INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

PART 4
SERVICES FOR THE DISTURBED
AND CONFUSED ELDERLY
AND THE FUTURE ROLE
OF STATE NURSING HOMES

MARCH 1983
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1. INTRODUCTION

The care of the aged in general is currently the subject of other reviews at State and Federal level. Part 4 of the Report of the Inquiry, however, addresses itself to the needs of the aged in two respects:

-the needs of elderly people who develop psychiatric symptoms (both functional and organic) and require appropriate care. Many of these people are currently cared for in the State psychiatric hospitals;

-the role and organisation of the State nursing homes (Garrawarra, Allandale, Strickland and Lidcombe) needs to be considered in conjunction with the broader recommendations of the Inquiry.

Neither of these aspects can be considered separately from wider planning for the development of integrated health and welfare services for the elderly. These services attract significant Commonwealth government resources directed largely to the private non-profit and profit sectors.

In this part of the Report, the Inquiry seeks to:

(i) identify the needs of the aged who become disturbed or confused.

(ii) outline some preferred strategies for provision of services for these elderly people.
(iii) suggest issues for consideration in the context of existing Commonwealth - State arrangements for the care of the aged.

(iv) identify appropriate roles for psychiatric hospitals and State nursing homes.

One issue which needs to be stressed at the outset is the inappropriateness of the label "psychogeriatric" used to identify confused or disturbed elderly people. Such a label adds further stigma and may reinforce inappropriate care.
2. RECOMMENDATIONS

The following recommendations arise from Part 4:-

1. That the primary focus of services for the disturbed and confused elderly be based on a multi-disciplinary community oriented geriatric assessment service (refer to Sections 3.2, 4.1).

2. That these services be provided in an integrated manner through linkages to appropriate area or regional acute health services (including psychiatric services), day hospital facilities and a range of supportive accommodation facilities (4.1).

3. That the Health Department implement a policy that all admissions of elderly people to public sector psychiatric or nursing home facilities be dependent on prior assessment by a community based geriatric assessment service (4.1).

4. That the Department of Health in conjunction with the relevant educational authorities and professional bodies review the adequacy of training of professionals involved in caring for the disturbed and confused elderly with a view to improving knowledge and understanding of their special needs. (4.2)

5. That the following issues be raised by the Minister for Health with the Commonwealth Ministers for both Health and Social Security:-

   (i) the need for Commonwealth funding of geriatric assessment services to ensure more appropriate care is provided to confused and disturbed elderly people and to minimise inappropriate private nursing home placements;
(ii) the need to eliminate administrative impediments to the adequate provision of "extensive care" benefits under the National Health Act for those elderly people who require intensive nursing care for non-physical reasons.

(iii) the need to foster the development of alternatives to nursing home accommodation through appropriate Commonwealth funding arrangements (5.2).

6. That in granting approvals for the establishment and/or extension of nursing homes the Department of Health give priority to proposals which provide facilities and programmes for the confused elderly and consider introduction of a requirement of this kind as a condition of licensing. (5.2)

7. That services for the elderly in specialised psychiatric hospital facilities be linked to acute geriatric and psychiatric services provided within the general hospitals to which these specialised facilities will be linked in future and/or to regional geriatric services. (6.1)

8. That existing Fifth Schedule Nursing Homes be transferred to the Second Schedule of the Public Hospital Act and linked to regional or area geriatric services as follows:

   Allandale Hospital - initially a separate Board with representation from the Cessnock, Kurri Kurri and Maitland Hospital Boards (subsequently to become part of a regional geriatric service).

   Lidcombe Hospital - separate Board.

   Garrawarra Hospital - transfer to management of the Board of St. George Hospital.

   Strickland House - transfer to management of the Prince Henry/Prince of Wales Board.
9. That the Boards responsible for the management of these services be given the clear responsibility to decentralise and rationalise the accommodation facilities, through the development of smaller community based accommodation, expanded day hospital facilities and improved home care. (6.2)

10. That use of the term "psychogeriatric" to describe the confused or disturbed elderly be discontinued. (1)

11. That the role of David Berry Hospital in geriatric, rehabilitation and long-term care be expanded, and the hospital be linked for management purposes to other health services in the Shoalhaven area, and transferred to the Second Schedule of the Public Hospitals Act. (6.2)
3. HOW ARE CLIENT NEEDS BEST SERVED?

3.1 What are client needs?

Although the classification has its inadequacies the Inquiry has followed the accepted practice of regarding as aged those people 65 years and over.

"During the next ten years there will probably be an additional 75,000 people in New South Wales over the age of 65, an increase of about 15%. This rate of increase is then expected to slow, but by the year 2000 it is expected that there will be a 20% increase in the aged population as compared to 1981. These increases need to be compared with the much slower rate of growth of the total population which is expected only to rise by approximately 6.5% between 1981 and 1991.

Elderly persons are high users of health and welfare services. Persons over the age of 65 years occupy one third of all general hospital beds, consume one third of prescribed medication and are responsible for a quarter of general practitioner consultations, yet they represent only a tenth of the total population of New South Wales."

("Planning Health Services in the 1980's": Health Commission of N.S.W., 1981)

Like many aspects of care of the aged, the care of those who develop symptoms of disturbed mental functioning has been characterised by myths and stereotypes. Several submissions to the Inquiry commented on the inappropriateness of care provided and the lack of understanding of their needs.
For example,

"The over 65 population is perhaps the greatest victim in our society of the dualistic mind-body attitude. The result is that many elderly patients are "dumped" on the psychiatric services because of disturbed behaviour or impaired intellectual function, despite the fact that this is often a result of physical illness or medication. Other cases without overt disturbance may be erroneously labelled "senile" when they have a depressive illness and continue to suffer with a treatable illness. The geriatric population most clearly shows the complex interplay between mind, body and environment, and the need for a comprehensive approach to treatment."

(Extract from 828: Banks House, Bankstown Hospital).

and

"A large number of old people are still being referred to the State psychiatric hospital system where they are usually treated in special wards designated as "psychogeriatric" wards.

These referrals are often inappropriate and many occur simply because there are no adequate alternative facilities available in the community.

Admission to a psychiatric hospital can be very damaging both psychologically and socially to old people and to their families. The negative effects of hospitalization should never be underestimated.

Once old people have been admitted to a psychiatric hospital they are often detained for longer periods than necessary. Nursing homes, for example, are often reluctant to take old people who have been in a psychiatric hospital, however inappropriate their initial admission may have been"

(Extract from 8213; N.S.W. Association for Mental Health)
"The myths that "senility" is a normal part of ageing and that one has to be old to become demented are very prevalent in the community. There is widespread avoidance of the problems of mental illness and of the aged in the community as people generally deny things which they do not understand or are afraid of. As a consequence dementia receives little publicity, is shunned by the media and by the public in general. Contrast this with public attitudes to Multiple Sclerosis which is fourteen times less common than Alzheimer's Disease. The community needs to be made aware of the facts about dementia and about what can be done. Families need to be told about diagnostic services and about help that they can receive in their homes and with placement."

(Extract from Sl42: Alzheimer's Disease and Related Disorders' Society)

Elderly people may suffer from any form of defined mental illness, and to any degree, as is the case with the rest of the population. In addition it is estimated approximately five per cent of those over 65 years suffer from moderate to severe dementia, and twelve per cent suffer from mild to moderate dementia.

"Dementia is a chronic organic brain syndrome characterised by relentless progression of loss of memory, deterioration in intellect and deterioration in personality. It is commonly called "senility" but as has been demonstrated one does not have to be old to become demented, nor is dementia a normal part of ageing. There are many causes of dementia, the commonest of which is Alzheimer's Disease, a degenerative process of the brain."

(Extract from Sl42: Alzheimer's Disease and Related Disorders' Society)
Because "senility" and "dementia" are assumed to be an inevitable part of ageing, not only do they often go untreated, but also other psychiatric conditions in the elderly may be recognised or assumed to be "dementia". Despite much evidence of the prevalence of psychiatric problems, most services emphasise physical care, and mental health services for the elderly have not been given much attention.

The dominant theme of submissions to the Inquiry was the importance of comprehensive physical, social and psychological assessment of the elderly person prior to decisions being made about treatment or placement. There is evidence that some of the psychiatric symptomatology in elderly patients is reversible providing full assessment and appropriate care is available.

Submissions highlighted the following major problems:

(1) Inadequate and inappropriate accommodation - maldistribution of and insufficient nursing homes in some areas; lack of facilities including appropriately designed nursing homes for the containment with dignity of the wandering or behaviourally disturbed patient; and lack of hospital accommodation including appropriate assessment units in general hospitals.

(2) Lack of skilled staff trained in assessing and treating the psychiatric disorders of old age.

(3) Lack of support services for families who are the major "therapists" for demented people.

(4) Lack of services such as laundry, home help, handyman, temporary care facilities, etc., the provision of which could obviate inappropriate nursing home placements.

(5) Lack of other community services which would assist in reducing social isolation.
In addition, the New South Wales Council on the Ageing (S.292) stressed the need for appropriate services for the migrant aged referring particularly to language and cultural barriers and to the needs of those without families.

Many of these problems have resulted from the fragmented and uncoordinated nature of services for the aged by all levels of government, the private sector and voluntary agencies. For example, the lack of good general medical care in psychiatric hospitals, and the lack of sophisticated psychological care in some general hospitals.

3.2 Principles of Service Delivery

(i) Integration

Perhaps in no other area of health care is the principle of integration so important as it is in the care of the aged:

"Psychogeriatric treatment and care requires a high standard of medical care in association with a high standard of psychiatric care. The old often suffer from multiple disorders, each of which contributes to the others and the management of each may contribute to the worsening or alleviation of the others."

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

Because of the complex inter-reaction between organic and psychiatric factors in elderly disturbed patients the only rational approach is one based on joint responsibility of geriatric and psychiatric personnel and the primary focus of their care should be in the multi-disciplinary setting of a geriatric assessment service.
Subsequently if it is apparent that an elderly person has a functional psychiatric illness, such as depression, then, in the Inquiry's view, they should have access to the same range of services and facilities as any other person with the same illness (as discussed in Part 3 of this Report).

(ii) Health-Welfare Coordination

The care of the elderly requires a high level of coordination between the various components of health and welfare services and a primary goal is the maintenance of the elderly person in his or her own home, for as long as it is desired and feasible. This is particularly important for the elderly person who has a chronic brain syndrome, and who is likely to be confused, as their confusion will usually be more contained while they are in familiar surroundings.
4. **HOW ARE SERVICES AND RESOURCES BEST STRUCTURED TO MEET NEEDS?**

4.1 Components of Service

(a) Comprehensive assessment

The primary health care provider in the care of the aged is and will continue to be the general practitioner. Consequently the general practitioner must be actively involved in the assessment and ongoing care of the client and his or her family.

The importance of comprehensive physical, social and psychological assessment in the care of the aged was stressed in submissions to the Inquiry. In particular, it was emphasised that as far as possible such assessment should take place in the client's own home, for example,

"Assessment and screening services for people who require, for reasons of ageing, psychosocial and welfare services, should be incorporated into a community-based total care service for old people (which should include staff trained in mental health)".

"Assessment should take place in a person's home or place of residence at the time of referral".

"After the initial assessment at home, short-term in-patient assessment may be considered necessary (for special tests etc.). Such assessment should not be carried out in a psychiatric unit".

"Where, at the time of assessment, it is determined that the person has a functional psychiatric illness, such as depression, they should be treated through the same network of services and facilities as any younger person with the same illness".
"Where it is determined, at the time of assessment, that the person has a chronic brain syndrome, then specific additional services should be available within the community to enable that person to be maintained at home in an environment with which they are familiar."

(Extracts from S213: N.s.w. Association for Mental Health)

The essential point is that assessment should be based on a geriatric service, with the availability of psychiatric consultation as required. In 1980, the Adviser in Geriatric and Rehabilitation Services, to the then Health Commission Dr. L. Mykyta, pointed out:

"Up to 40% of elderly patients admitted to hospital for any reason are likely to become seriously confused. In most instances the confusional state is due to an underlying physical disorder. Despite this large numbers of acutely confused elderly people are admitted to psychiatric hospitals or nursing homes that do not have the skills or facilities to diagnose, investigate and adequately treat the problem because the disturbed behaviour rather than the reason for it has determined the patient's destination".

"Full clinical assessment is of crucial importance. Most assessment clinics find that between 15 and 20% of referrals have a reversible cause. Nor is the plight of the remainder necessarily hopeless. There are many aspects of brain failure that are to some degree treatable such as the disturbed behaviour, depression, loss of ADL skills etc. Aggressive treatment programmes may enable an individual to maintain a higher level of functioning and live in a less supportive environment than would otherwise be possible".

"Initial assessment should ideally be carried out by a multidisciplinary joint unit i.e. the caring team should comprise of specialists in Geriatric Medicine, Psychiatry and the allied health professions".
"The unit should be established within the Geriatric Medicine Department of a major Regional teaching hospital. While administratively the responsibility of the Geriatric Services, the Unit must provide equal access to and demand equal responsibility from a consultant psychiatrist and his back-up team, where possible, from the Psychogeriatric Unit of a Regional psychiatric hospital".

"The unit should be the point of entry of acutely ill and disturbed elderly patients. Where possible, assessments should be carried out on a domiciliary basis deploying the personnel of the inpatient team".

"The reason for siting the unit in the Geriatric Department is that the psychogeriatric patient is commonly physically ill at the time of admission and requires medical care and nursing. The yield of organic pathology is high and most investigational and treatment services are sited at the General rather than the Psychiatric hospital. Geriatric services are on the whole more integrated with community support organisations than are psychiatric services and are more able to deploy these on the patient’s behalf".

"After acute assessment and treatment patients can be streamed into the next appropriate service. It must be emphasised that units operating in this way return a large percentage of their patients to the community after stays that average from 2 to 6 weeks."

The need for assessment to be routinely provided prior to admission to nursing home care has been canvassed in many reports. Such an arrangement has been implemented in relation to admission to some State nursing homes and this should be extended to all State nursing homes and "psychogeriatric" wards in psychiatric hospitals. The possible extension of assessment procedures as a pre-requisite to admission to private and deficit-financed nursing homes, clearly requires additional funding for assessment teams and is linked to the general issue of Commonwealth - State funding which is discussed below.
(b) Day Care

It has been demonstrated in a number of centres in Australia and overseas that the Day Hospital concept, widely utilised in Geriatric services, is able to achieve the same advantages for the psychiatrically ill elderly as for the physically disabled.

Day Hospital-based assessment can be used as an alternative to admission for many patients, and it can permit earlier discharge of in-patients. Living at home confers many benefits that cannot be attained in an institutional setting. Day hospital attenders remain in the community longer than non-attenders as the respite afforded to families enables them to cope more effectively. Day care is considerably cheaper to provide than inpatient care and limited resources can be more fully utilised for greater numbers of patients than would be possible on an institutional basis.

(c) Residential Care

Several submissions to the Inquiry highlighted problems in the provision of residential care for the disturbed or confused elderly including the following:

- lack of short-term, respite care arrangements, the availability of which would assist families to maintain their elderly relative at home for longer periods;

- lack of alternatives to nursing home accommodation, in the form of supervised group homes or hostels;

- lack of appropriate nursing home facilities to care for the confused elderly who do need physical care;

- inappropriate placement in "psychogeriatric" wards in State psychiatric hospitals.
The need for more specialised services and the development of alternatives was emphasised by the N.S.W. Association for Mental Health:

"If, for various reasons, it is not possible for an aged person to be maintained in their own home, then the next best alternative is living in a simulated domestic atmosphere provided by a small residential home. Ideally these homes should be small units located in the community and preferably outside the hospital environment. The smaller the number of residents in the home, the greater is the possibility of the creation of an intimate and homely atmosphere. Wherever possible such homes should be in the districts where the aged persons have lived to enable contact to be maintained, and visits made, by relatives and friends."

"Over recent years there has been a gradual build up of nursing homes which could be styled 'psychiatric nursing homes' that is nursing homes where all or nearly all the residents suffer from the effects of chronic brain syndromes, have psychiatric illnesses and/or are behaviourally disturbed. If the Government elects to continue to support the private entrepreneurial nursing home system of accommodation for the aged, it should recognise the special nature of the 'psychiatric nursing homes' and establish control over them so as to ensure that they are adequately and appropriately staffed so that psychological and social care as well as physical care is provided, and that they are not of a large size".

"Even if all the above services were available, there would still be a small group of patients who, for the time being, will require accommodation and care in facilities provided by the State. They are mainly patients with chronic brain syndromes who are unable to be placed elsewhere because of a combination of noisy, aggressive or violent behaviour, severe disorientation leading to wandering and/or chronic or severe functional psychiatric illness. Admission to such
services should be carefully controlled to ensure that inappropriate admission does not occur. Such services should also be adequately staffed and programmed so as to provide a model of care for such people in relatively small units."

(Extract from S213: N.S.W. Association for Mental Health)

These problems were discussed in some detail in the recent Report from the House of Representative Standing Committee on Expenditure which concluded:

"Information available on nursing home patients indicate that between 30 and 50 per cent have some degree of senile brain disorder. Care of these patients is a major problem facing staff in nursing homes. A nursing home designed for physically frail and sick elderly people in a typical four-bed ward situation is not necessarily an appropriate place to care for somebody who is physically well and ambulant, but is suffering from brain failure or senile dementia. There have however been few attempts to investigate what the appropriate forms of care might be.

The potential for developing special programs within non-segregated nursing homes and hostels depends on the availability of staff for diversional activity programs and suitable architectural settings. The modification of existing facilities is a preferable, and necessary, means of providing for this group as new construction of purpose built facilities would only ever cater for a small proportion of these patients. To complement developments in institutional settings, the introduction of community-based psychogeriatric services must be seen as a high priority as many families bear an enormous responsibility in caring for these patients at home. If community services in general are lacking, those for psycho-geriatric patients are non-existent".
"It was put very strongly to the Committee that attention to the needs of the ambulant demented patient is urgently required. Existing nursing homes do not have the required skills. A large part of care in nursing homes involves attempting to restrict these patients to a limited area rather than providing diversional therapy and activities. One of the problems is that while staffing levels are required to be fairly intensive only nursing staff are included in setting staff ratios. Many nursing homes find that their existing facilities and staff levels can no longer cope with the problem.

Care of the confused elderly was the single problem that was most repeatedly brought to the Committee’s attention. The conclusion reached is that the problem will not be solved simply by the construction of special nursing homes but that action is needed to stimulate a diversity of provision in small units in existing nursing homes, and in a range of community psychogeriatric services, such as relative support groups, relief sitting and admissions, and day-care. Fundamental to all these developments is the provision of proper diagnostic and assessment services."

(Extracts from "In a Home or At Home": Accommodation and Home Care for the Aged: Report from the House of Representatives Standing Committee on Expenditure—October 1982).

The Inquiry endorses the conclusions of the House of Representatives Standing Committee for the need for diversity in these services. This will require review of the role of both the public sector and the private sector, and encouragement of appropriate services through the existing financing mechanisms.
Some alternatives already exist and the Inquiry considers, for example, that the work of the Uniting Church in establishing supervised group homes, provides a useful model for further development. The principles outlined in the Uniting Church evaluation of their programme could usefully be adopted as principles by all the agencies providing residential care for this group and these are summarised in an abridged form below:-

(i) The ideal form of care is a warm, stable, supportive domestic type of environment in which the dementing old person can feel at home and take part in stimulating activities. Any necessary restrictions on wandering should be as unobtrusive as possible.

(ii) To make them feel more secure and more at home, residents should be encouraged to keep old photographs or treasured possessions in their rooms.

(iii) The environment should be kept simple and stable so that the residents can become familiar with it.

(iv) Residents are basically elderly people with an additional disability. They experience pleasure and pain, and until a late stage they respond fairly appropriately to social inter-actions.

(v) Residents should be treated with the patience and courtesy normally extended to respected elders.

(vi) Staff should spend time with residents and should talk to them slowly, clearly, and simply. They should learn to know as much as possible of their background, interests, families and achievements and their likes and dislikes.
Self-esteem and well-being are increased if they're encouraged to do all they can for themselves and each other, and to help staff, even in minor ways - no matter how slowly this is done.

Self-esteem and well-being are also enhanced when staff take particular interest in each resident's appearance, assisting them, when necessary, to maintain a high standard.

Active rather than passive participation in simple household chores, movements to music, craft work, discussions and outings helps them develop and make best use of their remaining faculties, and gain the maximum enjoyment from their lives.

Residents require normal, regular medical examinations to treat physical illnesses that are likely to occur in the elderly. Any sudden deterioration or change in behaviour requires prompt investigation.

(Sourced from "Forgetting but not Forgotten" - Community Services Division - Uniting Church in Australia, Melbourne 1982)

4.2 Staffing

In this, as in the other areas of the Inquiry's investigations, the emphasis in staffing must be on a multi-disciplinary approach. This is essential in the assessment and care of the elderly person whose physical, emotional and social needs are so interwoven. However, it has been argued to the Inquiry that the training of all health professionals is inadequate in the area of the care of the elderly with psychiatric problems, for example:
"Many general practitioners do not realise that a number of the dementias are treatable and reversible and that some conditions, the "pseudo-dementias" can mimic dementia and unless the cause of this pseudo-dementia, usually a depression, is treated then a person can languish for years in a "senile" state. Many doctors who are aware of the diagnostic difficulties with dementia are unaware of management strategies once the diagnosis is made. This is particularly true with Alzheimer's Disease patients for whom there is no specific treatment but there is much that can be done to improve the person's lot and that of his or her family."

(Extract from Sl42: Alzheimer's Disease and Related Disorders Society)

It was also proposed that the training of all disciplines in this area be upgraded, and that specific training posts be established in geriatric psychiatry, as follows:

"That specific attention is urgently given to the training of health professionals generally in aspects of geriatric psychiatry (e.g. the State government could, through its Higher Education Board encourage universities and colleges of advanced education to give greater emphasis to geriatric psychiatry, especially dementia and its management).

That attractive training posts for health professionals be established to encourage the selection of geriatric psychiatry as a career, (e.g. training posts for "2nd part" M.R.A.N.Z.C.P. candidates and/or post diploma fellowships at the N.s.w. Institute of Psychiatry could be established specifically in psychogeriatrics)."

(Extract from Sl41: Royal Australian and New Zealand College of Psychiatrists)
5. IMPLICATIONS FOR COMMONWEALTH – STATE COORDINATION

5.1 Funding

Financial and organisational arrangements for the provision of services for the care of the aged have been the subject of intense investigation and inquiry by both Federal and State governments over the last ten years. This is one of the most complex areas of all intergovernment relations. The need for a joint Commonwealth/State policy on the care of the aged has been argued in many of these Reports, and it is particularly important as the bulk of resources for the care of the aged are directed to institutional care (the most important being Commonwealth payment of Nursing Home Benefits - $550 million approximately per annum) while there is growing recognition of the need for a wider range of home-based services (currently the direct responsibility of State governments).

Unlike the other areas examined by the Inquiry most of the resources involved in care of the aged are interlinked with specific purpose Commonwealth funding directed largely to the private profit and nonprofit sectors. Proposals for redistribution of resources cannot be solely developed at State level and therefore specific funding recommendations have not been developed by the Inquiry.

The most recent Inquiry in this area (The Report from the House of Representatives Standing Committee on Expenditure – cited above), recommends a restructuring of Commonwealth resources and eventual transfer of all funding to the States, which would then have the complete responsibility for aged care services and their funding. The Inquiry does not consider it appropriate or possible to discuss these issues in detail. The following matters however, are particularly relevant to the Inquiry’s areas of concern.
5.2 Specific Issues

Firstly, the funding of assessment services is of crucial importance to the development of appropriate services for the confused and disturbed elderly. The Inquiry supports the comment of the House of Representatives Standing Committee on Expenditure:

"It is acknowledged that the establishment of assessment teams operating at the State and regional level would require additional funding. It would be difficult to build in an incentive for the States to pay for them and use them if the Commonwealth were still paying all nursing home benefits. There is a limited number of nursing home beds. The assessment teams could achieve better use of these beds being an appropriate rationing device."

and their recommendation that this funding be accepted as a Commonwealth responsibility.

The Inquiry is aware that there have been earlier approaches to the Commonwealth on this issue, however, it would be appropriate, in the light of the abovementioned Report, for this matter to be considered further by the next conference of Australian Health Ministers. It is therefore proposed that the Minister for Health raise the funding of geriatric assessment teams as an agenda item for the next Health Ministers' Conference.

Secondly, the Inquiry considers that the State government should take a more active role in seeking to ensure that the special needs of the confused elderly are met within the current organisational and funding arrangements. The Department of Health has the control of approvals for new nursing homes and extensions to existing homes. The Department has recently issued a document on "Guidelines for New Nursing
Home Accommodation for the Aged", (December 1982) which refers to the need for nursing homes to be prepared to care for and develop active programmes for the confused elderly. The Inquiry recommends that the Department of Health give more regard in future approvals of nursing homes to the care of the confused elderly, and consider the introduction of a requirement of this kind as a condition of licensing.

Thirdly, concern has been expressed to the Inquiry that extensive care benefits (the additional Commonwealth benefit for those who require more intensive nursing care) are not readily available for the care of the confused elderly, who may not need intensive physical care. The Auditor General’s Report (Efficiency Audit of Commonwealth Administration of Nursing Home Programmes -1981) also pointed out that New South Wales has the lowest percentage of all States of nursing home patients receiving the extensive care benefit (35.3% compared to the Australian total of 51.3%).

Extensive care is defined in the National Health Act as nursing home care required by a person -

"who is bedridden or virtually bedridden and is wholly or substantially dependent on nursing care; or

who is undergoing treatment for any illness, disease, incapacity or disability and, for the purposes of that treatment, is wholly or substantially dependent on nursing care. (S.40 AF(5))•"

Although this definition can be interpreted to include those patients who do not have major physical needs for intensive care, the problem appears to lie in the NH5 form, which is completed by doctors seeking admission of a patient to a nursing home. The information sought on this form would seem to place the emphasis on the patient’s physical needs.
In view of the intensity of care and supervision required by the confused elderly, irrespective of their physical needs, the Inquiry recommends that this issue be raised with the Commonwealth Department of Health to facilitate greater use of extensive care benefits for this group of patients.

Fourthly, as discussed above, it is important that action is taken to encourage a range of accommodation facilities as alternatives to nursing home accommodation for this client group. The primary source of capital funding for hostels and other alternative arrangements is the Aged and Disabled Persons' Homes Programme. The Department of Social Security has recently established a Committee with State government representatives, to co-ordinate planning for these services and to assist in the determination of priorities within the programme. The Inquiry has also proposed that the Minister for Health negotiate with the Minister for Social Security to improve co-ordination in relation to the needs of all the client groups it has examined. The special needs of the confused elderly should be recognised, and appropriate organisations encouraged to develop proposals to meet these needs.
6. SERVICES IN PSYCHIATRIC HOSPITALS AND STATE NURSING HOMES

6.1 Psychiatric Hospitals

The Inquiry has proposed that the psychiatric services in existing Fifth Schedule Hospitals be transferred to the management of existing Boards of general hospitals (and in the metropolitan Regions, hospitals which have regional specialist and teaching functions). This management change will obviously include the services provided for the aged in these hospitals within "psychogeriatric" wards. Within the new management arrangements these services for the aged should clearly be linked to acute geriatric and psychiatric services within the hospitals to which they are attached. (In the Hunter Region a different arrangement is proposed and special consideration of the link to geriatric services will be needed).

Services for the disturbed or confused elderly should be organised as part of a geriatric service, preferably at area level, with appropriate psychiatric consultation. The primary objective should be the development of domiciliary assessment services and day care facilities which can assist in the maintenance of the elderly person at home, and the appropriate use of inpatient and residential facilities.

Consequently, formal links should be developed between Regional or area geriatric and rehabilitation services and the geriatric services in existing psychiatric hospitals and State Nursing homes. These organisational arrangements should be considered in the context of the Inquiry's recommendations about particular hospitals in Part 3 of this Report.

All admissions of aged people to psychiatric hospitals should be controlled by a joint assessment service as discussed above. Pending the establishment of fully-staffed geriatric assessment teams, and acute assessment units, small assessment teams should be established by gradual redeployment of some of the existing staff of "psychogeriatric" services within the existing institutions.
"The admission of an old person to hospital should always be viewed as a serious step and never advised without careful consideration of the total situation that has led to the request for inpatient care. There is a real risk of long stay patients being treated as second or third rate citizens, interesting neither as medical or nursing cases but treated as social rejects. Legitimate reasons for admission can be considered under three headings:

. the need for treatment that is not possible on a domiciliary, out-patient or day patient basis:

. the impossibility of containing the patient in the community because of his behaviour or of inadequacies of community care:

. the need to give relatives and friends a period of rest and relief to enable them to continue helping the patient to live in the community."

(Extract from S280: Southern Metropolitan Region, Health Department) .

6.2 State Nursing Homes

In New South Wales, the State is involved in the provision of nursing home care both directly and indirectly - directly through the administration of geriatric hospitals and nursing homes under the Fifth Schedule of the Public Hospitals Act, and indirectly through funding of nursing homes administered by the Boards of public hospitals (under the Second Schedule of the Act) or by charitable organisations (under the Third Schedule of the Act). The State Government also acts as the licensing authority for all nursing homes.
Although State government nursing homes represent only a small proportion of the total stock of nursing home beds (12% in New South Wales) they could potentially play a role in providing for special needs which are not catered for by the non-government sector.

There are four Fifth Schedule Nursing Homes in New South Wales:

(i) Allandale Hospital (Hunter Region): 536 beds

(ii) Lidcornbe (non-recognised beds) (Western-Metropolitan Region): 310 beds.

(iii) Garrawarra Hospital (Southern Metropolitan Region): 331 beds.

(iv) Strickland House (Southern Metropolitan Region): 108 beds.

These facilities are approved under the National Health Act for payment of Commonwealth nursing home benefits. Private insurance benefits are not payable in respect of patients in these nursing homes. The main source of revenue (apart from nursing home benefits) is direct State government funding.

Public sector nursing home facilities should provide services complementary to those provided in the private sector, and have the potential to provide more specialised or intensive care for groups with special needs, including:

confused and disturbed aged persons, particularly those whose behaviour is disruptive to others, or who need intensive individual care;

frail elderly for whom the private sector nursing homes are unable to care, for example, very heavy patients.
Public sector facilities are able to offer a more comprehensive range of services, through the employment of ancillary health personnel, and can be integrated with rehabilitation and extended care assessment services. They have the potential to provide services such as respite care which can relieve the pressure on families and enable them to care for their aged or disabled relative for much longer periods than would otherwise be the case.

As indicated above, the majority of public sector nursing home beds are provided in the large Fifth Schedule Nursing Homes. There are a number of problems in this arrangement:

These services tend to be isolated geographically, making it difficult for relatives to maintain contact with patients, difficult to establish formal and informal links with "normal" community activities, and difficult to recruit an appropriate range of staff skills.

These services are also isolated organisationally and professionally, with the result that they are not linked to a comprehensive programme of care for the aged and disabled, and they are less likely to provide appropriate and on-going assessment, structured rehabilitation programmes, and continuity of care.

The Inquiry was impressed by the efforts being made, particularly at Garrawarra, to provide a more specialised and goal-directed service and to develop links with other services and the local community. However, the Inquiry considers that this process would be facilitated by changes to the management structure of these services and gradual decentralisation of these services. In Part 1 of the Report the Inquiry has argued the need for a more integrated health system, to provide more appropriate services for clients and improved opportunities for staff. As discussed above, integration is particularly important in the care of the frail aged, where the fundamental component of the service system is the provision of comprehensive multi-disciplinary assessment.
Consequently, the Inquiry proposes that each of the existing Fifth Schedule Nursing Homes be transferred to the Second Schedule of the Public Hospital Act and linked to regional or area geriatric services as proposed below:

(i) Allandale Hospital:— In the short term, in view of the isolation of the Hospital from existing geriatric services in the Region, a new Second Schedule Board should be created for Allandale Hospital, including representatives of the Board of the general hospitals in the same area, namely Cessnock Hospital, Kurri Kurri Hospital and Maitland Hospital. In the longer-term, it would be appropriate to link Allandale to the future development of geriatric services in the Region.

(ii) Lidcombe Hospital:— Lidcombe Hospital is a Fifth Schedule Hospital which has undergone a significant change of role in recent years, with the introduction of general acute hospital services to the hospital campus. The Hospital's role in care of the aged and disabled has been and continues to be significant. It provides nursing home facilities, a geriatric rehabilitation service and other specialised treatment and rehabilitation services for the disabled, of all ages. These services include those for traumatic brain damage and back injury patients and a group of physically disabled patients who have proven virtually unmanageable in other environments. It would be appropriate for Lidcombe to operate as an integrated hospital, managed by its own Board as a Second Schedule Hospital.

(iii) Garrawarra Hospital - Garrawarra is the most geographically isolated of the Fifth Schedule Nursing Homes. The Hospital, in consultation with the Regional Director of the Department of Health, has however taken a number of initiatives to develop closer links to other geriatric services. Although the Hospital services both
the Southern Metropolitan and Illawarra Regions, the Inquiry proposes that, for management purposes, the hospital be linked to general acute geriatric services in the Southern Metropolitan Region and be managed by the Board of the teaching hospital St. George Hospital, Kogarah. The Hospital should also maintain its close links to Sutherland Hospital and community services.

(iv) Strickland House: This facility should be linked to geriatric services as they develop at Prince of Wales Hospital, and be managed by the Prince Henry/Prince of Wales Hospitals Board.

The Boards responsible for the management of these services should be given a clear responsibility to rationalise and decentralise nursing home services through the development of smaller community based accommodation, expanded day hospital facilities and improved home care.

The Inquiry's attention has also been drawn to the potential of the David Berry Hospital (a Fifth Schedule hospital providing acute general health services - located near Berry) to be linked into regional services by broadening its current role to include geriatric, rehabilitation and developmental disability services. This may require amendments to the hospital's own incorporation legislation. The desirable way of proceeding is to transfer the hospital to the Second Schedule of the Public Hospitals Act and link its management to other health services in the Shoalhaven area.