INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

PART 1
GENERAL PROPOSALS
PART 1

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INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

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CONTENTS

1. CHAIRMAN'S INTRODUCTION 1

2. TERMS OF REFERENCE 4

3. SUMMARY OF RECOMMENDATIONS 5

4. OVERVIEW OF CURRENT SERVICES 12

5. SERVICE DELIVERY VALUES AND PRINCIPLES 17

6. METHODOLOGY 24

7. FIVE MAJOR INITIATIVES 27
   (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

8. STAFFING AND INDUSTRIAL ISSUES 47

9. TRAINING AND EDUCATION 71

10. COORDINATION WITH OTHER GOVERNMENT SERVICES 79

11. IMPLEMENTATION 80
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. Conoult, 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 ex-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 diagramatically below.

<table>
<thead>
<tr>
<th>Research</th>
<th>Development</th>
<th>Analysis</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation</td>
<td>of</td>
<td>of</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>Values</td>
<td>Specific Proposals</td>
<td></td>
</tr>
<tr>
<td>and</td>
<td>Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Client Input</td>
<td>Principles</td>
<td>Services</td>
<td></td>
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<td></td>
<td></td>
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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:-

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

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:

1. 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.

2. 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.

3. 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:-


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:-

<table>
<thead>
<tr>
<th>Fifth Schedule Hospitals</th>
<th>Public Hospitals</th>
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<tbody>
<tr>
<td>Nurses, State Hospitals and Homes</td>
<td>Health &amp; Research Employees Association</td>
</tr>
<tr>
<td>Psychiatric and Mental Retardation Nurses</td>
<td>Joint coverage of Health &amp; Research Employees Association and N.S.W. Nurses' Association</td>
</tr>
</tbody>
</table>
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.
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 therapeutical 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.