and community-based facilities.

"The enquiry will seek to determine the most appropriate pattern of services, review financial and manpower resources and the contribution of the voluntary sector. It will identify priorities for the development of new services," Mr Brereton said.

"It will commence on September 14, and I urge all those interested in the care of the psychiatrically ill and the developmentally disabled to co-operate fully with the enquiry."

26th August, 1982

INQUIRY INTO THE - PSYCHIATRIC SYSTEM

Terms of Reference

1. To determine the appropriate nature, extent and distribution of services for the psychiatrically **ill**, psycho-geriatrics and the developmentally disabled in New South Wales.
2. To review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.
3. To identify priority areas for the development of new services.
4. To assess resource requirements for the psychiatric system in the light of the findings in (1), (2), and {3) above.
5. To review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies.
6. To identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.



NEW SOUTH WALES GOVERNMENT

PUBLIC NOTICE

INQUIRY INTO HEALTH SERVICES FOR THE PSYCHIATRICALLY ILL AND DEVELOPMENTALLY DISABLED

The Minister for Health, Mr Laurie J. Brereton, announced on 27 August 1982, the establishment of an Inquiry into the provision of health services for the psychiatrically ill and the developmentally disabled. The Inquiry will be conducted by Mr David Richmond, a Member of the Public Service Board, who will be assisted by one assessor nominated by the Labor Council and one assessor nominated by the Health Commission of New South Wales.

The Inquiry commenced on 13 September 1982 and will report to the Minister at the end of December 1982.

The terms of reference of the Inquiry are as follows:

1. To determine the appropriate nature, extent and distribution of services for the psychiatrically ill, psycho-geriatrics and the developmentally disabled in New South Wales.
2. To review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.
3. To identify priority areas for the development of new services.
4. To assess resource requirements for the psychiatric system in light of the findings in (1), (2) and (3) above.
5. To review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government agencies.
6. To identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.

The Inquiry invites organisations and individuals with an interest in this area to make written submissions by 22 October 1982, and to indicate whether they would be prepared, if required, to make an oral presentation of their views to the Inquiry.

Submissions and enquiries should be addressed to:

**Ms P. Rutledge, Executive Officer,
Inquiry into Health Services for the
Psychiatrically Ill and Developmentally
Disabled,**

PO Box K110 Haymarket 2000
Telephone : 217 6666

Metropolitan and Ethnic Press

- September 1982

KEY ISSUES

Service Delivery Issues

- 'needs' of client groups
- costs and benefits of service modes
- equity issues
- community attitudes, etc.
- components of service delivery

Manpower and Industrial Relations Issues

- staffing
- conditions of employment
- consultative processes
- education of staff
- hours/structure of nursing shifts

Management Issues

- management performance
- task definition and skills required
- level and appropriateness of delegations
- organisational structure
- staff involvement

Training and Education Issues

- changing education needs
- recruitment of trainees
- provision of comprehensive clinical experience
- service/training nexus in nursing, etc.

Financial Issues

- resource deployment/priority-setting
- level of resources - operating
 - ... capital
- health insurance and revenue issues
- financial incentives

'Systems' Issues

- values and attitudes - management
 - staff
 - community
- openness of system
- boundary issues

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SUBMISSIONS

Non-Government Organisations

Action for Children

Action for Handicapped Children

Action for Handicapped Citizens

Action for Intellectually Handicapped Citizens

Aftercare Association

Alzheimer's Disease and Related Disorders Society

Armon Nursing Home

Arndell Public School P&C Association

Association for the Assistance of Intellectually and Socially
Handicapped Persons

Association of Relatives and Friends of the Mentally **iff**

Association for the Welfare of Children in Hospital

Australian Huntingdon's Disease Association

Australian Jewish Welfare Society

Australian Legal Workers' Group (NSW)

Blacktown City Accommodation Collective

Blacktown City Community Services Council

Blacktown Community Cottage Ltd

Careforce Anglican Home Mission Society

Centacare Catholic Family Welfare

Central Coast Hostel Action Committee of Parents and Friends of the
Intellectually Handicapped

Central Coast Social Development Council Ltd

Church of England Homes

Church of Scientology (Sydney Congregation)

Citizens' Committee on Human Rights

Committee on Mental Health Advocacy

Elemental

Everton House Committee

Fairfield Interagency Sub-committee

Family Planning Association of NSW (Ltd)

Gladesville Auxiliary Ltd

GROW

Hunter Region Accommodation Committee
 Illawarra Branch ARAFMI
 Illawarra Handicapped Persons' Trust
 Intellectually and Physically Handicapped Children's Association of NSW
 Interagency on Homelessness - Wesley Central Mission
 Kings Cross-Darlinghurst Youth Needs Project
 Louisa Lawson House
 Macquarie University Unit for Rehabilitation Studies
 Maitland Interagency
 Manly-Warringah Citizens' Advice Bureau
 Marconon Inc
 Mater Dei Special School, Camden
 Mental Health Co-ordinating Council
 Mental Liberation Association
 Milperra College of Advanced Education
 Morisset Intellectually Handicapped Association
 Narconon Inc
 Northside Clinic
 NSW Advisory Council on the Handicapped
 NSW Association for Mental Health
 NSW Council on the Aging
 NSW Council for the Mentally Handicapped
 NSW Health and Welfare Chaplains' Association (Psychiatric Committee)
 Occupational Therapy Study Group in Developmental Disability
 Orana Committee on the Handicapped
 PALA Society
 Polish Welfare and Information Bureau (NSW)
 Psychiatric Rehabilitation Association
 Richmond Fellowship
 Riverglade Centre Parents and Friends Association
 Rydalmere Hospital Parents and Friends Association
 Ryde-Hunters Hill Interagency
 Salvation Army
 Scone Interagency
 Shared Care
 Subnormal Children's Welfare Association
 Subnormal Children's Welfare Association (St. George Branch)

Subnormal Children's Welfare Association (Namoi Branch)
Support for Orthomolecular Medicine Association

The Chelmsford Survivors

The Compassionate Friends

2WG Old People's Homes Trust, Wagga Wagga

Uniscan Education Testing Centre, University of NSW

Uniting Church in Australia (NSW Synod)

Uniting church Chaplains' Committee

Wayside Chapel, Kings Cross

Wesley Central Mission

Western Sydney Citizen Advocacy Programme

Willoughby Municipal Council

Women's Legal Resources Project

Professional Groups

Association of Psychiatrists in Training (NSW)

Australian Association of Occupational Therapists

Australian Association of Speech and Hearing (NSW)

Australian Congress of Mental Health Nurses (NSW Branches)

Department of Community Medicine - University of NSW

NSW Institute of Psychiatry

Royal Australian and New Zealand College of Psychiatrists (NSW Branch)

School of Psychology - University of NSW

School of Psychology- University of Wollongong

Social Work Group, Southern Metropolitan Region

Social Workers for the Developmentally Disabled

Government Departments

Concord Hospital - Department of Veteran Affairs

Department of Social Security

Ethnic Affairs Commission of NSW

Health Commission of NSW

Industrial Associations

Health and Research Employees' Association

NSW Nurses' Association
Public Medical Officers' Association
Public Service Association
(Several hospital sub-branches of the above Unions also made submissions)
Health Department Services

Adolescent and Adult Unit, Grosvenor Hospital
Adolescent Medical Unit, Royal Alexandra Hospital for Children
Allandale Hospital
Armidale and New England Hospital Nursing Administration
Bankstown Hospital
Bloomfield Hospital
Burwood Community Health Centre
Canterbury Community Health Services
Central Coast Area Health Service
Community Health Unit

Development Disability Team, Southern Metropolitan Region
Division of Nursing
Eastern Suburbs Community Rehabilitation Service
Eastlakes Community Health Team
Gladesville Hospital
Gladesville Hospital Executive
Gladesville Hospital Management Committee for Developmental
Disability Services

Gladesville Hospital, Rehabilitation Management Team
Gladesville Hospital, Social Work Department
Grosvenor Hospital
Hunter Region Developmental Disabilities Unit
Illawarra Region
Illawarra Health Region Rehabilitation and Geriatric Services
Illawarra Region Migrant Health Team
Langton Clinic
Laurel House
Liverpool Area Health Centre
Lower North Shore Community Mental Health Service
Macquarie Hospital
Macquarie Hospital Alcohol and Drug Dependence Unit.
Macquarie Hospital, Arndell Children's Unit

Macquarie Hospital Psychogeriatric Services
 Macquarie Hospital Rehabilitation Programme
 Macquarie Hospital Surgical Unit
 Macquarie Hospital Ward 8
 Morisset Hospital
 Murray Region
 New England Region
 Newcastle Community Health Centre
 North Coast Region
 North Coast Region Mental Health Services
 Northern Metropolitan Health Region Resident Placement
 Committee
 Northern Metropolitan Region
 Nurse Training School, Kenmore
 Nutrition and Dietetics Service, Lidcombe Hospital
 Occupational Therapy Department, Marsden Hospital
 Occupational Therapy Department, Parramatta Psychiatric Centre
 •)fficial Visitors to Morisset Hospital
 Orana and Far West Region
 Parramatta Psychiatric Centre
 Peat Island Hospital
 Prince of Wales Children's Hospital
 Principal Clinical Psychologists, Southern Metropolitan Region
 Psychiatric Nurses' Educators, Hunter Region
 Psychiatric Nurses' Educators, Parramatta and Rydalmere Hospitals
 Psychiatric Unit, Prince of Wales Hospital
 Psychology Department, Kenmore Hospital
 Psychologists, Grosvenor Hospital
 Psychology Section, Marsden Hospital
 Redfern House Community Health Centre
 Riverina Region
 Rydalmere Hospital
 Scho3l of Nursing, Southern Metropolitan Region
 Shoalhaven Community Health Services

Social Work Department, Wollongong Hospital
Social Work and Occupational Therapy Departments, Rozelle Hospital
Social Workers, Rydalmere Hospital
Southern Metropolitan Region
Tamworth Base Hospital, Regional Service for the Developmentally
Disabled
•rransport Section - Kenmore Hospital
warilla community Health service
William Street Hostel Staff
western Metropolitan Region
Wollongong Community Health Support Team

Individuals

One hundred and seven submissions were received from individuals.

Oral Submissions

Approximately thirty individuals or groups presented oral submissions to the Inquiry.

VISITS BY THE INQUIRY

Allandale Hospital
 Bankstown Hospital
 'Baringa', Wollongong
 'Belhaven', Arncliffe
 Bloomfield Hospital
 Garrawarra Hospital
 Gladesville Hospital
 Grosvenor Hospital
 Hillview Community Health Centre
 Hornsby Hospital (and Developmental Disability Unit)
 Kenmore Hospital
 Laurel House
 Lidcornbe Hospital
 Liverpool Area Health Centre
 Liverpool Hospital
 Macquarie Hospital
 Marsden Hospital
 Morisset Hospital
 Newcastle Psychiatric Centre
 North Coast Region
 Parramatta Psychiatric Centre
 Peat Island Hospital
 Rozelle Hospital
 Rydalmere Hospital
 St. George Hospital
 South Australian Health Commission
 Stockton Hospital
 victorian Health Commission
 Westmead Hospital
 Wollongong Hospital

(Each Fifth Schedule hospital visit included:

meeting with hospital executive

inspection of hospital

open staff meeting

meeting with union dele<I e:_s

individual staff interviews)

Hostels, Nursing Homes and Boarding Homes

AAISH hostels

'Bambi', Liverpool

Crown Hotel, Ultimo

Distin Morgan House

Gladesville Hospital Satellite Housing

Lorna Hodgkinson Sunshine Home

Marsden Hospital hostels

Rochester Private Hotel

59 Cavendish Street, Stanmore

Subnormal Children's Welfare Association, Bankstown

CO-ORDINATION OF PUBLIC SECTOR SERVICES

Agency	services
Anti-Discrimination Board*	Advocacy for Disadvantaged Groups Research
Commonwealth Department of Health	Funding of nursing homes, etc.
Commonwealth Department of Social Security*	Commonwealth Rehabilitation Service Funding to Community Groups
Commonwealth Schools Commission	Funding of Early Intervention Programmes for Disabled Children
Department of Attorney General and Justice*	Guardianship Provisions for the Developmentally Disabled Mental Health Act
Department of Corrective Services*	Co-ordination between Probation and Parole Services and Health Assessment and Accommodation Services Services for Prisoners with special needs
Department of Education*	co-ordination of Education and Health Skills Early Intervention Programme School Counselling Services Special School Services
Department of Environment and Planning	Co-ordination of Services in New Areas State Policies on Provision of Group Homes, etc.
Department of Technical and Further Education	Education and Work Skills Training
Department of Youth and Community Services)(-	Child Protection Services Children's Services Family Crisis Services Family Support Services

	Funding of Community Groups Handicapped Persons' Bureau H9me Help Service Institutional Care Licensing of Hostels, etc.
Ethnic Affairs Commission*	Advocacy for Ethnic Groups
Housing Commission*	Accommodation
Local Government Councils	Local Welfare Services Town Planning Approvals for Residential Facilities
Police Department	Crisis Intervention Involuntary Psychiatric Admissions
Premier's Department *	Co-ordination of Government Activities generally

*(Inquiry met formally with representatives of these Departments, and also with representatives of the Local Government and Shires Association.)

BACKGROUND AND WORKING PAPERS

Assessment of Client Needs

Components of Services

Consultation with other Departments - brief notes

Crisis Service

Definitions

Discussion with Interim Evaluation Team - Community Health

Evaluating Objectives

Flow Charts of Models of Service Delivery

General Objectives

Key Issues Elaboration

Key Issues Summary

Literature Review - Models

Management Issues

Methodology

Nurse Training

Personnel and Roles

Prevention

Role of Community Groups

'Systems' Issues

Training of Psychiatrists

LITERATURE REVIEW - MODELS

The following is a review of recent literature on model and approaches to the delivery at health services to the psychiatrically ill and developmentally disabled.

It is not an exhaustive review, even of recent literature. Rather an attempt has been made to locate items which are representative; source items that are regularly quoted; or deal with critical issues such as the 'hospital versus community' debate.

The review is presented under the following headings:

Psychiatrically Ill (General): focus on hospital versus
community debate
Psychogeriatric
Children and Adolescents
Drug and Alcohol
Developmental Disability

Psychiatrically Ill - General

1. Black, B. 'A Pragmatic Rehabilitation Model', in P.R.A.,
Psychiatric Rehabilitation in Australia, Sydney, 1982, pp. 17-21.

Concepts:

- (a) Rehabilitation should begin as close to the onset of illness as possible.
- (b) Rehabilitation requires a holistic approach, considering the psychosocial, the medical and the environmental influences on the individual's ability to participate.
- (c) Rehabilitation requires a multidisciplinary approach.

Aspects:

- (a) Integration of hospital to community.
- (b) Integration of community services.
- (c) A residential facility not related to work and socialisation activities is unlikely to be successful.

- (d) and work programmes are one means of raising levels of training and competence.
- (e) Evaluation takes a long time.

2. Barclay, W. 'Deinstitutionalisation - Global experience and practical implications for Australia', in P.R.A., Psychiatric Rehabilitation in Australia, Sydney, 1982, pp. 25-29.

Necessary components of deinstitutionalisation:

- (a) prevention of inappropriate hospital admission through the provision of community alternatives for treatment.
- (b) The release to the community of all institutional patients who have been given adequate preparation for such a change.
- (c) The establishment and maintenance of community support systems for non-institutionalised persons receiving mental health services in the community.

Programmes fail when they do not provide for all three of these elements.

Lessons learned from the last three decades:

- (a) Mental hospitals have failed to provide an adequate standard of treatment and rehabilitation, even of care for the chronic mentally ill.
- (b) for the most part, hospitals have fulfilled this task better overall than other systems have.
- (c) Chronic schizophrenia is a disabling illness, and will not go away simply because we deinstitutionalise patients. Therefore, a hard, difficult and labour-intensive task remains of caring for the chronically disabled.
- (d) Government bureaucracies are the least efficient method of providing direct clinical services to patients. Other approaches, including private contracts, should be considered.
- (e) A 'middle of the road' psychiatric patient advocacy group is needed to increase political power.

3. Berk, A. and Chalmers, T. 'Cost and Efficacy of the Substitution of Ambulatory for Inpatient Care', The New England Journal of Medicine, 1981, 304, 7, pp. 393-397.

There is little published information that supports the assumption that the substitution of ambulatory for inpatient care results in equivalent or better clinical outcome at lower cost. Only four of 134 relevant papers provided enough data on both cost and efficacy to allow statistically valid conclusions; two of these showed ambulatory care to be as effective as inpatient care and less costly. Indirect cost cannot be ignored.

4. Braun, P., et al. 'Overview: Deinstitutionalisation of Psychiatric Patients: A Critical Review of Outcome Studies', American Journal of Psychiatry, 1981, 138, 6, pp. 736-749.

Experimental alternatives to hospital care of patients have led to psychiatric outcomes not different and occasionally superior to those of patients in control groups. The available studies do not permit firm conclusions regarding alternatives to continued long-term hospitalisation of chronically ill patients or for a critical analysis of the optimal management of specific subpopulations of psychiatric patients: ~~sa:tsr~~Factory-- deTnsfitutionaiTætlon appears- to depend on the availability of appropriate programmes for care in the community.

5. Brook, B., Cortes, M., March, R. and Sundberg-Stirling, M. 'Community Families: An Alternative to Psychiatric Hospital Intensive Care', Hospital and Community Psychiatry, 1976, 27, 3, pp. 195-197.

South West Denver Community Mental Health Services established a system of alternative families who take one or two psychiatric patients who need intensive treatment into their homes; the clients' average stay is ten days and so far 220 client placements have been effectively carried out. Research over a two-year period indicates that homes are more effective in certain respects than a psychiatric hospital in providing intensive care.

6. Commonwealth Department of Health. 'Review of Mental Health Care: A Discussion Paper', Policy and Planning Division, 1978, Canberra, Monograph Series No. 2, pp.42-46.

Options for present institutions:

- (a) A unified system of care: goal is to unify and co-ordinate the policies and procedures of the mental hospitals and community health centres to provide more effective delivery of services. Based on decentralisation of hospital administration and service delivery along geographical lines. Non-residential services are also provided from these geographic units, providing continuity of care.
- (b) Development of general hospital provisions: the psychiatric hospital to change its role to provide a small psychiatric unit plus medical, surgical and other specialist services (e.g. inpatient and day patient facilities for the elderly)
- (c) Provision of specialised residential services: appropriate parts of the mental hospital to provide services such as:
 - (i) treatment programme for alcoholics and drug addicts
 - (ii) intensive rehabilitation for geriatric patients
 - (iii) adolescent treatment units.
- (d) Disposal of mental hospitals.

7. Fenton, F., Tessier, L. and Struening, E. 'A Comparative Trial of Home and Hospital Psychiatric Care: One-year Follow-up', Arch. Gen. Psychiatry, 1979, 36, pp. 1073-1079.

155 patients destined for inpatient psychiatric care were randomly assigned to Home Care and Hospital Care. Evidence that community-based psychiatric care is an effective alternative to hospital-based care for many but not all severely disabled patients.

8. Glick, I., Hargreaves, W., Drues, J. and Showstack, J. 'Psychiatric Hospital Treatment for the 1980s: A Controlled Study of Short versus Long Hospitalisation', 1979, Lexington Books, USA.

The primary use of hospitalisation in the 1980s will be for brief intensive work with those with schizophrenia or affective disorders who need help in controlling a psychiatric or suicidal episode or exacerbation. For a very small subgroup longer hospitalisation may be needed. This style of clinical care requires close co-ordination with a variety of outpatient and residential non-hospital resources - a major clinical challenge. Continuous management by the same team through different levels of types of care may be a promising model.

9. Herz, M., Endicott, J., Spitzer, R. and Mesnikoff, A. 'Day versus Inpatient Hospitalisation: A Controlled Study', American Journal of Psychiatry, 1971, 127, 10, pp. 107-118.

Newly admitted inpatients were randomly assigned to either day or inpatient care. Outcome evaluations showed clear evidence of the superiority of day treatment on virtually every measure used to evaluate outcome.

10. Hoult, J., Reynolds, I., Charbonneau-Powis, M., Coles, P. and Briggs, J. 'A Controlled Study of Psychiatric Hospital versus Community Treatment: The Effect on Relatives', Australian and New Zealand Journal of Psychiatry, 1981, (in press).

120 patients presenting at North Ryde for admission were randomly allocated into two groups:

- (a) Control patients who received standard hospital care and follow-up.
- (b) Project patients, who were not admitted if this could be avoided and received intensive and comprehensive care from a community treatment team. It is clearly feasible to treat most psychiatric patients in the community without increasing the burden on their relatives.

11. Langsley, D., Machotka, P., and Flomenhaft, K. 'Avoiding Mental Hospital Admission: A Follow-up Study', American Journal of Psychiatry, 1971, 127, pp. 127-130.

300 patients were randomly assigned to outpatient family crisis therapy or admitted to a university psychiatric hospital. Follow-up at 18 months showed that patients treated without admission were less likely to be hospitalised after treatment and that their hospitalisation was significantly shorter; they were doing as well as the hospitalised patients on two measures of social adaptation and were managing crises more efficiently.

12. Lapsley, H. and Cass, Y. 'Evaluation of Selected Psychiatric Admission Wards', . . Vol. II, The Costing of Selected Psychiatric Admission Wards, 1981, Division of Health Services Research, Health Commission of New South Wales.

There was a wide range in average cost per bed day. Cost of labour, staff-patient ratios and occupancy rates were major cost factors. The Northside Clinic had a comparatively low average cost per bed day. Cost was not directly related to the patients' or their relatives' satisfaction with treatment.

13. Murphy, J. and Dattel, W. 'A Cost-Benefit Analysis of Community versus Institutional Treatment: Hospital and Community Psychiatry, 1976, 27, 3, pp. 165-170.

The methodology was used to project costs and benefits over a ten-year period for 52 clients successfully placed in the community. The results showed an average net saving for each client of \$20,800 over a ten-year period, mostly to the State Government.

14. Stein, L. and Test, M. (Eds). 'Alternatives to Mental Hospital Treatment', 1978, Plenum Press, New York.

Chronic patients were randomly allocated into Hospital or Community Treatment Groups and followed up at regular intervals. Outcome measures included patient outcome, family and community burden and a cost-benefit analysis. The results generally favoured the Community Treatment Group, but the authors warn that community

treatment must be comprehensive, assertive and prolonged. The study carried out by Holt, et al, in Sydney is basically a replicat]on of this study.

15. Stein, L., et al. 'Alternatives to Mental Hospital Treatment: I', Archives of General Psychiatry, April 1980, 37, pp. 392-397.

Study as per above. Developed conceptual model called 'TCL': training in community living. Community treatment requires:

- (a) Assuming responsibility for helping patients acquire material resources such as food, clothing, shelter and medical care.
- (b) Teaching patients coping skills in vivo, such as using public transport, preparation of meals and budgeting.
- (c) Ready availability of support system to help solve real-life problems, feel that he is not alone, and feel others are concerned.
- (d) Provision of supports to keep the patient involved in community life and to encourage growth towards greater autonomy.
- (e) Support and education of community members involved with patients.
- (f) Assertive support system that helps patients with all of the above; involves them in their own treatment; and is prepared to 'go to' the patient to prevent dropout.

Hospitals should only be used for:

- (a) Protection of the individual or others when the patient is imminently suicidal or homicidal.
- (b) When psychiatric illness is complicated by significant medical illness.
- (c) For patients whose psychosis is so severe that they require the structure and intensive nursing care of a hospital. The goal is to medicate and interrupt the psychotic process as early as possible.

16. Young, L. and Reynolds, I. 'Evaluation of Selected Psychiatric Admission Wards I, Vol. I. 1981, Division of Health Services Research, Health Commission of New South Wales.

Three different types of psychiatric admission wards:

- (a) State Psychiatric Hospitals (Gladesville and Parramatta)
- (b) General Hospitals (Liverpool and Hornsby)
- (c) Private Hospitals (Northside Clinic)

were compared and evaluated. There were sizeable differences between them in terms of the characteristics of patient admitted. The needs for:

- better staff-patient relationships
- more contact with doctors
- more comprehensive after-care

were particularly apparent at Gladesville, Parramatta and Liverpool.

17. Greene, L., et al. 'Psychiatric Day Treatment as alternative to and transition from full-time hospitalisation'; Community Mental Health Journal, 1981, 17(3), pp. 191-202.

Found substantial evidence that day treatment of psychiatric patients is superior to traditional full-time hospitalisation in facilitating the adjustment and re-integration of patients into the community.

Day treatment and full-time hospitalisation are equal on measures of cost effectiveness, family stress, symptom alleviation and relapse rate. Data on the efficacy of day treatment as a transitional facility from hospital to community was promising but incomplete.

18. Health Commission, Planning Health Services in the 1980s, Sydney, 1982, p. 59.

- (a) Commitment to continuing process of decentralisation and deinstitutionalisation. Continued important role for public

psychiatric hospitals, but--development of alternative accommodation is top priority. This includes expansion of acute psychiatric services at general hospitals, and development of small inpatient units, hostels, community mental health services, particularly crisis intervention centres.

- (b) Public psychiatric hospitals to become smaller, but will remain necessary for patients requiring totally sheltered accommodation by reason of age, infirmity or social deterioration.
- (c) For acute and sub-acute patients, hospital admission and readmission will be part of a long and continuous process of care and management. Such management, however, will increasingly be carried out at home by the family doctor, community health teams, or private arrangements. Flexible continuity of care is the critical factor.
- (d) Essential to establish effective working links between admission in patient units, in either general or psychiatric hospitals, community health centres and long-stay wards of psychiatric hospitals. One key person needs to have case responsibility at any one time.

The Confused and Disturbed Elderly

1. Health Commission. Planning Health Services in the 1980s, 1982, p. 60.

- (a) Need to develop further services for the assessment, treatment and care of elderly patients- : To be established in conjunction with general geriatric services.
- (b) Aim to set up multidisciplinary assessment units within the geriatric medicine departments of major teaching hospitals.
- (c) The psychiatrist from the psychogeriatric ward of the regional psychiatric hospital and his/her team will share joint responsibility for such units with the geriatrician.

- (d) Only long-stay patients with significant behavioural abnormalities should be cared for in Fifth Schedule system once initial assessment has been carried out.
- (e) Patients without severe behavioural disturbance should be cared for in nursing homes or in general hospitals.

2. Skinner. 'The Day Hospital - A Psychogeriatric Facility', in Health Commission Day Care for the Aged in an Integrated Health/Welfare Service, 1981, Sydney.

There is a need to put more emphasis on allowing people to have a choice of care and how their needs will be satisfied. Day hospitals provide day programmes for inpatients as well as day patients. Programmes can be maintenance only of three days per week, or rehabilitation.

3. carter, J. states of confusion---=.Australian Policies and the Elderly Confused, Social Welfare Research Centre, University of NSW, 1981.

Looks at services for elderly with brain failure. Raises a number of questions:

- (a) Has the ready availability of institutions and hospital care predisposed Australian old people and their families to think only of institutions as solutions?
- (b) What should be the role of private sponsorship in services?
- (c) Role of State welfare services? Few exist to support the elderly with brain failure. How can these be organised?

4. Clarke, M.G., et al. 'A psychogeriatric survey of old people's homes', British Medical Journal, November 14 1981, 283, pp. 1307-1309.

Recommends providing a community psychiatric nursing service as a support to old people's homes, particularly where there is a high proportion of disturbed residents and where staff lack training.

Of 289 residents in six homes, found 50.6 per cent were probably

demented. Sixty showed remediable psychiatric disorders or psychotoxic drug effects.

5. Jolley, D., et al. 'Organisation of Psychogeriatric Services', British Journal of Psychiatry, 1978, 132, pp. 1-11.

Recommends establishing psychogeriatric services in district hospitals. The service requires:

- (a) Definition of aims: define terminology, age, diagnostic characteristics of population to be served.
- (b) Availability and responsiveness: domiciliary assessment is the cornerstone of practice. Readiness to see a patient at home within 24-48 hours, or alternatively freely available access to outpatient or inpatient assessment,
- (c) The ability to work with different disciplines: need for psychogeriatric assessment units, involving a variety of different disciplines including a psychiatrist and geriatrician, to be set up in general hospitals.
- (d) A comprehensive service: responsibility for a whole range of mental disorders in the elderly, functional and organic. Ongoing flexible care available by a team over a long period.

6. Ratna, L. 'Crisis Intervention: A two-year follow-up study', British Journal of Psychiatry, 1982, 141, pp. 296-301.

Follow-up showed success of a community-oriented psychogeriatric service. The emphasis was on domiciliary management by initiating and supporting caring networks. Found the ability of the service to sustain patients in the community is related to:

- (a) Availability of a 24-hour emergency service by a doctor or nurse on call. Found this service used sparingly, but the knowledge of its availability reassured patients and relatives.
- (b) Emphasis on continuity of care: the patient saw the same professionals throughout contact.

(c) High standard day centre, which was willing to take on difficult cases.

7. Geeves, R. 'A model for an area geriatric and medical rehabilitation service', Australian Rehabilitation Review, 1981, 5(2), pp. 49-54.

Presents details of the model operating in the Hornsby and Kuring-gai area.

Model based on idea that the GP is the lynchpin or final common path of health care delivery. The area health and rehabilitation services provide resources and facilities for the GP. A primary aim is to help the GP keep the patient at home as long as possible. When this is no longer possible, appropriate institutional care should be guaranteed.

This aim can be achieved by providing an educational, preventive, medico-social crisis and long-term maintenance service for elderly and disabled people, including psychogeriatrics.

Argues that the model could be repeated in providing care to psychiatrically ill, drug and alcohol problems, adolescent services, etc.

Children and Adolescents

1. Health Commission. Planning Health Services in the 1980s, 1982, p. 60.

Need to increase supply of trained child psychiatrists and allied professionals.

Need for specialised inpatient units in addition to community child and family psychiatry services.

2. Bashir, M. 'Rivendell Adolescent Unit', R.P.A. Journal, September 1979, pp. 15-21.

Outlines the programme at Rivendell. Aims to provide a comprehensive residential, therapeutic and educational programme for adolescents aged 12-19 with psychological illness. Offers residential, day and short-stay facilities. Referrals are State-wide.

3. Johnson, S. 'Residential treatment for emotionally disturbed children and adolescents', in Canada's Mental Health, March 1982, pp. 5-8.

In past 20 years there has been an increasing demand for residential treatment. Three models are identified:

- (a) The sole goal of residence is to make the child available for individual treatment.
- (b) That living in a structured environment with healthy role models is all that's needed.
- (c) The whole residential experience is the therapy; providing a 'therapeutic community'.

There are no conclusive studies showing that residential treatment works.

M.H.S.P.R.C. 'Report of the Working Party on Child, Adolescent and Family Mental Health', 1978, suggests a model with three functional levels:

- (a) Child and family mental health workers, based at local health centres.
- (b) Child and family mental health specialists, based at either a hospital or health centre, as a regional resource.
- (c) Planners, as a State resource.

4. Winsberg, B. 'Home versus Hospital Care of Children with Behaviour Disorders', Archives of General Psychiatry, April 1980, 37, pp. 413-418.

Found community care effective with regard to behavioural control, and both treatments comparable concerning educational achievement, parent role function, family adjustment, and parent satisfaction with treatment.

Drug and Alcohol

1. Health Commission. Planning Health Services in the 1980s, March 1982.

Integrate drug programmes with other health care activities, particularly within the general hospital sector. This could be achieved by establishing small teams within hospitals to develop and implement programmes, and educate and support staff.

Similar support and education services required for community-based health staff.

Improve co-ordination between all groups. Facilitate local networks of services. Rationalisation of duplication.

2. Williams, E.S. Australian Royal Commission on Alcoholism; 1980, Book C, Parts X-XIII, pp. C57-C71.

No person should be too far geographically removed from:

- (a) Detoxification facilities.
- (b) Narcotic maintenance clinics.
- (c) Long-term residential facilities for those undergoing rehabilitation and requiring intensive physical and psychological care.
- (d) Short-term residential facilities for those requiring care for short periods following detoxification, or when relapse to former drug-using style appears imminent.
- (e) Outpatient rehabilitation facilities.
- (f) Emergency accommodation.
- (g) 24-hour counselling to aid in crisis intervention.
- (h) Family support facilities.
- (i) Information centres/shopfronts to provide information, counselling on drug use and legal advice to drug users and other concerned with drugs.
- (j) Drop-in centres providing open door for entry into any treatment regime. To attract those in early stages of misuse.

- (k) outreach programmes for those unaware of help or unwilling to accept it.

Developmentally Disabled

1. Health Commission. Planning Health Services in the 1980s, 1982, pp. 62-63.

Develop hostels and group homes to provide community-based care.

Establish and expand specialised community assessment and support teams to enable more developmentally disabled to be cared for in their homes.

Develop distinctive services and facilities for developmentally disabled separate from psychiatric facilities. Systematic screening of babies and children for developmental disability, and introduction of early remedial programme.

2. Palmer, G., et al. 'A critical overview of services for the mentally handicapped in Australia', in McIntyre, G. (ed), Preparation for Life, 1981, Sydney, Prentice-Hall, pp. 1-9.

Recommends:

- (a) Decentralisation of residential occupation for the majority of mentally handicapped to community-based hostels.
- (b) Development of regional assessment teams.
- (c) Increased emphasis on community support, early detection and prevention, and decreased emphasis on institutionalisation.
- (d) For those requiring institutionalisation, a greater sharing of responsibility for care and management between educators, psychologists, medical and nursing staff. These responsibilities should be related to specific treatment objectives determined on or prior to admission.
- (e) A review of funding by all levels of government.
- (f) A review of the organisational arrangements for providing services to the mentally handicapped. The review might

consider establishing a co-ordinating and policy office of mental retardation.

3. Similar views are expressed in the following:

Garadus, V., Greenberg, R., and Lockhead. Report of Working Party on Inappropriateness of Residential Care for Mentally Retarded Adults in 5th Schedule Hospitals for the Health Commission of New South Wales. 1980, Health Commission of New South Wales (unpublished).

Cramond, W.A. Plan for the Development of the Mental Health Services of New South Wales. 1980, Health Commission of New South Wales Business Paper.

Dey, J. Forward Plan of Physical Facilities for the Mentally Retarded. 1980, Health Commission of New South Wales Business Paper.

Dey, J. Need to Update Residential Care Provisions for the Intellectually Handicapped. 1981, Health Commission of New South Wales Business Paper.

Health Commission. Integration and Co-ordination of Services for the Developmentally Disabled. 1981.

Dey, J. Care of Intellectually Handicapped in the 1980s. Paper presented at Hosplan Seminar, 15 May 1981.

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

INDUSTRIAL RELATIONS FORUM
22 October 1982

Participants: Approximately 100 people attended.

Issues raised

Below are the points and issues raised at the Industrial Relations Forum. They do not include all points raised by speakers organised for the day. Points often belong in more than one of the key issues categories.

Service Delivery

1. Industrial relations cannot be isolated from service delivery issues.
2. Need for less reliance on institutional care, more on community health.
3. While desirable to move patients to community, need to increase community services before this is done. Commission needs to commit itself.
4. Fifth Schedule staff should not have to go out from hospital and supervise patients living in the community.
5. Transferring patients to the private sector bad. Private sector exists to make profit. If this transfer happens, need to increase monitoring and supervision procedures.
6. Schedule 2 units need to be in grassed, ground floor environments.
7. Schedule 2 units will reduce inequity which now requires some country patients to travel hundreds of kilometres even for acute treatment.

8. Item 4 of terms of reference should be expanded to include developmentally disabled and psychogeriatrics.
9. New South Wales currently has very few residential placements for patients outside hospitals.
10. Increased community psychiatric nursing staff would help prevent patients coming into hospitals.
11. A lot of lonely people with problems better off in institutions. Need to increase resources to institutions first, and then spend money on community care.
12. Institutions have continued to provide care, but community services have failed.
13. Poor Fifth Schedule bed distribution between Regions.
14. Staff/patient ratio inequitable between Regions.
15. The larger the institution, the more impersonal it becomes.
16. The majority of people in psychiatric hospitals are there as there are not adequate facilities in the community.
17. Need policies to monitor chemotherapy levels, housing standards and so on for community treatment.
18. Are large institutions only to become small institutions which in turn will be tacked on to other large institutions, i.e. general hospitals?
19. Innovations by staff at institutions have been decimated by staff and resource cutbacks.
20. Large institutions have been 'catch all' service. Need to set up proximate and specialised services.
21. The structure of the institution is less important than the needs of the people.
22. Who has legal responsibility for patients under various types of service delivery, especially community care?

Manpower and Industrial Relations

1. If Fifth Schedule is to be transferred out of Public Service, need to ensure portability of superannuation and other conditions. Need for common conditions.
2. Low staff levels lead to low staff morale, lead to decreased services, lead to increased patient aggression, lead to increase patient-related injuries lead to increased sick leave.
3. Common conditions between Fifth and Second Schedule a long way off.
4. Moves to smaller units may simply be a move to decrease union power base. As Government can no longer squeeze Schedule 2, are cutting Schedule 5 to cut costs.
5. Need to ensure promotional opportunities and career structure in smaller units, otherwise will have problems attracting staff.
6. Need to employ adequate trained psychiatric nurses in Schedule 2 acute facilities.
7. Need to give assurances to staff on their futures for at least next three-year period.
8. Need to consider increased stress on staff providing community care.
9. Need to consider promotional opportunities in community health.
10. Who will deliver care in Schedule 2 - general or psychiatric nurses?
11. Inquiry needs to develop new perspective on how staffing issues can be addressed.
12. Issue of employing 'second-level care workers' or 'residential care workers'. In reality this means non-nurses. They do not have the expertise needed to provide adequate services.
13. The structure of the nursing service needs to be examined before any changes occur.

14. Hospitals should be able to employ replacement staff provided they stay within budget.
- 15.' Employment of casual staff more acceptable than excessive overtime.
- ¹16. Low staffing levels lead to low job satisfaction.
17. Small institutions lead to raised job satisfaction.
18. Problem of increasing staff in country areas as no one wants to work there.
19. Problem of redundancies amongst ancillary staff in hospitals reduced in size or closed.
- 20, To reduce costs and provide therapy, patients could do a lot of work around the hospital. But industrially, this is problematic.

Management

1. Boards of Directors for Fifth Schedule? Would these allow greater political muscle for psychiatric/developmentally disabled system? Would they act as patient advocates?
2. Need for consultation at all levels - often tremendously difficult to obtain information from regional and head offices.
3. Should management decisions be on moral/religious grounds or professional grounds?

Training and Education

1. Staff shortages have affected student training, including clinical supervision.
2. Second Schedule units not viable as many staff members inadequately trained. Lack of training results in inappropriate transfer of their patients to Schedule 5. They need more clinical experience in training.

3. Transfer of patients to small units or the private sector will take away acute patients from schedule 5 hospitals, leaving students in these hospitals only chronic patients to gain clinical experience from.
4. Can current Schedule 5 staff adapt to new community roles, and roles in smaller units? What stages will they go through?
5. Need to ensure psychiatric trained nurse's certificate retains its value.
6. Need for more in-service training for Schedule 5 staff.
7. Comprehensive Nursing Course should be encouraged.
8. Need to educate community on needs of patients. Perhaps institutions could do this?

Financial

1. If Fifth Schedule functions came under general hospitals, they may be under-resourced, as traditionally hospitals favour high technology, high prestige areas for funding.
2. Whatever changes occur in the system, it will require more money being spent.
3. Basis for deploying resources: least cost or level of return on investments?
4. Cost is not an acceptable basis for determining needs of patients.
5. How should Fifth Schedule be funded in future? Should each hospital be given a block grant, rather than funded separately for different items of expenditure?
6. Need to look at health funds and their roles re different types of service delivery.

Systems

1. Need for consultation at all levels of system, and between system and community.
2. Staff speak for patients and relatives; they are not simply self-interested.
3. Being in Fifth Schedule system, and hence public servants, reduces ability to 'kick up a fuss' and act as patient advocates.
4. Study in Hunter Region (1979) of citizens' attitudes found most would prefer treatment in a general hospital psychiatric ward than a psychiatric hospital.
5. Most people do not want psychiatric patients living near them.
6. Need to consider adverse economic effects on local communities of closures or reductions in size of institutions.
7. Will psychiatric units in general hospitals be 'hidden away', resulting in stigma?
8. Change should occur slowly.
9. Need for public debate on issues raised by Inquiry. Time allowed too short.
10. Need to consider and develop time scales for all proposals - how long will change take?
11. Staff referenda one valuable form of consultation.

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

MANAGEMENT FORUM

16th November 1982 - Westmead Hospital

Participants: Approximately 100 individuals from management within Health Services.

Summary of issues raised

- (i) Consensus that change is necessary, with greater emphasis on decentralised community care.
- (ii) Need to transfer resources from general health services to meet needs in the less attractive areas being reviewed by the Inquiry.
- (iii) Acute services worked well in general hospitals and have promoted earlier intervention, reduced some of the stigma of mental illness and helped to integrate general and mental health services.
- (iv) Availability of health insurance cover stressed in relation to psychiatric units in general hospitals.
- (v) Strong support for (a) decentralising services away from institutions; (b) development of local networks of services; and (c) separation of psychiatric services from developmental disability services.
- (vi) Services should focus on Second Schedule hospitals coordinated with other support services and targeted for a defined population (move towards Area Board concept).
- (vii) Need for increased and continued advocacy for the chronically ill and for the long-term needs of the developmentally disabled.

- (viii) Need for increased and continued advocacy for the chronically ill and for the long-term needs of the developmentally disabled.
- (ix) Importance of providing adequate training for staff (particularly nurses) to enable them to provide services outside institutions.
- (x) Problems of training service providers (e.g. general practitioners) in special needs of clients (e.g. mental illness, particular problems of the aged).

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

FORUM FOR NON-GOVERNMENT ORGANISATIONS AND CONSUMER GROUPS

Tuesday, 7 December 1982 - McKell Building

Developmental Disability Services

Participants: Approximately 40 individuals and organisations.

1. The Inquiry presented a summary of major points made in submissions from non-government organisations and consumer groups.

These included:

- The importance of a developmental ethos rather than medical;
- The importance of care in the 'normal environment';
- The importance of continuity of care;
- The need for a statutory authority or similar organisation to undertake a coordinating, monitoring role;
- Concern by some organisations to 'move' these services out of the health setting altogether;
- The need to provide an integrated network of services;
- The importance of formal opportunities for consumer and non-government organisations to participate in planning and management;
- The need to deinstitutionalise services.

In addition the Inquiry had identified the following issues in relation to the role of consumer and non-government organisations:

- Concern that non-government organisations as providers of residential care may lead to isolation and a paternal stick approach;

Increasing role of non-government organisations as advocates, lobbyists, rather than direct service providers.

2. Summary of issues raised in discussion

- (i) Important to establish mechanisms for on-going involvement of non-government organisations and consumer groups in planning and delivery of government services; growing cynicism about one-off 'consultation' process.
- (ii) Important to negotiate for better access to Commonwealth funds for residential care; "care of the disabled is a national responsibility - should be a national approach".
- (iii) Health base for these services seen as inappropriate - not primarily a 'health' problem - but bulk of resources 'tied up' in health because of historical circumstances. Role of proposed statutory authority seen as important in this respect - coordination of funding and services would lead to gradual development of a more balanced services system.
- (iv) Problems in the current arrangements of Commonwealth assistance. Under Handicapped Person's Assistance Programme non-government organisations need to raise one-fifth of capital and one-half of operating funds. This places enormous pressure on small parent-based groups. Cannot get State assistance directly without jeopardising Commonwealth funds.
- (v) Concern re fragmentation - proliferation of small parent and other community groups - another argument for statutory authority?
- (vi) Need for research into causes and prevention of disabling conditions.
- (vii) Residential services provided by parents' groups are seen as acceptable by parents provided they are fully funded and can therefore provide continuity. However, access can be limited by the nature of the organisation.

- (viii) Importance of consistency of staffing in residential care services - i.e. live-in with other support - not rotating shifts.
- (ix) Importance of separation of care of developmentally disabled from care of mentally ill.
- (x) Permanency of placement - security - seen as primary concern of parents.
- (xi) Study for the Housing Commission on housing needs of single people - identified population of intellectually handicapped people who are homeless, single and rejected.
- (xii) Social and financial benefits of foster-care programmes provided adequate supports are available - recognise that continuity and adequate 'social' staffing less possible in institutions.
- (xiii) Forum run by intellectual handicap groups - stressed that even most profoundly handicapped 'better' if cared for in small facilities (maximum 30 people) .
- (xiv) Need for redistribution - problems of access for country people.
- (xv) Important to recognise that deinstitutionalisation will require increased levels of normal community services - e.g. home-help.
- (xvi) Training for movement into the community - residents should only be rehoused once - training should occur in their own house.
- (xvii) Question of a register of the developmentally disabled:
 - Two levels - local register which includes identifying data useful as a referral/access mechanism;
 - central registers for planning purposes useful, but should not include any identifying data.

- (xviii) Small group homes provide a setting where much greater expression of individual needs and development of individual potential can occur - even for the severely disabled.
- (xix) Need to run two systems in parallel - cannot reduce institutional services until adequate alternatives are developed.
- (xx) Importance of prevention and early intervention - supports to families in their own homes.
- (xxi) Early intervention needs to be free and freely available; increasing role of Education and T.A.F.E. in this area.
- (xxii) Need for guidelines for government relationship with the non-government sector.
- (xxiii) Need for specialised services for emotionally disturbed disabled.
- (xiv) Services for handicapped children in schools - Report on Special Education recommended this be a Health Department responsibility.

INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED

FORUM FOR NON-GOVERNMENT ORGANISATIONS AND CONSUMER GROUPS
Tuesday, 7 December 1982 - McKell Building

Mental Health Services

Participants: Approximately 40 individuals or groups.

1. The Inquiry presented a summary of major points made in submissions from non-government organisations and consumer groups.

These included:

Concern about the effects of deinstitutionalisation without prior increase of community support and treatment services.

The importance of availability of a range of alternatives to hospitalisation, including alternative approaches to treatment, and the potential role of the non-government sector in this area.

The need to provide an integrated network of services.
The importance of formal opportunities for consumer and non-government organisations to participate in planning and management.

2. Summary of Issues Raised in Discussion

- (i) Need for permanent structure for ongoing consultation with the non-government sector.
- (ii) Need for greater co-ordination of Commonwealth-State (and intra-State) funding arrangements.
- (iii) Need for more non-government organisation involvement in provision of residential care service .

- (iv) Need to upgrade/specialise services in psychiatric hospitals -should not be seen as a last resort ('garbage bin mentality').
- (v) Need for stronger organic perspective in assessment, prior to diagnosis; need to educate psychiatrists to understand and acknowledge this perspective.
- (vi) Need for a 'cascade' of services and levels of intervention, with priority to the most disadvantaged identified patients, and to the care of children with emotional problems.
- (vii) Concern about reliance on use of drugs in hospitals - need for better staffing to provide greater programme basis, and for research into alternative treatment modes.
- (viii) Importance of early intervention at times of stress, e.g. workplace-related stress, stress of unemployment.
- (ix) Need for better support of non-government agencies by mental health services.
- (x) Particular problems of mentally ill women - concern re exploitation and abuse.
- (xi) Need for a viable advocacy system in hospitals.
- (xii) Problems of homeless people.
- (xiii) Problems in Commonwealth funding of non-government services.
- (xiv) Need for improvements in patient and relative information.

STAFFING AND COSTING GUIDELINES

1. Community Mental Health Teams (based on Lower North Shore model) .

3 psychiatrists @ \$50,600	\$151,800
1 medical officer @ \$32,581	\$ 32,581
10 nurses @ \$20,936	\$209,630
5 social workers @ \$25,516	\$127,580
4 psychologists @ \$25,315	\$101,260
3 occupational therapists @ \$21,286	\$ 63,858
3 clerical assistants @ \$15,308	\$ 45,924
	\$732,633

Note: - "CairlCost for penalty rates is- included in oncosts - -(added to salaries); penalty loading on model used is 16.86% of base salary used.

Other operating costs:

Cars, beepers, rental -
calculated at: \$ 86,540

Total per team: \$819,903 per annum

40-Bed Acute Admission Ward - Fifth Schedule Hospital

5 medical, e.g. 2 psychiatrists (staff specialists)
3 registrars
21 nursing, plus 1 activities nurse
3 ancillary (1 social worker, 1 psychologist, 1 occupational therapist)
2 domestics

40-Bed Acute Admissions Unit - second and Third Schedule Hospital

5 medical, e.g. 2 psychiatrists
3 registrars (may be 3 psychiatrists and 1 registrars,
e.g. Banks House)

26 nursing, plus 1 activities nurse (includes 2 domestic nurses)
3 ancillary (1 social worker, 1 psychologist, 1 occupational
therapist)
2 domestics

Note: Nursing rostered as follows:

6 on 'A' shift
5 on 'B' shift
3 on 'C' shift
May include general student nurses.

Mental Health Team (Illawarra)

2 medical (1 psychiatrist, 1 medical officer)
4 nur in (3 psychiatric nurses, 1 ward orderly)
4 ancillary (2 social workers, 1 occupational therapist,
1 psychologist)
1 clerical assistant, administration (medical secretary)

Child Psychiatry Team

1 psychiatrist
5 ancillary (3 social workers, 2 psychologists)

2. Developmental Disability Community Residential Units

Staff patterns for Resident Groupings (weekly) - six persons
per group.

1:1 Maximum Assistance (Children)

(.,.0 1.4 houseparents (24-hour shifts) - 'live-in'
FTE 4.6 workers (8-hour shifts) - 'rostered'
(1 of above to be supervisor)
(3 x 1, 3 x 0.4, 1 x 0.4)

1:2 Moderate Assistance (Children)
4.2 1.4 houseparents (24-hour shifts)
FTE 2.8 workers (8-hour shifts)
(1 to be supervisor)

1:3 Minimal Assistance (Children)

3.2 1.4 houseparents (24-hour shifts)
FTE 1.8 workers (8-hour shifts)
(1 to be supervisor)

1:4 Maximum Assistance (Adults)

6.0 1.4 houseparents (24-hour shifts)
FTE 4.6 workers (8-hour shifts)
(1 to be supervisor)

1:5 Moderate Assistance (Adults)

4.2 1.4 houseparents (24-hour shifts)
FTE 2.8 workers (8-hour shifts)
(1 to be supervisor)

1:6 Minimal Assistance (Adults)

3.2 1.4 houseparents (24-hour shifts)
FTE 1.8 workers (8-hour shifts)
(1 to be supervisor)

Note: Plus additional staff hours as required (individual resident needs), plus holiday cover.

Add-on Holiday Cover (6 weeks)

1:1 1.6 houseparents (24-hour shifts)
5.2 workers (8-hour shifts)
6.8 (1 to be supervisor)
FTE

1:2 1.6 houseparents (24-hour shifts)

3.2 workers (8-hour shifts)
 4.8 (1 to be supervisor)
 FTE

1:3 1.6 houseparents (24-hour shifts)
 2.0 workers (8-hour shifts)
 3.6 (1 to be supervisor)
 FTE

Average of above: 5.07, i.e. 5.1 per residence

$$(1400-7-6) \quad 233.33$$

$$233.33 \times 5.1 = 1,188$$

Additional relief (behavioural disturbances):

$$= 0.33 \text{ per residence}$$

Total: 5.1 per residence

$$+ 0.33$$

5.43 per residence

Say 5.4 (7.13, 5.13, 3.93) + 0.3 relief.

1st Model

1.6 x \$16,575	\$26,520
5.5 x \$15,450	\$84,975
Total:	
7.1 \$15,704 (average)	\$111,495
Including 20% oncosts:	\$139,370

2nd Model

1.6 x \$16,575	\$26,520
3.5 x \$15,450	\$54,075
Total:	
5.1 \$15,803 (average)	\$80,595
Including 20% oncosts:	\$100,745

3rd Model

1.6 x \$16,575 \$26,520

2.3 x \$15,450 \$35,535

Total:

3.9 \$15,911 (average) \$62,055

Including 20% oncosts: \$ 77,570

Average of Models 1, 2, 3: \$105,895

Costs Without Contingency

1st Model (Maximum Live-in Supervision)

1.6 x \$16,575 \$26,520

5.2 x \$15,450 \$80,340

Total:

6.8 \$15,715 (average) \$106,860

Including 20% oncosts: \$133,575

2nd Model (Medium Live-in Supervision)

1.6 x \$16,575 \$26,520

3.2 x \$15,450 \$49,440

Total:

4.8 \$15,825 (average) \$75,960

Including 20% oncosts: \$ 94,950

-0. Model (Minimum Live-in Supervision)

1.6 x \$16,575 \$26,520

2.0 x \$15,450 \$30,900

3.6 \$15,950 (average) \$57,420

Including 20% oncosts: \$ 71,775

-Average of Models 1, 2, 3: \$100,100

STAFFING COSTS (JANUARY 1983)

Classification	'Average' Rate of Pay Weekly Annual		On-Costs	
			Hospital	Community Health
Student Nurse	\$206.00	\$10,741	30% \$13,963	20% \$12,889
Enrolled Nurse Aide	\$243.70	\$12,707	30% \$16,519	20% \$15,248
Registered Nurse	\$300.80	\$15,685	30% \$20,390	20% \$18,822
Charge Nurse	\$365.40	\$19,053	20% \$22,863	20% \$22,863
Supervisor	\$406.80	\$21,212	20% \$25,454	20% \$25,454
Community Nurse, Gde. 1	\$334.60	\$17,447	20% \$20,936	20% \$20,936
Community Nurse, Gde. 3 Senior	\$385.40	\$20,096	20% \$24,115	20% \$24,115
Hospital Asst., Gde. 1	\$246.60	\$12,858	25% \$16,072	20% \$15,429
Medical Officer		\$28,331	25% \$35,413	
Registrar		\$28,000	50% \$42,000	
Specialist		\$44,000	15% \$50,600	15% \$50,600
Psychologist		\$21,096	15% \$24,260	20% \$25,315
Social. Worker		\$21,264	15% \$24,453	20% \$25,516
Occupational Therapist	\$340.20	\$17,739	15% \$20,399	20% \$21,286
Physiotherapist	\$340.20	\$17,739	15% \$20,399	20% \$21,286
Speech Pathologist	\$345.50	\$18,026	15% \$20,729	20% \$21,631
Social Educator		\$22,246	15% \$25,582	20% \$26,695
Cook	\$268.20	\$13,985	25% \$17,481	15% \$16,082
Clerical Asst./Typist	\$255.30	\$13,312	15% \$15,308	15% \$15,308
Maintenance Staff (Tradesmen)	\$308.40	\$16,081	15% \$18,493	15% \$18,493

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

DEVELOPMENTAL DISABILITY HOSPITALS

1979/80 STATISTICS

	GROSVENOR	MARSDEN	STOCKTON	PEAT ISLAND	COLLAROY	TOTAL	Notes
Bed Days	26,594	146,012	297,719	60,190	18,261	548,776	a
Available Beds	86	476	877	174	60	1,673	b
Daily Average	72.7	398.9	813.4	164.5	49.9	1,499.4	c ₁
Occupancy Rate %	84.5	83.8	92.8	94.5	83.2	89.6	d
Number of Nurses	75	317	467	76	45	980	e
Cost of Nursing Staff	\$1,053,788	\$4,323,094	\$ 5,674,069	\$1,075,993	\$554,480	\$12,681,424	f
Number of Clinical Staff	90	354	490	79	47	1,060	e, g
Cost of Clinical Staff	\$1,358,665	\$4,889,738	\$ 6,082,247	\$1,188,405	\$565,948	\$14,085,003	f
Number of Non-Clinical Staff	46	187.5	326	77	21	657.5	e, h
Cost of Non-Clinical Staff	\$ 519,694	\$2,073,808	\$ 3,453,191	\$ 825,223	\$248,565	\$ 7,120,481	f
Total Staff	136	541.5	816	156	68	1,717.5	e
Total Staff Cost	\$1,878,359	\$6,963,546	\$ 9,535,438	\$2,013,628	\$814,513	\$21,205,484	f
Gross Operating Payments	\$2,205,307	\$8,457,805	\$11,425,484	\$2,554,352	\$989,644	\$25,632,592	i

Source: Annual Returns

TABLE ONE

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

DEVELOPMENTAL DISABILITY HOSPITALS

1980/81 STATISTICS

	GROSVENOR	MARSDEN	STOCKTON	PEAT ISLAND	COLLAROY	TOTAL	Notes
Bed Days	27,228	146,043	285,531	58,727	18,497	536,026	a
Available Beds	86	474	871	174	54	1,659	b
Daily Average	74.6	400.1	782.3	160.9	50.7	1,468.6	c ₂
Occupancy Rate %	86.7	84.4	89.8	92.5	93.8	88.5	d
Number of Nurses	66	336.5	505	73	43	1,023.5	e
Cost of Nursing Staff	\$1,109,716	\$5,037,968	\$ 6,906,774	\$1,276,264	\$ 660,526	\$14,991,248	f
Number of Clinical Staff	81.5	374	527	76	45	1,103.5	e, g
Cost of Clinical Staff	\$1,473,547	\$5,603,079	\$ 7,375,211	\$1,436,058	\$ 672,378	\$16,560,273	
Number of Non-Clinical Staff	49	196	335	76	20	676	e, h
Cost of Non-Clinical Staff	\$ 570,708	\$2,375,878	\$ 3,935,465	\$ 930,931	\$ 248,395	\$ 8,061,377	
Total Staff	130.5	570	862	152	65	1,779.5	
Total Staff Cost	\$2,044,255	\$7,978,957	\$11,310,676	\$2,366,989	\$ 920,773	\$24,621,650	
Gross Operating Payments	\$2,430,363	\$9,616,766	\$13,496,719	52,994,098	\$1,143,680	\$29,681,626	

Source: Annual Returns

TABLE TWO.

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA
DEVELOPMENTAL DISABILITY HOSPITALS
1981/82 STATISTICS

	GROSVENOR	MARSDEN	STOCKTON	PEAT ISLAND	COLLAROY	TOTAL	Notes
Bed Days	25,381	138,824	278,517	54,560	18,712	515,994	a
Available Beds	86	443	844	174	54	1,601	b
Daily Average	69.5	380.3	763.1	149.5	51.3	1,413.7	c ₂
Occupancy Rate %	80.9	85.9	90.4	85.9	94.9	88.3	
Number of Nurses	72.5	322	502.5	74	41.5	1,012.5	
Cost of Nursing Staff	\$1,369,692	\$ 6,401,972	\$ 8,753,702	\$1,623,290	\$ 749,681	\$18,898,337	
Number of Clinical Staff	84.5	359.5	521.5	77.5	42.5	1,085.5	e, g
Cost of Clinical Staff	\$1,773,592	\$ 7,106,921	\$ 9,296,400	\$1,758,711	\$ 765,939	\$20,701,563	f
Number of Non-Clinical Staff	43	181	332	67	19	642	e, h
Cost of Non-Clinical Staff	\$ 642,048	\$ 2,629,737	\$ 4,413,992	\$1,045,236	\$ 292,691	\$ 9,023,704	
Total Staff	127.5	540.5	853.5	144.5	61.5	1,727.5	
Total Staff Cost	\$2,415,640	\$ 9,736,658	\$13,710,392	\$2,803,947	\$1,058,630	\$29,725,267	
Gross Operating Payments	\$2,816,448	\$11,515,497	\$16,201,624	\$3,453,816	\$1,268,448	\$35,255,833	

Source: Annual Returns

TABLE THREE

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

APPROVED NURSING HOMES

1979/80 STATISTICS

	ALLANDALE	GARRAWARRA	LIDCOMBE (NON-RECOGNISED)	STRICKLAND	TOTAL	Notes
Bed Days	191,701	117,612	104,926	28,033	442,272	a
Available Beds	536	331	330	108	1,305	b
Daily Average	523.8	321.3	286.7	76.6	1,208.4	c
Occupancy Rate %	97.7	97.1	86.9	70.9	92.6	d
Number of Nurses	269	152.5	141	31	593.5	
Cost of Nursing Staff	\$3,403,162	\$1,938,606	\$2,066,010	\$406,173	\$ 7,813,951	f
Number of Clinical Staff	279	172.5	147	32	630.5	e, g
Cost of Clinical Staff	\$3,641,917	\$2,241,717	\$2,153,284	\$417,424	\$ 8,454,342	f
Number of Non-Clinical Staff	192	117	99.5	23.5	432	e, h
Cost of Non-Clinical Staff	\$2,081,659	\$1,343,988	\$1,264,863	\$259,025	\$ 4,949,535	f
Total Staff	471	289.5	246.5	55.5	1,062.5	
Total Staff Cost	\$5,723,576	\$3,585,705	\$3,418,147	\$676,449	\$13,403,877	f
Gross Operating Payments	\$6,947,876	\$4,507,412	\$4,253,383	\$866,087	\$16,574,758	

Source: Annual Returns

TABLE FOUR

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

APPROVED NURSING HOMES

1980/81 STATISTICS

	ALLANDALE	GARRAWARRA	LIDCOMBE (NON-RECOGNISED)	STRICKLAND	TOTAL	Notes
Bed Days	185,139	118,425	99,673	29,296	435,533	a
Available Beds	536	331	310	108	1,285	b
Daily Average	507.2	324.5	273.1	80.3	1,193.2	c
Occupancy Rate %	94.6	98.0	88.1	74.3	92.9	d
Number of Nurses	263	154.5	127	36	580.5	
Cost of Nursing Staff	\$3,970,352	\$2,135,657	\$2,509,614	\$ 468,426	\$ 9,084,049	
Number of Clinical Staff	273	174.5	132	37	616.5	e, g
Cost of Clinical Staff	\$4,245,390	\$2,461,091	\$2,624,983	\$ 479,142	\$ 9,810,606	
Number of Non-Clinical Staff	190	123.5	111	28	452.5	e, h
Cost of Non-Clinical Staff	\$2,386,917	\$1,556,628	\$1,423,289	\$ 379,095	\$ 5,745,929	
Total Staff	463	298	243	65	1,069	
Total Staff Cost	\$6,632,307	\$4,017,719	\$4,048,272	\$ 858,237	\$15,556,535	
Gross Operating Payments	\$8,174,990	\$5,198,650	\$5,110,360	\$1,141,839	\$19,625,839	

Source: Annual Returns

TABLE FIVE

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

APPROVED NURSING HOMES

1981/82 STATISTICS

	ALLANDALE	GARRAWARRA	LIDCOMBE (NON-RECOGNISED)	STRICKLAND	TOTAL	Notes
Bed Days	167,881	113,391	96,133	32,561	409,966	a
Available Beds	536	331	310	108	1,285	b
Daily Average	459.9	310.7	263.4	89.2	1,123.2	c
Occupancy Rate %	85.8	93.9	85.0	82.6	87.4	d
Number of Nurses	267	166	119	36	588	
Cost of Nursing Staff	\$5,289,521	\$2,932,294	\$2,942,543	\$ 648,095	\$11,812,453	
Number of Clinical Staff	277	185	125	37	624	e, g
Cost of Clinical Staff	\$5,613,274	\$3,335,143	\$3,079,103	\$ 662,843	\$12,690,363	
Number of Non-Clinical Staff	190	126	113	26	455	e, h
Cost of Non-Clinical Staff	\$2,700,586	\$1,845,906	\$1,717,718	\$ 433,106	\$ 6,697,316	
Total Staff	467	311	238	63	1,079	
Total Staff Cost	\$8,313,860	\$5,181,049	\$4,796,821	\$1,095,949	\$19,387,679	
Gross Operating Payments	\$9,789,935	\$6,332,137	\$5,921,041	\$1,334,304	\$23,377,417	

Source: Annual Returns

TABLE SIX

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

PSYCHIATRIC HOSPITALS

1981/82 STATISTICS

	BLOOMFIELD	ROZELLE	GLADESVILLE	KENMORE	MORISSET	NEWCASTLE
Bed Days	192,134	184,642	210,939	202,869	214,916	34,284
Available Beds	665	627	718	596	689	110
Daily Average	526.4	505.9	577.9	555.8	588.8	93.9
Occupancy Rate %	79.2	80.7	80.5	93.3	85.5	85.4
Number of Nurses	313	457	387	290	329	114
Cost of Nursing Staff	\$ 7,139,359	\$ 9,712,286	\$ 8,434,424	\$ 6,246,254	\$ 8,018,127	\$2,553,965
Number of Clinical Staff	330	516	443.5	315.5	352	138
Cost of Clinical Staff	\$ 7,653,783	\$11,572,951	\$ 9,987,179	\$ 6,943,659	\$ 8,696,291	\$3,252,389
Number of Non-Clinical Staff	183.5	361	286.5	215.5	296	74
Cost of Non-Clinical Staff	\$ 2,708,278	\$ 4,761,009	\$ 4,188,533	\$ 3,294,738	\$ 4,160,642	\$1,083,795
Total Staff	513.5	877	730	531	648	212
Total Staff Cost	\$10,362,061	\$16,333,960	\$14,175,712	\$10,238,397	\$12,856,933	\$4,336,184
Gross Operating Payments	\$12,684,682	\$18,664,928	\$16,294,727	\$12,206,361	\$15,216,030	\$5,079,832

Source: Annual Returns

TABLE SEVEN

1981/82 STATISTICS

	MACQUARIE	PARRAMATTA	RYDALMERE	TOMAREE	TOTAL	Notes
Bed Days	108,122	171,020	152,804	20,774	1,492,504	a
Available Beds	374	675	556	72	5,082	b
Daily Average	296.2	468.5	418.6	56.9	4,089.1	c
Occupancy Rate %	79.2	69.4	75.3	79.0	80.5	d
Number of Nurses	317	351	282	5	2,845	
Cost of Nursing Staff	\$ 6,370,456	\$ 7,434,766	\$ 6,536,821	\$143,899	\$ 62,590,357	
Number of Clinical Staff	390	425.5	321.5	5	3,237	e, g
Cost of Clinical Staff	\$ 8,317,908	\$ 9,286,742	\$ 7,866,331	\$143,899	\$ 73,721,132	
Number of Non-Clinical Staff	238	238	231	12.5	2,136	e, h
Cost of Non-Clinical Staff	\$ 3,370,232	\$ 3,468,944	\$ 3,217,431	\$211,085	\$ 30,464,687	
Total Staff	628	663.5	552.5	17.5	5,373	
Total Staff Cost	\$11,688,140	\$12,755,686	\$11,083,762	\$354,984	\$104,185,819	
Gross Operating Payments	\$13,751,122	\$15,110,774	\$12,954,428	\$489,091	\$122,451,975	

Source: Annual Returns

TABLE SEVEN (CONTINUED)

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA

1981/82 CUMULATIVE STATISTICS

	5 D.D.	HOSPITALS	4 NURSING HOMES	10 PSYCHIATRIC HOSPITALS	TOTAL	Notes
Bed Days		515,994	409,966	1,492,504	2,418,464	a
Available Beds		1,601	1,285	5,082	7,968	b
Daily Average		1,413.7	1,123.2	4,089.1	6,625.9	c
Occupancy Rate %		88.3	87.4	80.5	83.2	d
Number of Nurses		1,012.5	588	2,845	4,445.5	e
Cost of Nursing Staff		\$18,898,337	\$11,812,453	\$ 62,590,357	\$ 93,301,147	f
Number of Clinical Staff		1,085.5	624	3,237	4,946.5	e, g
Cost of Clinical Staff		\$20,701,563	\$12,690,363	\$ 73,721,132	\$107,113,058	
Number of Non-Clinical Staff		642	455	2,136	3,233	e, h
Cost of Non-Clinical Staff		\$ 9,023,704	\$ 6,697,316	\$ 30,464,687	\$ 46,185,707	
Total Staff		1,727.5	1,079	5,373	8,179.5	
Total Staff Cost		\$29,725,267	\$19,387,679	\$104,185,819	\$153,298,765	f
Gross Operating Payments		\$35,255,833	\$23,377,417	\$122,451,975	\$181,085,225	

TABLE EIGHT

Notes

- a. Bed Days as indicated on the Part A Annual Return (Statement 2).
- b. Available Beds as indicated on the Part A Annual Return (Statement 1).
- c1. $\text{Daily Average} = \text{Bed Days} / 366$.
- c2. $\text{Daily Average} = \text{Bed Days} / 365$.
- d. $\text{Occupancy Rate} = (\text{Daily Average} * 100) / \text{Available Beds}$.
- e. Number of staff is the actual number employed at 30th June as indicated on the Part A Annual Return (Statement 8). Part-time staff units have been counted as 0.5 of full-time staff units.
- f. Cost of staff is the total of all elements of salaries and wages for the year to 30th June as indicated on the Part A Annual Return (Statement 7).
- g. Clinical staff are defined as:
 - (i) Nursing Services
 - (ii) Medical Support Services
 - (iii) Medical Staff as indicated on the Part A Annual Return (Statement 8).
- h. Non-clinical staff are defined as:
 - (i) General Admin. and Clerical Services
 - (ii) Hotel Services
 - (iii) General Maintenance and Allied Services as indicated in Part A Annual Return (Statement 8).
- i. Gross operating payments for the year to 30th June as indicated in the Part A Annual Return (Statement 6A).

FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA
1981/82 Overtime and Sick Leave Analysis for 19 Establishments

	Nurses	Clinical Staff	Non-Clinical Staff	Total Staff	Notes
Number of Staff	4,445.5	4,946.5	3,233	8,179	a
Cost of staff	\$93,301,147	\$107,113,058	\$46,185,707	\$153,298,765	
Cost of Overtime	S 8,626,816	\$ 8,650,866	\$ 1,484,392	\$ 10,135,358	
Cost of Overtime/Cost of Staff %	9.2	8.1	3.2	6.6	
Days of Sick Leave	65,015	68,273	47,529	115,802	
Sick Leave as Percentage of Available Staffing %	6.6	6.2	6.7	6.4	

Source: Annual Returns

TABLE NINE

Notes

- a. Cumulative numbers of staff, aggregated from the actual number employed at 30th June 1982, as indicated on the Part A Annual Return (Statement 8). Part-time staff units have been counted as 0.5 of full-time staff units.
- b. Cost of staff is the total of all elements of salaries and wages for the year to 30th June 1982 as indicated on the Part A Annual Return (Statement 7).
- c. Cost of overtime is one of the elements of the cost of staff (Statement 7) of the Part A Annual Return.
- d.
$$\frac{\text{Cost of overtime} * 100}{\text{Cost of staff}}$$
- e. Days of sick leave as provided by the former Health Commission of NSW. Data for Lidcombe (Non-Recognised), Strickland and Tomaree not included.
- f.
$$\frac{\text{Sick leave}/230}{\text{Number of staff}}$$
 (Adjusted for exclusions as follows)

	Lidcombe	Strickland	Tomaree	Total
Nurses	119	36	5	160
Clinical Staff	125	37	5	167
Non-Clinical Staff	113	26	12.5	151.5
Total Staff	238	63	17.5	318.5

"MISSIONS AND BED CAPACITY= FIFTH SCHEDULE PSYCHIATRIC HOSPITALS

	Admiss. 1976/77	Bed Capacity June 77	Admiss. 1977/78	Bed Capacity June 78	Admiss. 1978/79	Bed Capacity June 79	Admiss. 1979/80	Bed Capacity June 80	Admiss. 1980/81	Bed Capacity June 81	Admiss. 1981/82	Bedl Capacity June 82	
Bloomfield	641	758	610	716	512	716	546	663	508	665	534	665	
Rozelle	3657	1017	3425	1017	3123	703	3278	652	3251	627	3293	627	
Gladesville	1183	795	1110	792	974	756	978	727	854	726	856	718	
Kenmore	675	748	685	666	599	650	668	648	607	640	600	596	
Morisset	1151	783	954	783	1039	760	1249	724	1223	706	1063	689	
Newcastle	1652	151	1570	140	1629	134	1791	134	1777	134	1664	110	
Macquarie	2032	423	2034	414	1872	386	2214	379	2189	374	2126	374	
Parramatta	2754	742	2536	714	2350	705	2418	705	2121	675	2195	675	
Rydalmere	1120	616	1160	566	1105	558	1449	568	1504	556	1212	556	
Tomaree	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	924	72	924	72	82	72	
TOTAL (excluding Tomaree	14865	6033	14084	5808	13203	5368	14591	5200	14034	5103	13543	5010	
% Change from Previous Year	0.0	0.0	-15.3	-13.7	-6.3	-17.6	4.1	10.5	-3.1	-13.8	-1.9	-13.5	-11.8
Source: Annual Returns						Including Tomaree	15515	5272	14958	5175	13625	5082	
1. Bed capacity: refers to available beds							4-117.5	--11.8	--13.6	-11.8	-18.9	-11.8	

TABLE ONE

ADMISSIONS AND BED CAPACITY - FIFTH SCHEDULE MENTAL RETARDATION HOSPITALS

	Admiss. 1976/77	Bed Capacity June 77	Admiss. 1977/78	Bed Capacity June 78	Admiss. 1978/79	Bed Capacity June 79	Admiss. 1979/80	Bed Capacity June 80	Admiss. 1980/81	Bed Capacity June 81	Admiss. 1981/82	Bed Capacity June 82
Grosvenor	224	140	163	86	130	92	185	86	167	86	91	86
Marsden	193	484	218	476	188	476	322	476	368	474	465	443
Peat Island	309	196	395	174	388	174	334	174	280	174	75	174
Stockton	105	910	132	902	139	902	138	877	53	871	41	844
Collaroy	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	63	60	63	54	107	54
TOTAL	831	1730	908	1646	845	1644	1042	1673	931	1659	779	1601
% Change from Previous Year	0.0	0.0	+0.3		-16.9	-0.1	+ 23.3	4-11.8			--116.31	
Source: Annual Returns						Exluding Collaroy	976 4115.5	1613 H1.9	868 -116.7	1605 -4.1	672 -22.6	1547 - .3.6

TABLE TWO

ADMISSIONS AND BED CAPACITY - FIFTH SCHEDULE APPROVED NURSING HOMES

	Admiss. 1979/80	Bed Capacity June 80	Admiss. 1980/81	Bed Capacity June 81	Admiss./ 1981/82	Bed' Capacity June 82
Allandale	311	536	313	536	243	536
Gprrawarra	243	331	249	331	214	331
Lidcombe (non-recog.)	324	330	408	310	409	310
Strickland	237	108	286	108	233	108
TOTAL	1115	1305	1256	1285	1099	1285
% Change from Previous Year	0.0	0.0	442.6	-11.5	-12.5	0.0

Source: Annual Returns

TABLE THREE

ADMISSIONS AND BED CAPACITY - AUTHORISED PRIVATE HOSPITALS

	Admiss. 1976/77	Bed Capacity June 77	Admiss. 1977/78	Bed Capacity June 78	Admiss. 1978/79	Bed Capacity June 79	Admiss. 1979/80	Bed Capacity June 80	Admiss. 1980/81	Bed Capacity June 81
Evesham Clinic	499	42	740	42	699	42	644	42	628	42
Mt. St. Margaret Northside	624	148	772	149	735	161	793	169	697	150,
Clinic	1320	99	1383	98	1543	98	1518	98	1504	98
St. John of God Sydney Clinic	758	95	800	95	1007	95	1019	95	1001	95
Chatswood	519	20	472	20	565	20	552	20	542	20
Sydney Clinic, Waverley	608	44	1081	44	812	44	998	44	698	44
TOTAL	4328	348	5248	447	5361	460	5524	468	5070	449
% Change from Previous Year	0.0	0.0	+121.3	1-128.4	+12.2	+12.9	+13.0	4-4.7	-p.2	14.1

Source: Annual Returns

TABLE FOUR

BED CAPACITY - GAZETTED SECOND SCHEDULE HOSPITAL PSYCHIATRIC UNITS

		Admiss. 1976/77	Bed Capacity June 77	Admiss. 1977/78	Bed Capacity June 78	Admiss. 1973/79	Bed Capacity June 79	Admiss. 1979/80	Bed Capacity June 80	Admiss. 1980/81	Bed Capacity June 81
∞ 1.	Palmerston Unit, Hornsby Banks House	411	30	461	29	337	23	302	24	334	24
	Bankstown Macquarie Clinic, Liverpool	136	40	636	40	492	40	550	40	415	34
	Ward 20 Wollongong Robinson House	598	40	1038	40	769	40	1477	40	1267	40
	Wagga Wagga Richmond Clinic	803	30	804	30	734	30	748	30	740	28
	Lismore Caritas, St. Vincents	310	23	282	23	260	23	215	23	233	23
		629	25	782	23	674	23	878	23	799	26
		N.A.	37	644	36	811	36	837	36	865	36
		commenced Aug. '76									
	P.O.W. Unit	N.A.	40	594	40	658	40	766	39	714	39
		commenced Feb. '77									
	Prince Henry Unit Albury Base	N.A. N.A.	N.A. N.A.	N.A. N.A.	N.A. N.A.	554 N.A.	51 N.A.	572 N.A.	51 N.A.	633 296	50 12
TOTAL		2887	265	5241	261	5289	306	6345	306	6296	312
% change from previous year		0.0	0.0	+81.5	-1.5	+0.9	+17.2	+20.0	0.0	-0.8	+2.0

Source: Annual Returns and Inquiry's Investigations

MA70R FIFTH SCHEDULE PSYCHIATRIC AND AUTHORISED PRIVATE HOSPITALS
MISSIONS FOR PRINCIPAL DIAGNOSIS PSYCHIATRIC (1980)

	1	7	I	I	I		4
	Prior Admissions 1980	Prior Admissions Previous Year	Total Readmissions	Total Readmissions as Percentage all admissions	First Admissions	TOTAL	
Rozelle	530	631	1161	73.5	418	1579	
Gladesville	262	283	545	79.0	145	690	
Macquarie	281	300	581	61.7	361	942	
Parramatta	405	468	873	64.2	486	1359	
Rydalmere	414	262	676	79.9	170	846	
Bloomfield	56	146	202	53.4	176	378	
Kenmore	199	175	374	62.4	225	599	
Morisset	174	118	292	65.8	152	444	
Newcastle	163	179	342	70.4	144	486	
Auth. Priv.	2115	786	2901	73.3	1056	3957	
	4	4.	4	73.3	1	1	
TOTAL	4599	3348	7947	73.3	3333	11280	
1	4		1	70.5	1	1	
40.8		29.7	1	70.5	1	1	

Source: Morbidity Collection (1980)

TABLE ONE

MAJOR FIFTH SCHEDULE PSYCHIATRIC AND AUTHORISED PRIVATE HOSPITALS.
READMISSIONS FOR PRINCIPAL DIAGNOSIS DRUG_I1980)

Prior 1980	Admissions	j	Prior Admissions Previous Year	Total Readmissions	Total Readmissions as Percentage all Admissions	First Admissions	TOTAL
----- 4			----- 1				
Rozelle	53		82	135	56.3	105	240
Gladesville	5		4	9	64.3	5	14
Macquarie	18		18	36	64.3	20	56
Parramatta	61		67	128	50.0	128	256
Rydalmere	28		27	55	76.4	17	72
Bloomfield	1		0	1	8.3	11	12
Kenmore	2		1	3	50.0	3	6
Morisset	11		9	20	48.8	21	41
Newcastle	3		7	10	52.6	9	19
Auth. Priv.	57		42	99	63.5	57	156
----- 1		1		7			-----
TOTAL	239	257		496		376	872
-4	27.4	29.5	+ 1	r -	56.9	-4 43.1	100.0
		1					

Source: Morbidity Collection (1980)

TABLE TWO

FIFTH SCHEDULE PSYCHIATRIC AND AUTHORISED PRIVATE HOSPITALS
READMISSIONS FOR PRINCIPAL DIAGNOSIS ALCOHOLISM 11980)

	I Prior	Admission 1980	Prior Admissions Previous Year	Total Readmissions	Total Readmission as Percentage all Admissions	I j First Admissions	TOTAL
Rozelle		196	304	500	61.4	314	814
Gladesville		18	33	51	68.9	23	74
Macquarie		118	81	199	75.4	65	264
Parramatta		203	147	350	73.7	125	475
Rydalmere		120	56	176	85.9	29	205
Bloomfield		30	64	94	66.2	48	142
Kenmore		29	44	73	61.9	45	118
Morisset		159	106	265	71.8	104	369
Newcastle		109	85	194	74.3	67	261
Auth. Priv.			150	284	58.8	199	483
		134					
TOTAL		1116	1070	2186		1019	3205
	34.8		33.4	I	68.2	31.8	100.0
	I			1	L	L	JL

Source: Morbidity Collection (1980)

TABLE TBREEh

MAJOR FIFTH SCHEDULE PSYCHIATRIC AND AUTHORISED PRIVATE HOSPITALS
 READMISSIONS FOR PRINCIPAL DIAGNOSIS MENTAL RETARDATION (1980)

00

	Prior Admissions 1980	Prior Admissions Previous Year	Total Readmissions	Total Readmission As Percentage All Admissions	First Admissions	TOTAL
-----		-----	-----	-----		
Rozelle	23	22	45	71.4	18	63
Gladesville	56	19	75	90.4	8	83
Macquarie	25	14	39	67.2	19	58
Parramatta	26	25	51	78.5	14	65
Rydalmere	99	38	137	86.7	21	158
Bloomfield	12	38	50	64.9	27	77
Kenmore	36	11	47	75.8	15	62
Morisset	59	28	87	74.4	30	117
Newcastle	3	10	13	86.7	2	15
Auth. Priv.	13	4	17	85.0	3	20
TOTAL	352	209	561		157	718
-----	49.0	29.1		78.1	21.9	100.0

Source: Morbidity Collection (1980)

TABLE-FOUR;

TOTAL FOR READMISSIONS 11980)

Prior	Admissions 1980	Prior Previous Year 7	Admissions T	Total Readmissions r	Total Readmission as Percentage all Admissions r	First Admissions	TOTAL
Rozelle	802		1039	1841	68.3	855	2696
Gladesville	341		339	680	79.0	181	861
Macquarie	442		413	855	64.8	465	1320
Parramatta	695		707	1402	65.1	753	2155
Rydalmere	661		383	1044	81.5	237	1281
Bloomfield	99		248	347	57.0	262	609
Kenmore	266		231	497	63.3	288	785
Morisset	403		261	664	68.4	307	971
Newcastle	278		281	559	71.6	222	781
Auth. Private	2319		982	3301	71.5	1315	4616
TOTAL	6306		4884	11,190	69.6	4885	16,075
Total Excluding Auth. Private	3987		3902	7889	69.6	3570	11,459
% Excluding Auth. Private	34.8	6	8	8	69.6		100.0
Source: Mor	Collection	(1980)					

TABLE FIVE

COST OF IMPLEMENTING THE FINAL 1979 STAFF REVIEW REPORT

	(1) Actual Salaries and Wages 1981/82 (1981/82 Costs) SM	(2) Initial Salaries and Wages Allocation July 1982 SM	(2) Budget Salaries and Wages Allocation October 1982 SM	Salaries and (3) Wages Costs to Implement 1979 Staff Review (Oct 82 costs) SM	Difference Between Budget Allocation and 1979 Review SM
HOSPITAL					
Peat Island	2.8	2.9	2.8	3.1	. 0.3
Newcastle Psych.	4.3	4.4	4.0	4.3	+ 0.3
Stockton	13.7	13.7	13.6	13.6	0.0
Rydalmere	11.1	10.8	10.6	12.6	+ 2.0
Grosvenor	2.4	2.2	2.1	2.9	+ 0.8
Kenmore	10.2	10.0	9.5	10.4	+ 0.9
Rozelle	16.3	16.4	15.9	15.3	- 0.5
Macquarie	11.7	11.9	11.1	11.9	+ 0.8
Morisset	12.9	12.8	12.8	15.0	+ 2.2
Bloomfield	10.4	10.0	9.7	9.7	0.0
Collaroy	1.1	1.1	1.0	1.4	+ 0.4
Parramatta	12.8	12.3	12.1	12.4	+ 0.3
Marsden	9.7	9.5	9.3	9.9	+ 0.6
Strickland	1.1	1.2	1.1	1.1	0.0
Garrawarra	5.2	4.9	4.9	5.9	+ 1.0

HOSPITAL	Salaries 1981/82 (1981/82	dal (1) Nages Costs)	Initial Salaries and Wages Allocation July 1982	(2)	Budget Salaries Wages A October
	\$m		\$m		\$M
Allendale	8.3		8.3		7.9
Lidcombe (R and N.R.)	21.9		21.3		21.5
Gladesville	14.2		14.0		13.1
Tomaree	0.4		0.4		0.1
TOTAL	170.5		168.1		163.6

CO
1/40

1. Annual returns costs not adjusted to October, 1982 levels.

2. Finance sections, Regional OfficeS.i

3. Adjusted to include supernumary! staff at the hospitals at June, 1982.
Excludes overtime, but includes all other staff on-costs.
Calculated using October, 1982 salary and wage levels, and allowing 5% awa
Does not include the 131 extraneous nursing and 36 extraneous appren

**INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALY ILL
AND DEVELOPMENTALLY DISABLED**

RETURN TO
DEPT. OF HEALTH
N.S.W.
LIBRARY

**SUMMARY OF
RECOMMENDATIONS**

Part 6



362.2
NHDL 22
V. 6 C. 1

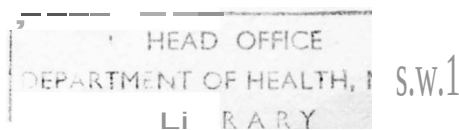
MARCH 1983

PART 1 GENERAL PROPOSALS

The following recommendations arise from Part 1:

1. That services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required.
(refer to Section 5)
2. That the two prime operational objectives be to -
 - (i) fund and/or provide services which maintain clients in their normal community environment and
 - (ii) progressively reduce the size and the number of existing Fifth Schedule hospitals by decentralising the services they provide. (5)
3. That services for the developmentally disabled, as far as possible, be funded separately and services delivered under separate management from mental health services and

that priorities for funding in developmental disability be -
 - (i) provision of additional community services staff to provide diagnostic assessment, early intervention and home support services
 - (ii) development of small community residential units to re-house residents from existing institutions
 - (iii) development of small community residential units particularly for adults unable to continue living with their families;



(iv) provision of opportunities for training of existing Fifth Schedule hospital staff for new roles in community services. (5)

4. That priorities for funding in mental health be -

- (i) provision of additional community based crisis teams;
- (ii) provision of staffing to provide adequate follow up for mentally ill people in the community;
- (iii) provision of psychiatric staff for assessment services in general hospitals;
- (iv) provision of linked networks of hostels and satellite housing;
- (v) provision for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services. (5)

5. That the current direct provision of services for the mentally ill, developmentally disabled and the aged through Fifth Schedule hospitals and community health services be transferred from the direct administration of the Department of Health and provided instead under the management of Boards of Directors, in the form of either an Area Board, a newly created Board for a particular specialised service, or the reconstituted Board of an existing public hospital as appropriate to particular services or locations as proposed in this Report. (7)

6. That staff presently employed in the provision of these services in Fifth Schedule hospitals and community health services be transferred from the provisions of the Public Service Act, 1979, on the basis and conditions provided for in Schedule Three of the Health Administration Act, 1982, to become employees of the above Boards. (7)

7. That staff commencing employment in these areas in future receive salary and other employment conditions applicable to staff employed under the current Second and Third Schedules of the Public Hospitals Act. (7,8)
8. That membership of existing and proposed Boards of Directors encompass representation reflecting the range of client interests of the services covered by this Report and that the size of existing hospital boards be expanded, where appropriate, to achieve this end. (7)
9. That provision be progressively made for elected representation from employees on all Hospital and other Boards. (8)
10. That the Department of Health and the Public Service Board establish a Task Force to implement Recommendations 5 and 6 in consultation with the Labor Council of New South Wales. (11)
11. That these services be managed through a management structure based on -
 - administration by a Chief/Area Executive Officer;
 - a global and incentive budget system as proposed by the Parliamentary Public Accounts Committee rather than a staff number and establishment control. (7)
12. That as a priority the Health Department develop a programme budgeting approach to the funding of these areas of health care in order to monitor the level of resources utilised for particular programmes or client groups. (7)

13. That in funding of health services generally a higher priority for the next three years be given to the provision of improved services to meet mental health needs and those of the developmentally disabled. (7)
14. That the distinction in current New South Wales Government budget allocations between "recognised" and "non recognised" hospitals be eliminated to provide for a total allocation to the Minister for Health. (7)
15. That for each of the next three years an amount of half of one percent per annum (approximately \$9 million per annum} of these funds be "earmarked" for specific purpose funding of the new services proposed by this Report which are necessary to provide adequate community based support and to facilitate reduction in the size of the existing institutions, including priority projects in deficit Regions. (7)
16. That a specific budget (commencing with \$1.7 million in 1983/84) be allocated to fund community non-profit organisations to provide supportive accommodation and innovative services. These funds, separately earmarked for mental health and developmental disability services, to be provided from Recommendation 15 above, and by redirection of existing health funding of non-government organisations. (7)
17. That as savings are achieved from the rationalisation and reduction of existing hospitals, these savings be committed to the development of community services. (7)

18. That from 1984/85, these savings be progressively used to fund the community services proposed by the Inquiry and their future expansion; from 1986/87 these savings to be the major source of funding for such services, replacing the allocation proposed for 1983/84, 1984/85, and 1985/86 in Recommendation 15. (7)
19. That fees policy for long stay patients in specialised psychiatric hospitals be reviewed and that the patient contribution be increased from 66.6 percent to 87.5 percent of the pension to bring this contribution into line with that required by private and deficit financed nursing homes. (7)
20. That subject to "heritage" and environmental considerations land currently unused on the existing sites, or released through the rationalisation programme be released for other purposes and any proceeds realised be available for expansion of community health services. (7).
21. That action be taken to progressively introduce 8-hour shifts to replace 12-hour shifts in the care of the psychiatrically ill and developmentally disabled. (8)
22. That greater emphasis be given to the use of part-time staff to cover excessive workload periods in hospitals (to reduce overtime expenditure and excessive work demands on full time staff). (8)
23. That in the process of transfer of these services to the Second Schedule system a review be undertaken of the number of promotional positions in the specialised hospitals to ensure that adequate numbers are maintained to meet ward management requirements. (8)

24. That a more effective independent grievance procedure be established within the health system to deal with complaints of individual staff against management decisions affecting their employment. (8)
25. That at the level of individual hospital or Area Boards, improved consultative mechanisms be established with the Unions through the upgrading of existing "Welfare" meetings. (8)
26. That in the development of a Single Register Nurse education programme, adequate theoretical and clinical psychiatric nursing content be included, and that the views of experienced psychiatric nurse educators be sought in this regard. (9)
27. That clinical education of psychiatric nurses be provided through an integrated arrangement involving community services, general hospitals and rehabilitation services in specialised hospitals and that the Nurses Registration Board remove existing procedural constraints on this arrangement. (8)
28. That the curriculum of the First-line Management Course be reviewed to produce a refresher course for nurses trained prior to the introduction of the 1000 hour syllabus. (9)
29. That the Department of Health consult with the College of General Practitioners regarding appropriate programmes designed to encourage improved co-ordination between general practitioners and public sector mental health services. (9)

30. That clinical education of psychiatrists be provided through an integrated arrangement involving community services, general hospitals and specialised hospitals, (both public and private) and that the Department, the training bodies, and the College of Psychiatrists review current arrangements in order to achieve this objective.
(9)

PART 2 SERVICES FOR THE DEVELOPMENTALLY DISABLED

1. That the Minister for Health -
- (i) endorse the principle that the provision of services for the developmentally disabled within the health administration should be based on:
 - (a) promotion of maximum development and education of each individual:
 - (b) pursuit of the objectives of normalisation and integration:
 - (c) promotion of the rights of people with disabilities; and
 - (ii) recommend to the government their adoption and application to all areas of government policy relating to the care of the developmentally disabled. (refer to Section 3.2)
3. That the role of health services in the area of developmental disability be endorsed as follows:

(i) Development and implementation of preventive programmes;

(ii) Provision of comprehensive diagnostic/assessment and associated counselling.

(These services should be available to all developmentally disabled children and their families)

(iii) Provision of early intervention programmes (in consultation with the Education Department and the Department of Youth and Community Services to ensure a range of programmes are developed);

(iv) Provision of home support services (in consultation with the Department of Youth and Community Services, the Home Care Service of N.S.W. and Local Government as appropriate);

(v) Development of small community residential units to rehouse residents from existing institutions;

(vi) Development of small community residential units for the severely disabled, particularly the severely intellectually handicapped, and others with severe physical conditions, both children and adults, who are unable to continue living with their families;

(vii) Provision of respite and shared care arrangements within these units;

(viii) Provision of specialised therapeutic services as required;

(ix) Access to general health services for the "routine" physical and mental health needs of the disabled. (5)

3. That an amount of \$200,000 be allocated in 1983/84 from the Hospital Health Promotion Programme for a public education programme on the importance of ante-natal care and the availability of screening and genetic counselling services. (6.1).
4. That from the specific allocation referred to in Part 1 (approximately \$9 million per annum for the next three years), an amount of \$4 million per annum be allocated to developmental disability services. (6.1, 8.1).
5. That \$1.5 million of these funds be allocated per annum to the expansion of diagnostic, assessment and community support services, with priority to the Western Metropolitan, Hunter, South East and Central West Regions in the first year. (6.1, 8.1)
6. That all public hospitals implement a policy to ensure that parents of all handicapped children identified at or soon after birth are automatically given access to counselling and assessment and early intervention services. (6.1)
7. That the Health Department implement a policy that all admissions to health services residential facilities and participation in programmes be dependent on prior assessment and subject to regular review by community assessment services. (6.1)
8. That each Region establish a Residential Placement Committee (6.1).

9. That Regional and local management review the location of work oriented facilities and initiate their relocation to community-based premises. (6.1)
10. That the Department of Health consult with the Department of Social Security regarding the potential expansion of co-operative arrangements in the provision of activity and work-related programmes. (6.1)
11. That the Health Department adopt a long term policy of providing all health care residential services for the developmentally disabled in small residential units (with varying staffing levels depending on particular clients' levels of disability).
12. That in each Region a network of community residential units which would normally be ordinary houses each accommodating from 5-10 people be established to provide both short (including respite) and long term residential care and social and living skills training for developmentally disabled people. (6.2)
13. That from the specific allocation (\$4million per annum) referred to in Recommendation 4, an amount of \$2 million be allocated to Regions to assist in the development (either directly or through non-government organisations) of community residential units to re-house adults currently resident in institutions and those at home urgently in need of placement. (6.2)
14. That priority for the funding of such units in the first year should go to the Hunter, Western Metropolitan, Southern Metropolitan and Northern Metropolitan Regions. (6.2).

15. That initially these services be funded from the total hospital budget and that from 1984/85 resources for this purpose be augmented from savings to be achieved through proposed reductions in the size and number of existing institutions. (6.2)
16. That from the specific allocation (\$4million per annum) referred to in Recommendation 4, an amount of \$500,000 be earmarked for the support of innovative programmes such as supportive accommodation for developmentally disabled women with children ("Women in Limbo" proposal). (6.2)
17. That the Minister for Health, in consultation with the Minister for Youth and Community Services, negotiate with the Minister for Social Security to improve co-ordination of planning and service delivery and to develop proposals for joint Commonwealth/State funding of these services. (6.2)
18. That the Minister for Health negotiate an arrangement with the Minister for Housing whereby a proportion of welfare housing stock in existing and proposed developments is specifically made available as community residential units for developmentally disabled people. (6.2)
19. That within existing hospitals emphasis in client care be based on the implementation of independent living training programmes. Direct care staff to be responsible to the programme staff for programme maintenance and achievement. (6.2)
20. That as resident numbers in existing hospitals decrease, the ratio of direct care staff per resident at Stockton Hospital be gradually increased. (6.2)

21. That Regional Directors negotiate formal contractual arrangements between hospitals and Regions to provide social work, psychology and occupational therapy services, where recruitment difficulties are experienced. (6.2)
 22. That a new category of direct care staff be established -to be titled "Residential Care Assistant". This category to be used in the expansion of community residential units and eventually as direct care staff in hospitals. (7.1)
 23. That the Department of Health negotiate with the Department of Technical and Further Education for the development of an appropriate "apprenticeship-type" educational programme for this category of staff. (7.1)
- That the employment of "Programme Officers" be expanded as a major staff category in community developmental disability teams, and in specialised hospitals. (7.1)
- That the Department of Health negotiate with the appropriate education authorities for the development of a suitable undergraduate or postgraduate programme at College of Advanced Education level for this category of staff. (7.1)
26. That at the appropriate level (Regional or supra Regional) a community based Board of Directors be established with the responsibility for the management of all services within the health administration for the developmentally disabled, both residential and non-residential. Appropriate advisory mechanisms should be established to ensure input from parent and voluntary groups and from local government and the Departments of Youth and Community Services, Education and Social Security. (7.2)

27. That these services be managed by a Chief Executive Officer responsible to the above Board. (7.2)
28. That care of the developmentally disabled in specialised hospital settings should be separated from the care of the psychiatrically ill by the establishment of a distinct management organisation, responsible to the above Boards, and by the degazettal and physical separation of services. (7.2)
29. That the role of the Senior Specialist for Developmental Disability Services in the Central Administration of the Health Department be strengthened by involving him or her to a greater extent in budget decisions affecting provisions of services. (7.2)
30. That the Minister for Health consult with the Attorney-General regarding the development of appropriate guardianship legislation for these clients. (7.4)
31. That the following targets be adopted for the expansion of community residential services recommended above and the reduction of existing institutional services for the developmentally disabled by 1986. (The following targets should be viewed as interim pending the further expansion of community services). (8.2)

Region	FIFTH SCHEDULE HOSPITALS			Community	Target
	Current	Reductions	Target	Residential Target	Total 1986
Western Metropolitan	871	301	570	390	960
Southern Metropolitan	276	244	32	300	332
Northern Metropolitan	316	174	142	150	292
Hunter	1052	382	670	390	1060
South-East	200	100	100	100	200
Central West	198	100	98	100	198
Illawarra				12	12
North Coast				12	12
Orana & Far West				12	12
South-West				12	12
New England					
Total	2913	1301	1612	1478	3090

PART 3 MENTAL HEALTH SERVICES AND SERVICES FOR THE MENTALLY ILL

The following recommendations arise from Part 3:-

1. That as a matter of policy the highest priority in mental health services be the community-based care and rehabilitation of the seriously mentally ill. (refer to Section 3.1)

2. That these services be provided in an integrated manner for each defined catchment area, through the appointment of one person with joint clinical responsibility for the inpatient and community services servicing that catchment area. (3.2)

3. That the Health Department implement a policy that all admissions to public sector psychiatric services be dependent on prior assessment by a community-based assessment team. (3.2)

4. That each Region develop a preventative programme which is tightly defined and targeted at specific client groups or needs. (4.1)

5. That the highest priority in the funding of mental health services be given to the development of adequately staffed community-based assessment, crisis-care and treatment services. (4.1)

6. That from the specific allocation referred to in Part 1 (approximately \$9 million per annum for the next three years), an amount of \$5 million per annum be allocated to mental health services. (5.3 ; 6)

7. That from 1983/84 a specific fund be established (\$1.2 million initially) from these funds for the funding of non-government non-profit organisations to provide supportive and therapeutic hostel and group-home accommodation for the mentally ill, and services for special needs groups. (4)

8. That guidelines be developed to ensure adequate accountability of organisations allocated funding. These guidelines should be developed in consultation with the Department of Youth and Community Services and the Commonwealth Department of Social Security. (4.1)
9. That within this non-government fund an amount of \$400,000 be "earmarked" in 1983/84 for the support of innovative programmes to meet special needs, such as Louisa Lawson House and the Kings Cross Youth Refuge assessment service. (4.1)
10. That the Minister for Health, in consultation with the Minister for Youth and Community Services, negotiate with the Minister for Social Security to improve co-ordination of planning and service delivery and to develop proposals for joint Commonwealth/State funding of these services. (4.1)
11. That the Minister for Health negotiate an arrangement with the Minister for Housing whereby a proportion of welfare housing stock in existing and proposed developments is specifically made available as hostel and group home accommodation for mentally ill people. (4.1)
12. That the Minister for Health explore with the Ministers for Planning and Environment, Housing and Youth and Community Services, potential for implementation of a programme of subsidies to private boarding-houses for housing of people with long-term psychological disabilities. (4.2)
13. That as a matter of policy all acute psychiatric admission services be located in general public hospitals; existing acute admission units and staff in state psychiatric hospitals should be relocated or administratively attached to general public hospitals. (4.1)

14. That all acute psychiatric units in general hospitals be authorised for admissions under the Mental Health Act. (4.1)
15. That in association with Recommendation 13 above, services currently provided in general public hospitals for people with acute psychiatric diagnoses be upgraded through the employment of psychiatric nurses and sessional psychiatrists to provide direct services and a formal consultancy service in accident and emergency departments and in general hospital wards. (4.1)
16. That as psychiatric services in general public hospitals are upgraded these hospitals be authorised for admissions under the Mental Health Act. (4.1)
17. That use of Enrolled Nursing Aides be expanded in the staffing of specialised psychiatric hospitals. (4.1: 5.1)
18. That the Health Department and the Nurses' Registration Board urgently review the curriculum and length of Nursing Aide training with a view to upgrading the psychiatric component. (4.1)
19. That Regional Directors negotiate expansion of arrangements for purchase of social work, psychology, and occupational therapy services between hospitals and regions. (4.1)
20. That services in psychiatric hospitals be made more specialised on the basis of diagnostic groupings and programmes. (4.1)
21. That in staffing to meet clinical needs within available resources, more use be made of sessional arrangements for use of private practitioners. (5.1)

22. That Regional Directors negotiate arrangements for greater use of authorised private psychiatric hospitals for the provision of services for public patients. (4.1)
23. That within hospitals emphasis be placed on rehabilitation programmes developed and monitored by programme staff. Direct care ward staff be responsible to the programme staff for programme maintenance and achievement. (5.1)
24. That the Department of Health approach the College of Nursing to develop a training programme to facilitate the transfer of nurses to community care services. (5.1)
25. That services for children and adolescents (located in community health centres, child health centres or in hospitals) be administered as a specialised network at regional or sub-regional level. (5.2)
26. That Advisory Committees on Child, Adolescent and Family Mental Health be established at regional and state level, including representatives of the Departments of Youth and Community Services and Education. (5.2)
27. That from the specific allocation (\$5 million per annum) referred to in Recommendation 6, an amount of \$3.8 million be allocated to Regions to develop community mental health assessment crisis-care and treatment services necessary to facilitate reduction in the utilisation and size of the existing specialised psychiatric hospitals. Priority to be given to the Western Metropolitan, Hunter, Southern Metropolitan and Illawarra Regions. (5.3)
28. That the existing psychiatric services in the following hospitals be responsible to the Boards of the following hospitals:

Rozelle and Gladesville Hospitals - Royal Prince Alfred Hospital Board (with widened membership to represent psychiatric services)

Parramatta Psychiatric Centre (and services at Rydalmere Hospital until 1985/6) - Parramatta Hospitals Board (with widened membership to represent psychiatric services)

Macquarie Hospital - Royal North Shore Hospital Board (with widened membership to represent psychiatric services)

Newcastle Psychiatric Centre and Morisset Hospital - Regional Psychiatric Board (with teaching hospital representation)

Kenmore Hospital - Area Board for Goulburn

Bloomfield Hospital - Area Board for Orange

29. That the following targets be adopted for the expansion of community services and the relocation of acute admission services, and the reduction in size of specialised psychiatric hospitals:

Region	PSYCHIATRIC HOSPITALS			Target	Target	Target
	Current	Proposed	Proposed	Target	Hostels	Commun-
	Beds	Reduction	Transfer	Beds		ity
						Mental
						Health
						Positions
Western Metropolitan	803	100	100	603	n	56
Southern Metropolitan	1155	305	100	750	o	20
Northern Metropolitan	286		40	246	t	
Hunter	591	241	100	250	s	29
South-East	396	106	40	250	p	10
Central West	467	245	60	162	e	10
Illawarra					c	15
South-West					f	29
Orana & Far West					c	
North Coast					a	29
New England					1	
					1	
					y	
					a	
					1	
					1	
					o	
					c	
					a	
					t	
					e	
					d	
	3698	997	440	2261	500	256

30. That in each specialised psychiatric hospital a migrant health advocate be designated from among the existing staff. (7.1)

PART 4 SERVICES FOR THE DISTURBED AND CONFUSED ELDERLY AND THE
FUTURE ROLE OF STATE NURSING HOMES

The following recommendations arise from Part 4:-

1. That the primary focus of services for the disturbed and confused elderly be based on a multi-disciplinary community oriented geriatric assessment service {refer to Sections 3.2, 4.1}.
2. That these services be provided in an integrated manner through linkages to appropriate area or regional acute health services {including psychiatric services}, day hospital facilities and a range of supportive accommodation facilities (4.1).
3. That the Health Department implement a policy that all admissions of elderly people to public sector psychiatric or nursing home facilities be dependent on prior assessment by a community based geriatric assessment service (4.1).
4. That the Department of Health in conjunction with the relevant educational authorities and professional bodies review the adequacy of training of professionals involved in caring for the disturbed and confused elderly with a view to improving knowledge and understanding of their special needs. (4.2)
5. That the following issues be raised by the Minister for Health with the Commonwealth Ministers for both Health and Social Security:-
 - {i) the need for Commonwealth funding of geriatric assessment services to ensure more appropriate care is provided to confused and disturbed elderly people and to minimise inappropriate private nursing home placements;

(ii) the need to eliminate administrative impediments to the adequate provision of "extensive care" benefits under the National Health Act for those elderly people who require intensive nursing care for non-physical reasons.

(iii) the need to foster the development of alternatives to nursing home accommodation through appropriate Commonwealth funding arrangements (5.2).

6. That in granting approvals for the establishment and/or extension of nursing homes the Department of Health give priority to proposals which provide facilities and programmes for the confused elderly and consider introduction of a requirement of this kind as a condition of licensing. (5.2)

7. That services for the elderly in specialised psychiatric hospital facilities be linked to acute geriatric and psychiatric services provided within the general hospitals to which these specialised facilities will be linked in future and/or to regional geriatric services. (6.1)

8. That existing Fifth Schedule Nursing Homes be transferred to the Second Schedule of the Public Hospital Act and linked to regional or area geriatric services as follows:

Allandale Hospital - initially a separate Board with representation from the Cessnock, Kurri Kurri and Maitland Hospital Boards (subsequently to become part of a regional geriatric service).

Lidcombe Hospital - separate Board.

Garrawarra Hospital- transfer to management of the Board of St. George Hospital.

Strickland House - transfer to management of the Prince Henry/Prince of Wales Board.

9. That the Boards responsible for the management of these services be given the clear responsibility to decentralise and rationalise the accommodation facilities, through the development of smaller community based accommodation, expanded day hospital facilities and improved home care. (6.2)
10. That use of the term "psychogeriatric" to describe the confused or disturbed elderly be discontinued. (1)
11. That the role of David Berry Hospital in geriatric, rehabilitation and long-term care be expanded, and the hospital be linked for management purposes to other health services in the Shoalhaven area, and transferred to the Second Schedule of the Public Hospitals Act. (6.2)

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