INQUIRY INTO HEALTH SERVICES
FOR THE PSYCHIATRICALLY ILL
AND DEVELOPMENTALLY DISABLED

PART 5

APPENDICES

MARCH 1983
PART 5

APPENDICES

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LIST OF STAFF AND CONSULTANTS

staff

Mr P. Primrose Research Officer
Mr I. Dempsey Administrative Officer
Ms J. Marston Stenographer

Part-time Consultants

Professor W. Cramond Former Clinical Director, Mental Health Services, Health Commission of NSW
Dr J. Dey Senior Specialist, Developmental Disability Services, Department of Health, NSW
Ms K. O'Connor Senior Manpower Policy Analyst, Planning and Research, Department of Health
Dr P. Shea Medical Superintendent, Rozelle Hospital
Dr N. Shiraev Senior Planner, Planning and Research, Department of Health
Ms L. Solomons Director of Nursing, Gladesville Hospital
Mr J. Taylor Senior Industrial Officer, Department of Health
Mr H. Wirth Assistant Director, Management Division, Public Service Board of NSW
The Minister for Health, Mr Laurie Brereton, today announced an enquiry into health care services provided for the psychiatrically ill and the intellectually handicapped.

Mr Brereton said the enquiry would be chaired by Mr David Richmond, a member of the Public Service Board and a senior administrator of many years' experience.

The enquiry will include one assessor from the unions involved in the 5th Schedule (psychiatric) hospital system, to be nominated by the Labor Council, and one assessor from the Health Commission.

Mr Brereton said the enquiry would examine the present range of services provided for the psychiatrically ill and the intellectually handicapped, both in institutions and community-based facilities.

"The enquiry will seek to determine the most appropriate pattern of services, review financial and manpower resources and the contribution of the voluntary sector. It will identify priorities for the development of new services," Mr Brereton said.

"It will commence on September 14, and I urge all those interested in the care of the psychiatrically ill and the developmentally disabled to co-operate fully with the enquiry."

26th August, 1982
Terms of Reference

1. To determine the appropriate nature, extent and distribution of services for the psychiatrically ill, psycho-geriatrics and the developmentally disabled in New South Wales.

2. To review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.

3. To identify priority areas for the development of new services.

4. To assess resource requirements for the psychiatric system in the light of the findings in (1), (2), and (3) above.

5. To review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies.

6. To identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.
NEW SOUTH WALES GOVERNMENT
PUBLIC NOTICE
INQUIRY INTO HEALTH SERVICES FOR THE
PSYCHIATRICALLY ILL AND DEVELOPMENTALLY DISABLED

The Minister for Health, Mr. Laurie J. Brereton, announced on 27 August 1982, the establishment of an Inquiry into the provision of health services for the psychiatrically ill and the developmentally disabled.

The Inquiry will be conducted by Mr. David Richmond, a Member of the Public Service Board, who will be assisted by one assessor nominated by the Labor Council and one assessor nominated by the Health Commission of New South Wales.

The Inquiry commenced on 13 September 1982 and will report to the Minister at the end of December 1982.

The terms of reference of the Inquiry are as follows:

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

The Inquiry invites organisations and individuals with an interest in this area to make written submissions by 22 October 1982, and to indicate whether they would be prepared, if required, to make an oral presentation of their views to the Inquiry.

Submissions and enquiries should be addressed to:
Ms P. Rutledge, Executive Officer,
Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled,
PO Box K110 Haymarket 2000
Telephone: 217 6666
KEY ISSUES

Service Delivery Issues
 'needs' of client groups
costs and benefits of service modes
equity issues
community attitudes, etc.
components of service delivery

Manpower and Industrial Relations Issues
staffing
conditions of employment
consultative processes
education of staff
hours/structure of nursing shifts

Management Issues
management performance
task definition and skills required
level and appropriateness of delegations
organisational structure
staff involvement

Training and Education Issues
changing education needs
recruitment of trainees
provision of comprehensive clinical experience
service/training nexus in nursing, etc.

Financial Issues
resource deployment/priority-setting
level of resources - operating
..... capital
health insurance and revenue issues
financial incentives

'Systems' Issues
values and attitudes - management
- staff
- community

openness of system
boundary issues
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short-term and long-term effects on residents', *British Journal of Subnormality*, 1982, 28(54), 3-12.


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SUBMISSIONS

Non-Government Organisations

Action for Children
Action for Handicapped Children
Action for Handicapped Citizens
Action for Intellectually Handicapped Citizens
Aftercare Association
Alzheimer's Disease and Related Disorders Society
Armon Nursing Home
Arndell Public School P&C Association
Association for the Assistance of Intellectually and Socially Handicapped Persons
Association of Relatives and Friends of the Mentally Ill
Association for the Welfare of Children in Hospital
Australian Huntington's Disease Association
Australian Jewish Welfare Society
Australian Legal Workers' Group (NSW)
Blacktown City Accommodation Collective
Blacktown City Community Services Council
Blacktown Community Cottage Ltd
Careforce Anglican Home Mission Society
Centacare Catholic Family Welfare
Central Coast Hostel Action Committee of Parents and Friends of the Intellectually Handicapped
Central Coast Social Development Council Ltd
Church of England Homes
Church of Scientology (Sydney Congregation)
Citizens' Committee on Human Rights
Committee on Mental Health Advocacy
Elemental
Everton House Committee
Fairfield Interagency Sub-committee
Family Planning Association of NSW (Ltd)
Gladesville Auxiliary Ltd
GROW
Hunter Region Accommodation Committee
Illawarra Branch ARAFMI
Illawarra Handicapped Persons' Trust
Intellectually and Physically Handicapped Children's Association of NSW
Interagency on Homelessness - Wesley Central Mission
Kings Cross-Darlinghurst Youth Needs Project
Louisa Lawson House
Macquarie University Unit for Rehabilitation Studies
Maitland Interagency
Manly-Warringah Citizens' Advice Bureau
Marconon Inc
Mater Dei Special School, Camden
Mental Health Co-ordinating Council
Mental Liberation Association
Milperra College of Advanced Education
Morisset Intellectually Handicapped Association
Narconon Inc
Northside Clinic
NSW Advisory Council on the Handicapped
NSW Association for Mental Health
NSW Council on the Aging
NSW Council for the Mentally Handicapped
NSW Health and Welfare Chaplains' Association (Psychiatric Committee)
Occupational Therapy Study Group in Developmental Disability
Orana Committee on the Handicapped
PALA Society
Polish Welfare and Information Bureau (NSW)
Psychiatric Rehabilitation Association
Richmond Fellowship
Riverglade Centre Parents and Friends Association
Rydelmere Hospital Parents and Friends Association
Ryde-Hunters Hill Interagency
Salvation Army
Scone Interagency
Shared Care
Subnormal Children's Welfare Association
Subnormal Children's Welfare Association (St. George Branch)
Subnormal Children's Welfare Association (Namoi Branch)
Support for Orthomolecular Medicine Association
The Chelmsford Survivors
The Compassionate Friends
2WG Old People's Homes Trust, Wagga Wagga
Uniscan Education Testing Centre, University of NSW
Uniting Church in Australia (NSW Synod)
Uniting church Chaplains' Committee
Wayside Chapel, Kings Cross
Wesley Central Mission
Western Sydney Citizen Advocacy Programme
Willoughby Municipal Council
Women's Legal Resources Project

Professional Groups

Association of Psychiatrists in Training (NSW)
Australian Association of Occupational Therapists
Australian Association of Speech and Hearing (NSW)
Australian Congress of Mental Health Nurses (NSW Branches)
Department of Community Medicine - University of NSW
NSW Institute of Psychiatry
Royal Australian and New Zealand College of Psychiatrists (NSW Branch)
School of Psychology - University of NSW
School of Psychology - University of Wollongong
Social Work Group, Southern Metropolitan Region
Social Workers for the Developmentally Disabled

Government Departments

Concord Hospital - Department of Veteran Affairs
Department of Social Security
Ethnic Affairs Commission of NSW
Health Commission of NSW

Industrial Associations

Health and Research Employees' Association
NSW Nurses' Association
Public Medical Officers' Association
Public Service Association
(Several hospital sub-branches of the above Unions also made submissions)

Health Department Services

Adolescent and Adult Unit, Grosvenor Hospital
Adolescent Medical Unit, Royal Alexandra Hospital for Children
Allandale Hospital
Armidale and New England Hospital Nursing Administration
Bankstown Hospital
Bloomfield Hospital
Burwood Community Health Centre
Canterbury Community Health Services
Central Coast Area Health Service
Community Health Unit

Development Disability Team, Southern Metropolitan Region
Division of Nursing
Eastern Suburbs Community Rehabilitation Service
Eastlakes Community Health Team
Gladesville Hospital
Gladesville Hospital Executive
Gladesville Hospital Management Committee for Developmental Disability Services
Gladesville Hospital, Rehabilitation Management Team
Gladesville Hospital, Social Work Department
Grosvenor Hospital
Hunter Region Developmental Disabilities Unit
Illawarra Region
Illawarra Health Region Rehabilitation and Geriatric Services
Illawarra Region Migrant Health Team
Langton Clinic
Laurel House
Liverpool Area Health Centre
Lower North Shore Community Mental Health Service
Macquarie Hospital
Macquarie Hospital Alcohol and Drug Dependence Unit.
Macquarie Hospital, Arndell Children’s Unit

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Macquarie Hospital Psychogeriatric Services
Macquarie Hospital Rehabilitation Programme
Macquarie Hospital Surgical Unit
Macquarie Hospital Ward 8
Morisset Hospital
New England Region
Newcastle Community Health Centre
North Coast Region
North Coast Region Mental Health Services
Northern Metropolitan Health Region Resident Placement Committee
Northern Metropolitan Region
Nurse Training School, Kenmore
Nutrition and Dietetics Service, Lidcombe Hospital
Occupational Therapy Department, Marsden Hospital
Occupational Therapy Department, Parramatta Psychiatric Centre
Official Visitors to Morisset Hospital
Orana and Far West Region
Parramatta Psychiatric Centre
Peat Island Hospital
Prince of Wales Children's Hospital
Principal Clinical Psychologists, Southern Metropolitan Region
Psychiatric Nurses' Educators, Hunter Region
Psychiatric Nurses' Educators, Parramatta and Rydalmere Hospitals
Psychiatric Unit, Prince of Wales Hospital
Psychology Department, Kenmore Hospital
Psychologists, Grosvenor Hospital
Psychology Section, Marsden Hospital
Redfern House Community Health Centre
Riverina Region
Rydalmere Hospital
School of Nursing, Southern Metropolitan Region
Shoalhaven Community Health Services
Social Work Department, Wollongong Hospital
Social Work and Occupational Therapy Departments, Rozelle Hospital
Social Workers, Rydalmere Hospital
Southern Metropolitan Region
Tamworth Base Hospital, Regional Service for the Developmentally Disabled
•ransport Section - Kenmore Hospital
warilla community Health service
William Street Hostel Staff
western Metropolitan Region
Wollongong Community Health Support Team

Individuals

One hundred and seven submissions were received from individuals.

Oral Submissions

Approximately thirty individuals or groups presented oral submissions to the Inquiry.
VISITS BY THE INQUIRY

Allandale Hospital
Bankstown Hospital
'Baringa', Wollongong
'Belhaven', Arncliffe
Bloomfield Hospital
Garrawarra Hospital
Gladesville Hospital
Grosvenor Hospital
Hillview Community Health Centre
Hornsby Hospital (and Developmental Disability Unit)
Kenmore Hospital
Laurel House
Lidcombe Hospital
Liverpool Area Health Centre
Liverpool Hospital
Macquarie Hospital
Marsden Hospital
Morisset Hospital
Newcastle Psychiatric Centre
North Coast Region
Parramatta Psychiatric Centre
Peat Island Hospital
Rozelle Hospital
Rydalmere Hospital
St. George Hospital
South Australian Health Commission
Stockton Hospital
victorian Health Commission
Westmead Hospital
Wollongong Hospital

(Each Fifth Schedule hospital visit included:
  meeting with hospital executive
  inspection of hospital)
open staff meeting
meeting with union dele...individual staff interviews)

Hostels, Nursing Homes and Boarding Homes

AAISH hostels
'Bambi', Liverpool
Crown Hotel, Ultimo
Distin Morgan House
Gladesville Hospital Satellite Housing
Lorna Hodgkinson Sunshine Home
Marsden Hospital hostels
Rochester Private Hotel
59 Cavendish Street, Stanmore
Subnormal Children's Welfare Association, Bankstown
## CO-ORDINATION OF PUBLIC SECTOR SERVICES

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<td>co-ordination of Education and Health Skills Early Intervention Programme School Counselling Services Special School Services</td>
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Funding of Community Groups
Handicapped Persons' Bureau
Home Help Service
Institutional Care
Licensing of Hostels, etc.

Ethnic Affairs Commission* Advocacy for Ethnic Groups

Housing Commission* Accommodation

Local Government Councils Local Welfare Services
Town Planning Approvals for Residential Facilities

Police Department Crisis Intervention
Involuntary Psychiatric Admissions

Premier's Department * Co-ordination of Government Activities generally

*(Inquiry met formally with representatives of these Departments, and also with representatives of the Local Government and Shires Association.)
BACKGROUND AND WORKING PAPERS

Assessment of Client Needs
Components of Services
Consultation with other Departments - brief notes
Crisis Service
Definitions
Discussion with Interim Evaluation Team - Community Health
Evaluating Objectives
Flow Charts of Models of Service Delivery
General Objectives
Key Issues Elaboration
Key Issues Summary
Literature Review - Models
Management Issues
Methodology
Nurse Training
Personnel and Roles
Prevention
Role of Community Groups
'Systems' Issues
Training of Psychiatrists
LITERATURE REVIEW - MODELS

The following is a review of recent literature on model and approaches to the delivery at health services to the psychiatrically ill and developmentally disabled.

It is not an exhaustive review, even of recent literature. Rather an attempt has been made to locate items which are representative; source items that are regularly quoted; or deal with critical issues such as the 'hospital versus community' debate.

The review is presented under the following headings:

- Psychiatically Ill (General): focus on hospital versus community debate
- Psychogeriatric
- Children and Adolescents
- Drug and Alcohol
- Developmental Disability

Psychiatically Ill - General


Concepts:

(a) Rehabilitation should begin as close to the onset of illness as possible.
(b) Rehabilitation requires a holistic approach, considering the psychosocial, the medical and the environmental influences on the individual's ability to participate.
(c) Rehabilitation requires a multidisciplinary approach.

Aspects:

(a) Integration of hospital to community.
(b) Integration of community services.
(c) A residential facility not related to work and socialisation activities is unlikely to be successful.
and work programmes are one means of raising levels of
tioning and competence.

(e) Evaluation takes a long time.

2. Barclay, W. 'Deinstitutionalisation - Global experience and practical
implications for Australia', in P.R.A., Psychiatric Rehabilitation

Necessary components of deinstitutionalisation:

(a) Prevention of inappropriate hospital admission through
the provision of community alternatives for treatment.

(b) The release to the community of all institutional patients
who have been given adequate preparation for such a change.

(c) The establishment and maintenance of community support
systems for non-institutionalised persons receiving mental
health services in the community.

Programmes fail when they do not provide for all three of these
elements.

Lessons learned from the last three decades:

(a) Mental hospitals have failed to provide an adequate

standard of treatment and rehabilitation, even of care
for the chronic mentally ill.

(b) for the most part, hospitals have fulfilled this task
better overall than other systems have.

(c) 9nic schizophrenia is a disabling illness, and will not

away simply because we deinstitutionalise patients.

Therefore, a hard, difficult and labour-intensive task
remains of caring for the chronically disabled.

(d) Government bureaucracies are the least efficient method
of providing direct clinical services to patients. Other
approaches, including private contracts, should be considered.

(e) A 'middle of the road' psychiatric patient advocacy group is
needed to increase political power.

There is little published information that supports the assumption that the substitution of ambulatory for inpatient care results in equivalent or better clinical outcome at lower cost. Only four of 134 relevant papers provided enough data on both cost and efficacy to allow statistically valid conclusions; two of these showed ambulatory care to be as effective as inpatient care and less costly. Indirect cost cannot be ignored.


Experimental alternatives to hospital care of patients have led to psychiatric outcomes not different and occasionally superior to those of patients in control groups. The available studies do not permit firm conclusions regarding alternatives to continued long-term hospitalisation of chronically ill patients or for a critical analysis of the optimal management of specific subpopulations of psychiatric patients: -satisfactory--deinstitutionalisation appears- to depend on the availability of appropriate programmes for care in the community.


South West Denver Community Mental Health Services established a system of alternative families who take one or two psychiatric patients who need intensive treatment into their homes; the clients' average stay is ten days and so far 220 client placements have been effectively carried out. Research over a two-year period indicates that homes are more effective in certain respects than a psychiatric hospital in providing intensive care.

Options for present institutions:

(a) A unified system of care: goal is to unify and co-ordinate the policies and procedures of the mental hospitals and community health centres to provide more effective delivery of services. Based on decentralisation of hospital administration and service delivery along geographical lines. Non-residential services are also provided from these geographic units, providing continuity of care.

(b) Development of general hospital provisions: the psychiatric hospital to change its role to provide a small psychiatric unit plus medical, surgical and other specialist services (e.g. inpatient and day patient facilities for the elderly

(c) Provision of specialised residential services: appropriate parts of the mental hospital to provide services such as:

(i) treatment programme for alcoholics and drug addicts
(ii) intensive rehabilitation for geriatric patients
(iii) adolescent treatment units.

(d) Disposal of mental hospitals.


155 patients destined for inpatient psychiatric care were randomly assigned to Home Care and Hospital Care. Evidence that community-based psychiatric care is an effective alternative to hospital-base care for many but not all severely disabled patients.

8. Glick, I., Hargreaves, W., Drues, J. and Showstack, J. 'Psychiatric Hospital Treatment for the 1980s: A Controlled Study of Short versus Long Hospitalisation', 1979, Lexington Books, USA.
The primary use of hospitalisation in the 1980s will be for brief intensive work with those with schizophrenia or affective disorders who need help in controlling a psychiatric or suicidal episode or exacerbation. For a very small subgroup longer hospitalisation may be needed. This style of clinical care requires close coordination with a variety of outpatient and residential non-hospital resources - a major clinical challenge. Continuous management by the same team through different levels of types of care may be a promising model.


Newly admitted inpatients were randomly assigned to either day or inpatient care. Outcome evaluations showed clear evidence of the superiority of day treatment on virtually every measure used to evaluate outcome.


120 patients presenting at North Ryde for admission were randomly allocated into two groups:

(a) Control patients who received standard hospital care and follow-up.

(b) Project patients, who were not admitted if this could be avoided and received intensive and comprehensive care from a community treatment team. It is clearly feasible to treat most psychiatric patients in the community without increasing the burden on their relatives.

300 patients were randomly assigned to outpatient family crisis therapy or admitted to a university psychiatric hospital. Follow-up at 18 months showed that patients treated without admission were less likely to be hospitalised after treatment and that their hospitalisation was significantly shorter; they were doing as well as the hospitalised patients on two measures of social adaptation and were managing crises more efficiently.


There was a wide range in average cost per bed day. Cost of labour, staff-patient ratios and occupancy rates were major cost factors. The Northside Clinic had a comparatively low average cost per bed day. Cost was not directly related to the patients' or their relatives' satisfaction with treatment.


The methodology was used to project costs and benefits over a ten-year period for 52 clients successfully placed in the community. The results showed an average net saving for each client of $20,800 over a ten-year period, mostly to the State Government.


Chronic patients were randomly allocated into Hospital or Community Treatment Groups and followed up at regular intervals. Outcome measures included patient outcome, family and community burden and a cost-benefit analysis. The results generally favoured the Community Treatment Group, but the authors warn that community
treatment must be comprehensive, assertive and prolonged. The study carried out by Holt, et al, in Sydney is basically a replication of this study.


Study as per above. Developed conceptual model called 'TCL': training in community living. Community treatment requires:

(a) Assuming responsibility for helping patients acquire material resources such as food, clothing, shelter and medical care.

(b) Teaching patients coping skills in vivo, such as using public transport, preparation of meals and budgeting.

(c) Ready availability of support system to help solve real-life problems, feel that he is not alone, and feel others are concerned.

(d) Provision of supports to keep the patient involved in community life and to encourage growth towards greater autonomy.

(e) Support and education of community members involved with patients.

(f) Assertive support system that helps patients with all of the above; involves them in their own treatment; and is prepared to 'go to' the patient to prevent dropout.

Hospitals should only be used for:

(a) Protection of the individual or others when the patient is imminently suicidal or homicidal.

(b) When psychiatric illness is complicated by significant medical illness.

(c) For patients whose psychosis is so severe that they require the structure and intensive nursing care of a hospital. The goal is to medicate and interrupt the psychotic process as early as possible.

Three different types of psychiatric admission wards:

(a) State Psychiatric Hospitals (Gladesville and Parramatta)
(b) General Hospitals (Liverpool and Hornsby)
(c) Private Hospitals (Northside Clinic)

were compared and evaluated. There were sizable differences between them in terms of the characteristics of patient admitted. The needs for:

- better staff-patient relationships
- more contact with doctors
- more comprehensive after-care

were particularly apparent at Gladesville, Parramatta and Liverpool.


Found substantial evidence that day treatment of psychiatric patients is superior to traditional full-time hospitalisation in facilitating the adjustment and re-integration of patients into the community.

Day treatment and full-time hospitalisation are equal on measures of cost effectiveness, family stress, symptom alleviation and relapse rate. Data on the efficacy of day treatment as a transitional facility from hospital to community was promising but incomplete.


(a) Commitment to continuing process of decentralisation and deinstitutionalisation. Continued important role for public
psychiatric hospitals, but development of alternative accommodation is top priority. This includes expansion of acute psychiatric services at general hospitals, and development of small inpatient units, hostels, community mental health services, particularly crisis intervention centres.

(b) Public psychiatric hospitals to become smaller, but will remain necessary for patients requiring totally sheltered accommodation by reason of age, infirmity or social deterioration.

(c) For acute and sub-acute patients, hospital admission and readmission will be part of a long and continuous process of care and management. Such management, however, will increasingly be carried out at home by the family doctor, community health teams, or private arrangements. Flexible continuity of care is the critical factor.

(d) Essential to establish effective working links between admission in patient units, in either general or psychiatric hospitals, community health centres and long-stay wards of psychiatric hospitals. One key person needs to have case responsibility at any one time.

The Confused and Disturbed Elderly


(a) Need to develop further services for the assessment, treatment and care of elderly patients: To be established in conjunction with general geriatric services.

(b) Aim to set up multidisciplinary assessment units within the geriatric medicine departments of major teaching hospitals.

(c) The psychiatrist from the psychogeriatric ward of the regional psychiatric hospital and his/her team will share joint responsibility for such units with the geriatrician.
Only long-stay patients with significant behavioural abnormalities should be cared for in Fifth Schedule system once initial assessment has been carried out.

Patients without severe behavioural disturbance should be cared for in nursing homes or in general hospitals.


There is a need to put more emphasis on allowing people to have a choice of care and how their needs will be satisfied.

Day hospitals provide day programmes for inpatients as well as day patients. Programmes can be maintenance only of three days per week, or rehabilitation.


Looks at services for elderly with brain failure. Raises a number of questions:

(a) Has the ready availability of institutions and hospital care predisposed Australian old people and their families to think only of institutions as solutions?
(b) What should be the role of private sponsorship in services?
(c) Role of State welfare services? Few exist to support the elderly with brain failure. How can these be organised?


Recommends providing a community psychiatric nursing service as a support to old people's homes, particularly where there is a high proportion of disturbed residents and where staff lack training.

Of 289 residents in six homes, found 50.6 per cent were probably
demented. Sixty showed remediable psychiatric disorders or psychotoxic drug effects.


Recommends establishing psychogeriatric services in district hospitals. The service requires:

(a) Definition of aims: define terminology, age, diagnostic characteristics of population to be served.

(b) Availability and responsiveness: domiciliary assessment is the cornerstone of practice. Readiness to see a patient at home within 24-48 hours, or alternatively freely available access to outpatient or inpatient assessment,

(c) The ability to work with different disciplines: need for psychogeriatric assessment units, involving a variety of different disciplines including a psychiatrist and geriatrician, to be set up in general hospitals.

(d) A comprehensive service: responsibility for a whole range of mental disorders in the elderly, functional and organic. Ongoing flexible care available by a team over a long period.


Follow-up showed success of a community-oriented psychogeriatric service. The emphasis was on domiciliary management by initiating and supporting caring networks. Found the ability of the service to sustain patients in the community is related to:

(a) Availability of a 24-hour emergency service by a doctor or nurse on call. Found this service used sparingly, but the knowledge of its availability reassured patients and relatives.

(b) Emphasis on continuity of care: the patient saw the same professionals throughout contact.
(c) High standard day centre, which was willing to take on difficult cases.


Presents details of the model operating in the Hornsby and Kuring-gai area.
Model based on idea that the GP is the lynchpin or final common path of health care delivery. The area health and rehabilitation services provide resources for the GP. A primary aim is to help the GP keep the patient at home as long as possible. When this is no longer possible, appropriate institutional care should be guaranteed.
This aim can be achieved by providing an educational, preventive, medico-social crisis and long-term maintenance service for elderly and disabled people, including psychogeriatrics.
Argues that the model could be repeated in providing care to psychiatrically ill, drug and alcohol problems, adolescent services, etc.

Children and Adolescents


   Need to increase supply of trained child psychiatrists and allied professionals.
   Need for specialised inpatient units in addition to community child and family psychiatry services.

Outlines the programme at Rivendell. Aims to provide a comprehensive residential, therapeutic and educational programme for adolescents aged 12-19 with psychological illness. Offers residential, day and short-stay facilities. Referrals are State-wide.

In past 20 years there has been an increasing demand for residential treatment. Three models are identified:

(a) The sole goal of residence is to make the child available for individual treatment.
(b) That living in a structured environment with healthy role models is all that's needed.
(c) The whole residential experience is the therapy, providing a 'therapeutic community'.

There are no conclusive studies showing that residential treatment works.

M.H.S.P.R.C. 'Report of the Working Party on Child, Adolescent and Family Mental Health', 1978, suggests a model with three functional levels:

(a) Child and family mental health workers, based at local health centres.
(b) Child and family mental health specialists, based at either a hospital or health centre, as a regional resource.
(c) Planners, as a State resource.

4. Winsberg, B. 'Home versus Hospital Care of Children with Behaviour Disorders', Archives of General Psychiatry, April 1980, 37, pp. 413-418.

Found community care effective with regard to behavioural control, and both treatments comparable concerning educational achievement, parent role function, family adjustment, and parent satisfaction with treatment.
Drug and Alcohol


Integrate drug programmes with other health care activities, particularly within the general hospital sector. This could be achieved by establishing small teams within hospitals to develop and implement programmes, and educate and support staff.

Similar support and education services required for community-based health staff.

Improve co-ordination between all groups. Facilitate local networks of services. Rationalisation of duplication.


No person should be too far geographically removed from:

(a) Detoxification facilities.
(b) Narcotic maintenance clinics.
(c) Long-term residential facilities for those undergoing rehabilitation and requiring intensive physical and psychological care.
(d) Short-term residential facilities for those requiring care for short periods following detoxification, or when relapse to former drug-using style appears imminent.
(e) Outpatient rehabilitation facilities.
(f) Emergency accommodation.
(g) 24-hour counselling to aid in crisis intervention.
(h) Family support facilities.
(i) Information centres/shopfronts to provide information, counselling on drug use and legal advice to drug users and other concerned with drugs.
(j) Drop-in centres providing open door for entry into any treatment regime. To attract those in early stages of misuse.
outreach programmes for those unaware of help or unwilling to accept it.

Developmentally Disabled


   - Develop hostels and group homes to provide community-based care.
   - Establish and expand specialised community assessment and support teams to enable more developmentally disabled to be cared for in their homes.
   - Develop distinctive services and facilities for developmentally disabled separate from psychiatric facilities.
   - Systematic screening of babies and children for developmental disability, and introduction of early remedial programme.


   Recommends:

   (a) Deentralisation of residential occupation for the majority of mentally handicapped to community-based hostels.
   (b) Development of regional assessment teams.
   (c) Increased emphasis on community support, early detection and prevention, and decreased emphasis on institutionalisation.
   (d) For those requiring institutionalisation, a greater sharing of responsibility for care and management between educators, psychologists, medical and nursing staff. These responsibilities should be related to specific treatment objectives determined on or prior to admission.
   (e) A review of funding by all levels of government.
   (f) A review of the organisational arrangements for providing services to the mentally handicapped. The review might
consider establishing a co-ordinating and policy office of mental retardation.

3. Similar views are expressed in the following:


Participants: Approximately 100 people attended.

Issues raised

Below are the points and issues raised at the Industrial Relations Forum. They do not include all points raised by speakers organised for the day. Points often belong in more than one of the key issues categories.

Service Delivery

1. Industrial relations cannot be isolated from service delivery issues.
2. Need for less reliance on institutional care, more on community health.
3. While desirable to move patients to community, need to increase community services before this is done. Commission needs to commit itself.
4. Fifth Schedule staff should not have to go out from hospital and supervise patients living in the community.
5. Transferring patients to the private sector bad. Private sector exists to make profit. If this transfer happens, need to increase monitoring and supervision procedures.
6. Schedule 2 units need to be in grassed, ground floor environments.
7. Schedule 2 units will reduce inequity which now requires some country patients to travel hundreds of kilometres even for acute treatment.
8. Item 4 of terms of reference should be expanded to include developmentally disabled and psychogeriatrics.

9. New South Wales currently has very few residential placements for patients outside hospitals.

10. Increased community psychiatric nursing staff would help prevent patients coming into hospitals.

11. A lot of lonely people with problems better off in institutions. Need to increase resources to institutions first, and then spend money on community care.

12. Institutions have continued to provide care, but community services have failed.

13. Poor Fifth Schedule bed distribution between Regions.

14. Staff/patient ratio inequitable between Regions.

15. The larger the institution, the more impersonal it becomes.

16. The majority of people in psychiatric hospitals are there as there are not adequate facilities in the community.

17. Need policies to monitor chemotherapy levels, housing standards and so on for community treatment.

18. Are large institutions only to become small institutions which in turn will be tacked on to other large institutions, i.e. general hospitals?

19. Innovations by staff at institutions have been decimated by staff and resource cutbacks.

20. Large institutions have been 'catch all' service. Need to set up proximate and specialised services.

21. The structure of the institution is less important than the needs of the people.

22. Who has legal responsibility for patients under various types of service delivery, especially community care?
Manpower and Industrial Relations

1. If Fifth Schedule is to be transferred out of Public Service, need to ensure portability of superannuation and other conditions. Need for common conditions.

2. Low staff levels lead to low staff morale, lead to decreased services, lead to increased patient aggression, lead to increase patient-related injuries lead to increased sick leave.

3. Common conditions between Fifth and Second Schedule a long way off.

4. Moves to smaller units may simply be a move to decrease union power base. As Government can no longer squeeze Schedule 2, are cutting Schedule 5 to cut costs.

5. Need to ensure promotional opportunities and career structure in smaller units, otherwise will have problems attracting staff.

6. Need to employ adequate trained psychiatric nurses in Schedule 2 acute facilities.

7. Need to give assurances to staff on their futures for at least next three-year period.

8. Need to consider increased stress on staff providing community care.

9. Need to consider promotional opportunities in community health.

10. Who will deliver care in Schedule 2 - general or psychiatric nurses?

11. Inquiry needs to develop new perspective on how staffing issues can be addressed.

12. Issue of employing 'second-level care workers' or 'residential care workers'. In reality this means non-nurses. They do not have the expertise needed to provide adequate services.

13. The structure of the nursing service needs to be examined before any changes occur.
14. Hospitals should be able to employ replacement staff provided they stay within budget.

15. Employment of casual staff more acceptable than excessive overtime.

16. Low staffing levels lead to low job satisfaction.

17. Small institutions lead to raised job satisfaction.

18. Problem of increasing staff in country areas as no one wants to work there.

19. Problem of redundancies amongst ancillary staff in hospitals reduced in size or closed.

20. To reduce costs and provide therapy, patients could do a lot of work around the hospital. But industrially, this is problematic.

Management

1. Boards of Directors for Fifth Schedule? Would these allow greater political muscle for psychiatric/developmentally disabled system? Would they act as patient advocates?

2. Need for consultation at all levels – often tremendously difficult to obtain information from regional and head offices.

3. Should management decisions be on moral/religious grounds or professional grounds?

Training and Education

1. Staff shortages have affected student training, including clinical supervision.

2. Second Schedule units not viable as many staff members inadequately trained. Lack of training results in inappropriate transfer of their patients to Schedule 5. They need more clinical experience in training.
3. Transfer of patients to small units or the private sector will take away acute patients from schedule 5 hospitals, leaving students in these hospitals only chronic patients to gain clinical experience from.

4. Can current Schedule 5 staff adapt to new community roles, and roles in smaller units? What stages will they go through?

5. Need to ensure psychiatric trained nurse's certificate retains its value.

6. Need for more in-service training for Schedule 5 staff.

7. Comprehensive Nursing Course should be encouraged.

8. Need to educate community on needs of patients. Perhaps institutions could do this?

Financial

1. If Fifth Schedule functions came under general hospitals, they may be under-resourced, as traditionally hospitals favour high technology, high prestige areas for funding.

2. Whatever changes occur in the system, it will require more money being spent.

3. Basis for deploying resources: least cost or level of return on investments?

4. Cost is not an acceptable basis for determining needs of patients.

5. How should Fifth Schedule be funded in future? Should each hospital be given a block grant, rather than funded separately for different items of expenditure?

6. Need to look at health funds and their roles re different types of service delivery.
Systems

1. Need for consultation at all levels of system, and between system and community.

2. Staff speak for patients and relatives; they are not simply self-interested.

3. Being in Fifth Schedule system, and hence public servants, reduces ability to 'kick up a fuss' and act as patient advocates.

4. Study in Hunter Region (1979) of citizens' attitudes found most would prefer treatment in a general hospital psychiatric ward than a psychiatric hospital.

5. Most people do not want psychiatric patients living near them.

6. Need to consider adverse economic effects on local communities of closures or reductions in size of institutions.

7. Will psychiatric units in general hospitals be 'hidden away', resulting in stigma?

8. Change should occur slowly.


10. Need to consider and develop time scales for all proposals - how long will change take?

11. Staff referenda one valuable form of consultation.
Participants: Approximately 100 individuals from management within Health Services.

Summary of issues raised

(i) Consensus that change is necessary, with greater emphasis on decentralised community care.

(ii) Need to transfer resources from general health services to meet needs in the less attractive areas being reviewed by the Inquiry.

(iii) Acute services worked well in general hospitals and have promoted earlier intervention, reduced some of the stigma of mental illness and helped to integrate general and mental health services.

(iv) Availability of health insurance cover stressed in relation to psychiatric units in general hospitals.

(v) Strong support for (a) decentralising services away from institutions; (b) development of local networks of services; and (c) separation of psychiatric services from developmental disability services.

(vi) Services should focus on Second Schedule hospitals coordinated with other support services and targeted for a defined population (move towards Area Board concept).

(vii) Need for increased and continued advocacy for the chronically ill and for the long-term needs of the developmentally disabled.
(viii) Need for increased and continued advocacy for the chronically ill and for the long-term needs of the developmentally disabled.

(ix) Importance of providing adequate training for staff (particularly nurses) to enable them to provide services outside institutions.

(x) Problems of training service providers (e.g. general practitioners) in special needs of clients (e.g. mental illness, particular problems of the aged).
FORUM FOR NON-GOVERNMENT ORGANISATIONS AND CONSUMER GROUPS

Tuesday, 7 December 1982 - McKell Building

Developmental Disability Services

Participants: Approximately 40 individuals and organisations.

1. The Inquiry presented a summary of major points made in submissions from non-government organisations and consumer groups.

These included:

- The importance of a developmental ethos rather than medical;
- The importance of care in the 'normal environment';
- The importance of continuity of care;
- The need for a statutory authority or similar organisation to undertake a coordinating, monitoring role;
- Concern by some organisations to 'move' these services out of the health setting altogether;
- The need to provide an integrated network of services;
- The importance of formal opportunities for consumer and non-government organisations to participate in planning and management;
- The need to deinstitutionalise services.

In addition the Inquiry had identified the following issues in relation to the role of consumer and non-government organisations:

- Concern that non-government organisations as providers of residential care may lead to isolation and a paternal stick approach;
Increasing role of non-government organisations as advocates, lobbyists, rather than direct service providers.

2. Summary of issues raised in discussion

(i) Important to establish mechanisms for on-going involvement of non-government organisations and consumer groups in planning and delivery of government services; growing cynicism about one-off 'consultation' process.

(ii) Important to negotiate for better access to Commonwealth funds for residential care; "care of the disabled is a national responsibility - should be a national approach".

(iii) Health base for these services seen as inappropriate - not primarily a 'health' problem - but bulk of resources 'tied up' in health because of historical circumstances. Role of proposed statutory authority seen as important in this respect - coordination of funding and services would lead to gradual development of a more balanced services system.

(iv) Problems in the current arrangements of Commonwealth assistance. Under Handicapped Person's Assistance Programme non-government organisations need to raise one-fifth of capital and one-half of operating funds. This places enormous pressure on small parent-based groups. Cannot get State assistance directly without jeopardising Commonwealth funds.

(v) Concern re fragmentation - proliferation of small parent and other community groups - another argument for statutory authority?

(vi) Need for research into causes and prevention of disabling conditions.

(vii) Residential services provided by parents' groups are seen as acceptable by parents provided they are fully funded and can therefore provide continuity. However, access can be limited by the nature of the organisation.
Importance of consistency of staffing in residential care services - i.e. live-in with other support - not rotating shifts.

Importance of separation of care of developmentally disabled from care of mentally ill.

Permanency of placement - security - seen as primary concern of parents.

Study for the Housing Commission on housing needs of single people - identified population of intellectually handicapped people who are homeless, single and rejected.

Social and financial benefits of foster-care programmes provided adequate supports are available - recognise that continuity and adequate 'social' staffing less possible in institutions.

Forum run by intellectual handicap groups - stressed that even most profoundly handicapped 'better' if cared for in small facilities (maximum 30 people).

Need for redistribution - problems of access for country people.

Important to recognise that deinstitutionalisation will require increased levels of normal community services - e.g. home-help.

Training for movement into the community - residents should only be rehoused once - training should occur in their own house.

Question of a register of the developmentally disabled:
Two levels - local register which includes identifying data useful as a referral/access mechanism;
- central registers for planning purposes useful, but should not include any identifying data.
(xviii) Small group homes provide a setting where much greater expression of individual needs and development of individual potential can occur - even for the severely disabled.

(xix) Need to run two systems in parallel - cannot reduce institutional services until adequate alternatives are developed.

(xx) Importance of prevention and early intervention - supports to families in their own homes.

(xxii) Early intervention needs to be free and freely available; increasing role of Education and T.A.F.E. in this area.

(xxiii) Need for guidelines for government relationship with the non-government sector.

(xxiii) Need for specialised services for emotionally disturbed disabled.

(xiv) Services for handicapped children in schools - Report on Special Education recommended this be a Health Department responsibility.
Mental Health Services

Participants: Approximately 40 individuals or groups.

1. The Inquiry presented a summary of major points made in submissions from non-government organisations and consumer groups.

These included:

Concern about the effects of deinstitutionalisation without prior increase of community support and treatment services.
The importance of availability of a range of alternatives to hospitalisation, including alternative approaches to treatment, and the potential role of the non-government sector in this area.
The need to provide an integrated network of services.
The importance of formal opportunities for consumer and non-government organisations to participate in planning and management.

2. Summary of Issues Raised in Discussion

(i) Need for permanent structure for ongoing consultation with the non-government sector.
(ii) Need for greater co-ordination of Commonwealth-State (and intra-State) funding arrangements.
(iii) Need for more non-government organisation involvement in provision of residential care service.
(iv) Need to upgrade/specialise services in psychiatric hospitals - should not be seen as a last resort ('garbage bin mentality').

(v) Need for stronger organic perspective in assessment, prior to diagnosis; need to educate psychiatrists to understand and acknowledge this perspective.

(vi) Need for a 'cascade' of services and levels of intervention, with priority to the most disadvantaged identified patients, and to the care of children with emotional problems.

(vii) Concern about reliance on use of drugs in hospitals - need for better staffing to provide greater programme basis, and for research into alternative treatment modes.

(viii) Importance of early intervention at times of stress, e.g. workplace-related stress, stress of unemployment.

(ix) Need for better support of non-government agencies by mental health services.

(x) Particular problems of mentally ill women - concern re exploitation and abuse.

(xi) Need for a viable advocacy system in hospitals.

(xii) Problems of homeless people.

(xiii) Problems in Commonwealth funding of non-government services.

(xiv) Need for improvements in patient and relative information.
STAFFING AND COSTING GUIDELINES


3 psychiatrists @ $50,600 $151,800
1 medical officer @ $32,581 $ 32,581
10 nurses @ $20,936 $209,630
5 social workers @ $25,516 $127,580
4 psychologists @ $25,315 $101,260
3 occupational therapists @ $21,286 $ 63,858
3 clerical assistants @ $15,308 $ 45,924

$732,633

Note: Cost for penalty rates is included in oncosts -- (added to salaries); penalty loading on model used is 16.86% of base salary used.

Other operating costs:

Cars, bleepers, rental - calculated at: $ 86,540

Total per team: $819,903 per annum

40-Bed Acute Admission Ward - Fifth Schedule Hospital

5 medical, e.g. 2 psychiatrists (staff specialists)
3 registrars
21 nursing, plus 1 activities nurse
3 ancillary (1 social worker, 1 psychologist, 1 occupational therapist)
2 domestics

40-Bed Acute Admissions Unit - second and Third Schedule Hospital

5 medical, e.g. 2 psychiatrists
3 registrars (may be 3 psychiatrists and 1 registrars, e.g. Banks House)
26 nursing, plus 1 activities nurse (includes 2 domestic nurses)
3 ancillary (1 social worker, 1 psychologist, 1 occupational therapist)
2 domestics

Note: Nursing rostered as follows:
6 on 'A' shift
5 on 'B' shift
3 on 'C' shift
May include general student nurses.

Mental Health Team (Illawarra)

2 medical (1 psychiatrist, 1 medical officer)
4 nur in (3 psychiatric nurses, 1 ward orderly)
4 ancillary (2 social workers, 1 occupational therapist, 1 psychologist)
1 clerical assistant, administration (medical secretary)

Child Psychiatry Team

1 psychiatrist
5 ancillary (3 social workers, 2 psychologists)

2. Developmental Disability Community Residential Units

Staff patterns for Resident Groupings (weekly) - six persons per group.

1:1  Maximum Assistance (Children)

1.4 houseparents (24-hour shifts) - 'live-in'
FTE 4.6 workers (8-hour shifts) - 'rostered'
(1 of above to be supervisor)
(3 x 1, 3 x 0.4, 1 x 0.4)
1:2 Moderate Assistance (Children)
4.2 1.4 houseparents (24-hour shifts)
FTE 2.8 workers (8-hour shifts)
(1 to be supervisor)

1:3 Minimal Assistance (Children)
3.2 1.4 houseparents (24-hour shifts)
FTE 1.8 workers (8-hour shifts)
(1 to be supervisor)

1:4 Maximum Assistance (Adults)
6.0 1.4 houseparents (24-hour shifts)
FTE 4.6 workers (8-hour shifts)
(1 to be supervisor)

1:5 Moderate Assistance (Adults)
4.2 1.4 houseparents (24-hour shifts)
FTE 2.8 workers (8-hour shifts)
(1 to be supervisor)

1:6 Minimal Assistance (Adults)
3.2 1.4 houseparents (24-hour shifts)
FTE 1.8 workers (8-hour shifts)
(1 to be supervisor)

Note: Plus additional staff hours as required (individual resident needs), plus holiday cover.

Add-on Holiday Cover (6 weeks)

1:1 1.6 houseparents (24-hour shifts)
5.2 workers (8-hour shifts)
(1 to be supervisor)
FTE

1:2 1.6 houseparents (24-hour shifts)
3.2 workers (8-hour shifts)  
4.8  (1 to be supervisor)  
FTE

1:3  1.6 houseparents (24-hour shifts)  
2.0 workers (8-hour shifts)  
3.6  (1 to be supervisor)  
FTE

Average of above: 5.07, i.e. 5.1 per residence
(1400-7-6)  233.33
233.33 x 5.1 = 1,188

Additional relief (behavioural disturbances):
= 0.33 per residence

Total:  
5.1 per residence
+ 0.33
5.43 per residence

Say 5.4 (7.13, 5.13, 3.93) + 0.3 relief.

1st Model

1.6 x $16,575 $26,520
5.5 x $15,450 $84,975

Total:
7.1 $15,704 (average) $111,495

Including 20% oncosts: $139,370

2nd Model

1.6 x $16,575 $26,520
3.5 x $15,450 $54,075

Total:
5.1 $15,803 (average) $80,595

Including 20% oncosts: $100,745
3rd Model

1.6 x $16,575 = $26,520
2.3 x $15,450 = $35,535
Total:
3.9 x $15,911 (average) = $62,055
Including 20% oncosts: = $77,570

Average of Models 1, 2, 3: = $105,895

Costs Without Contingency

1st Model (Maximum Live-in Supervision)

1.6 x $16,575 = $26,520
5.2 x $15,450 = $80,340
Total:
6.8 x $15,715 (average) = $106,860
Including 20% oncosts: = $133,575

2nd Model (Medium Live-in Supervision)

1.6 x $16,575 = $26,520
3.2 x $15,450 = $49,440
Total:
4.8 x $15,825 (average) = $75,960
Including 20% oncosts: = $94,950

3rd Model (Minimum Live-in Supervision)

1.6 x $16,575 = $26,520
2.0 x $15,450 = $30,900
3.6 x $15,950 (average) = $57,420
Including 20% oncosts: = $71,775

Average of Models 1, 2, 3: = $100,100
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<td>20% $21,286</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>$340.20</td>
<td>$17,739</td>
<td>15% $20,399</td>
<td>20% $21,286</td>
</tr>
<tr>
<td>Speech Pathologist</td>
<td>$345.50</td>
<td>$18,026</td>
<td>15% $20,729</td>
<td>20% $21,631</td>
</tr>
<tr>
<td>Social Educator</td>
<td>$22,246</td>
<td>$25,582</td>
<td>20% $26,695</td>
<td></td>
</tr>
<tr>
<td>Cook</td>
<td>$268.20</td>
<td>$13,985</td>
<td>25% $17,481</td>
<td>15% $16,082</td>
</tr>
<tr>
<td>Clerical Asst./Typist</td>
<td>$255.30</td>
<td>$13,312</td>
<td>15% $15,308</td>
<td>15% $15,308</td>
</tr>
<tr>
<td>Maintenance Staff</td>
<td>$308.40</td>
<td>$16.081</td>
<td>15% $18,493</td>
<td>15% $18,493</td>
</tr>
<tr>
<td>( Tradesmen)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

STAFFING COSTS (JANUARY 1983)
## DEVELOPMENTAL DISABILITY HOSPITALS

### 1979/80 STATISTICS

<table>
<thead>
<tr>
<th></th>
<th>GROSVENOR</th>
<th>MARSDEN</th>
<th>STOCKTON</th>
<th>PEAT ISLAND</th>
<th>COLLAROY</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Days</strong></td>
<td>26,594</td>
<td>146,012</td>
<td>297,719</td>
<td>60,190</td>
<td>18,261</td>
<td>548,776</td>
</tr>
<tr>
<td><strong>Available Beds</strong></td>
<td>86</td>
<td>476</td>
<td>877</td>
<td>174</td>
<td>60</td>
<td>1,673</td>
</tr>
<tr>
<td><strong>Daily Average</strong></td>
<td>72.7</td>
<td>398.9</td>
<td>813.4</td>
<td>164.5</td>
<td>49.9</td>
<td>1,499.4</td>
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<tr>
<td><strong>Occupancy Rate %</strong></td>
<td>84.5</td>
<td>83.8</td>
<td>92.8</td>
<td>94.5</td>
<td>83.2</td>
<td>89.6</td>
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<table>
<thead>
<tr>
<th><strong>Notes</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a</strong></td>
<td></td>
</tr>
<tr>
<td><strong>b</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c</strong></td>
<td></td>
</tr>
<tr>
<td><strong>d</strong></td>
<td></td>
</tr>
<tr>
<td><strong>e</strong></td>
<td></td>
</tr>
<tr>
<td><strong>f</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Number of Nurses**       | 75 | 317 | 467 | 76 | 45 | 980 |
| **Cost of Nursing Staff**  | $1,053,788 | $4,323,094 | $5,674,069 | $1,075,993 | $554,480 | $12,681,424 |

| **Number of Clinical Staff** | 90 | 354 | 490 | 79 | 47 | 1,060 |
| **Cost of Clinical Staff**  | $1,358,665 | $4,889,738 | $6,082,247 | $1,188,405 | $565,948 | $14,085,003 |

| **Number of Non-Clinical Staff** | 46 | 187.5 | 326 | 77 | 21 | 657.5 |
| **Cost of Non-Clinical Staff**  | $519,694 | $2,073,808 | $3,453,191 | $825,223 | $248,565 | $7,120,481 |

| **Total Staff**             | 136 | 541.5 | 816 | 156 | 68 | 1,717.5 |
| **Total Staff Cost**        | $1,878,359 | $6,963,546 | $9,535,438 | $2,013,628 | $814,513 | $21,205,484 |

| **Gross Operating Payments** | $2,205,307 | $8,457,805 | $11,425,484 | $2,554,352 | $989,644 | $25,632,592 |

**Source:** Annual Returns

**TABLE ONE**
**FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA**

**DEVELOPMENTAL DISABILITY HOSPITALS**

**1980/81 STATISTICS**

<table>
<thead>
<tr>
<th></th>
<th>GROSVENOR</th>
<th>MARSDEN</th>
<th>STOCKTON</th>
<th>PEAT ISLAND</th>
<th>COLLAROY</th>
<th>TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Days</strong></td>
<td>27,228</td>
<td>146,043</td>
<td>285,531</td>
<td>58,727</td>
<td>18,497</td>
<td>536,026</td>
<td>5</td>
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<tr>
<td><strong>Available Beds</strong></td>
<td>86</td>
<td>474</td>
<td>871</td>
<td>174</td>
<td>54</td>
<td>1,659</td>
<td>6</td>
</tr>
<tr>
<td><strong>Daily Average</strong></td>
<td>74.6</td>
<td>400.1</td>
<td>782.3</td>
<td>160.9</td>
<td>50.7</td>
<td>1,468.6</td>
<td>c2</td>
</tr>
<tr>
<td><strong>Occupancy Rate %</strong></td>
<td>86.7</td>
<td>84.4</td>
<td>89.8</td>
<td>92.5</td>
<td>93.8</td>
<td>88.5</td>
<td>d</td>
</tr>
</tbody>
</table>

|                      |           |         |          |             |          |          |       |
| **Number of Nurses** | 66        | 336.5   | 505      | 73          | 43       | 1,023.5  | e     |
| **Cost of Nursing Staff** | $1,109,716 | $5,037,968 | $6,906,774 | $1,276,264 | $660,526 | $14,991,248 | f     |
|                      |           |         |          |             |          |          |       |
| **Number of Clinical Staff** | 81.5      | 374     | 527      | 76          | 45       | 1,103.5  | e, g  |
| **Cost of Clinical Staff** | $1,473,547 | $5,603,079 | $7,375,211 | $1,436,058 | $672,378 | $16,560,273 |       |
|                      |           |         |          |             |          |          |       |
| **Number of Non-Clinical Staff** | 49       | 196     | 335      | 76          | 20       | 676      | e, h  |
| **Cost of Non-Clinical Staff** | $570,708 | $2,375,878 | $3,935,465 | $930,931   | $248,395 | $8,061,377 |       |
|                      |           |         |          |             |          |          |       |
| **Total Staff**      | 130.5     | 570     | 862      | 152         | 65       | 1,779.5  |       |
| **Total Staff Cost** | $2,044,255 | $7,978,957 | $11,310,676 | $2,366,989 | $920,773 | $24,621,650 |       |
|                      |           |         |          |             |          |          |       |
| **Gross Operating Payments** | $2,430,363 | $9,616,766 | $13,496,719 | $52,994,098 | $1,143,680 | $29,681,626 |       |

Source: Annual Returns

**TABLE TWO**
<table>
<thead>
<tr>
<th></th>
<th>Grosvenor</th>
<th>Marsden</th>
<th>Stockton</th>
<th>Peat Island</th>
<th>Collaroy</th>
<th>Total</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>25,381</td>
<td>138,824</td>
<td>278,517</td>
<td>54,560</td>
<td>18,712</td>
<td>515,994</td>
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</tr>
<tr>
<td>Available Beds</td>
<td>86</td>
<td>443</td>
<td>844</td>
<td>174</td>
<td>54</td>
<td>1,601</td>
<td>b</td>
</tr>
<tr>
<td>Daily Average</td>
<td>69.5</td>
<td>380.3</td>
<td>763.1</td>
<td>149.5</td>
<td>51.3</td>
<td>1,413.7</td>
<td>c</td>
</tr>
<tr>
<td>Occupancy Rate %</td>
<td>80.9</td>
<td>85.9</td>
<td>90.4</td>
<td>85.9</td>
<td>94.9</td>
<td>88.3</td>
<td>c</td>
</tr>
<tr>
<td>Number of Nurses</td>
<td>72.5</td>
<td>322</td>
<td>502.5</td>
<td>74</td>
<td>41.5</td>
<td>1,012.5</td>
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</tr>
<tr>
<td>Cost of Nursing Staff</td>
<td>$1,369,692</td>
<td>$6,401,972</td>
<td>$8,753,702</td>
<td>$1,623,290</td>
<td>$749,681</td>
<td>$18,898,337</td>
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</tr>
<tr>
<td>Number of Clinical Staff</td>
<td>84.5</td>
<td>359.5</td>
<td>521.5</td>
<td>77.5</td>
<td>42.5</td>
<td>1,085.5</td>
<td>e, g</td>
</tr>
<tr>
<td>Cost of Clinical Staff</td>
<td>$1,773,592</td>
<td>$7,106,921</td>
<td>$9,296,400</td>
<td>$1,758,711</td>
<td>$765,939</td>
<td>$20,701,563</td>
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<tr>
<td>Number of Non-Clinical Staff</td>
<td>43</td>
<td>181</td>
<td>332</td>
<td>67</td>
<td>19</td>
<td>642</td>
<td>e, h</td>
</tr>
<tr>
<td>Cost of Non-Clinical Staff</td>
<td>$642,048</td>
<td>$2,629,737</td>
<td>$4,413,992</td>
<td>$1,045,236</td>
<td>$292,691</td>
<td>$9,023,704</td>
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</tr>
<tr>
<td>Total Staff</td>
<td>127.5</td>
<td>540.5</td>
<td>853.5</td>
<td>144.5</td>
<td>61.5</td>
<td>1,727.5</td>
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<tr>
<td>Total Staff Cost</td>
<td>$2,415,640</td>
<td>$9,736,658</td>
<td>$13,710,392</td>
<td>$2,803,947</td>
<td>$1,058,630</td>
<td>$29,725,267</td>
<td></td>
</tr>
<tr>
<td>Gross Operating Payments</td>
<td>$2,816,448</td>
<td>$11,515,497</td>
<td>$16,201,624</td>
<td>$3,453,816</td>
<td>$1,268,448</td>
<td>$35,255,833</td>
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</table>

Source: Annual Returns

TABLE THREE
<table>
<thead>
<tr>
<th></th>
<th>ALLANDALE</th>
<th>GARRAWARRA</th>
<th>LI DCOMBE (NON-RECOGNISED)</th>
<th>STRICKLAND</th>
<th>TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days (1,000)</td>
<td>191.7</td>
<td>117.6</td>
<td>104.9</td>
<td>28.0</td>
<td>442.3</td>
<td>a</td>
</tr>
<tr>
<td>Available Beds</td>
<td>536</td>
<td>331</td>
<td>330</td>
<td>108</td>
<td>1,305</td>
<td>b</td>
</tr>
<tr>
<td>Daily Average (beds/b)</td>
<td>523.8</td>
<td>321.3</td>
<td>286.7</td>
<td>76.6</td>
<td>1,208.4</td>
<td>c</td>
</tr>
<tr>
<td>Occupancy Rate (%)</td>
<td>97.7</td>
<td>97.1</td>
<td>86.9</td>
<td>70.9</td>
<td>92.6</td>
<td>d</td>
</tr>
<tr>
<td>Number of Nurses</td>
<td>269</td>
<td>152.5</td>
<td>141</td>
<td>31</td>
<td>593.5</td>
<td>f</td>
</tr>
<tr>
<td>Cost of Nursing Staff</td>
<td>$3,403,162</td>
<td>$1,938,606</td>
<td>$2,066,010</td>
<td>$406,173</td>
<td>$7,813,951</td>
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<tr>
<td>Number of Clinical Staff</td>
<td>279</td>
<td>172.5</td>
<td>147</td>
<td>32</td>
<td>630.5</td>
<td>e, g</td>
</tr>
<tr>
<td>Cost of Clinical Staff</td>
<td>$3,641,917</td>
<td>$2,241,717</td>
<td>$2,153,284</td>
<td>$417,424</td>
<td>$8,454,342</td>
<td>f</td>
</tr>
<tr>
<td>Number of Non-Clinical Staff</td>
<td>192</td>
<td>117</td>
<td>99.5</td>
<td>23.5</td>
<td>432</td>
<td>e, h</td>
</tr>
<tr>
<td>Cost of Non-Clinical Staff</td>
<td>$2,081,659</td>
<td>$1,343,988</td>
<td>$1,264,863</td>
<td>$259,025</td>
<td>$4,949,535</td>
<td>f</td>
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<tr>
<td>Total Staff</td>
<td>471</td>
<td>289.5</td>
<td>246.5</td>
<td>55.5</td>
<td>1,062.5</td>
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</tr>
<tr>
<td>Total Staff Cost</td>
<td>$5,723,576</td>
<td>$3,585,705</td>
<td>$3,418,147</td>
<td>$676,449</td>
<td>$13,403,877</td>
<td>f</td>
</tr>
<tr>
<td>Gross Operating Payments</td>
<td>$6,947,876</td>
<td>$4,507,412</td>
<td>$4,253,383</td>
<td>$866,087</td>
<td>$16,574,758</td>
<td>f</td>
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Source: Annual Returns

TABLE FOUR
### Approved Nursing Homes - 1980/81 Statistics

#### Table Five

<table>
<thead>
<tr>
<th></th>
<th>Allandale</th>
<th>Garrawarra</th>
<th>Lidcombe</th>
<th>Strickland</th>
<th>Total</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Days</strong></td>
<td>185,139</td>
<td>118,425</td>
<td>99,673</td>
<td>29,296</td>
<td>435,533</td>
<td>a</td>
</tr>
<tr>
<td><strong>Available Beds</strong></td>
<td>536</td>
<td>331</td>
<td>310</td>
<td>108</td>
<td>1,285</td>
<td>b</td>
</tr>
<tr>
<td><strong>Daily Average</strong></td>
<td>507.2</td>
<td>324.5</td>
<td>273.1</td>
<td>80.3</td>
<td>1,193.2</td>
<td>c</td>
</tr>
<tr>
<td><strong>Occupancy Rate %</strong></td>
<td>94.6</td>
<td>98.0</td>
<td>88.1</td>
<td>74.3</td>
<td>92.9</td>
<td>d</td>
</tr>
</tbody>
</table>

|                  |           |            |          |            | Notes     |       |
| **Number of Nurses** |          |            |          |            | 580.5     |       |
| **Cost of Nursing Staff** | $3,970,352 | $2,135,657 | $2,509,614 | $468,426 | $9,084,049 |       |

|                  |           |            |          |            | Notes     |       |
| **Number of Clinical Staff** |          |            |          |            | 616.5     |       |
| **Cost of Clinical Staff** | $4,245,390 | $2,461,091 | $2,624,983 | $479,142 | $9,810,606 |       |

|                  |           |            |          |            | Notes     |       |
| **Number of Non-Clinical Staff** |          |            |          |            | 452.5     |       |
| **Cost of Non-Clinical Staff** | $2,386,917 | $1,556,628 | $1,423,289 | $379,095 | $5,745,929 |       |

|                  |           |            |          |            | Notes     |       |
| **Total Staff**  | 463       | 298        | 243      | 65         | 1,069     |       |
| **Total Staff Cost** | $6,632,307 | $4,017,719 | $4,048,272 | $858,237 | $15,556,535 |       |
| **Gross Operating Payments** | $8,174,990 | $5,198,650 | $5,110,360 | $1,141,839 | $19,625,839 |       |

**Source:** Annual Returns
**FIFTH SCHEDULE HOSPITALS - FINANCIAL AND STAFFING DATA**

**APPROVED NURSING HOMES**

**1981/82 STATISTICS**

<table>
<thead>
<tr>
<th></th>
<th>ALLANDALE</th>
<th>GARRAVARRA</th>
<th>LI DCOMBE (NON-RECOGNISED)</th>
<th>STRICKLAND</th>
<th>TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>167,881</td>
<td>113,391</td>
<td>96,133</td>
<td>32,561</td>
<td>409,966</td>
<td>a</td>
</tr>
<tr>
<td>Available Beds</td>
<td>536</td>
<td>331</td>
<td>310</td>
<td>108</td>
<td>1,285</td>
<td>b</td>
</tr>
<tr>
<td>Daily Average</td>
<td>459.9</td>
<td>310.7</td>
<td>263.4</td>
<td>89.2</td>
<td>1,123.2</td>
<td>c</td>
</tr>
<tr>
<td>Occupancy Rate %</td>
<td>85.8</td>
<td>93.9</td>
<td>85.0</td>
<td>82.6</td>
<td>87.4</td>
<td>d</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Nurses</td>
<td>267</td>
<td>166</td>
<td>119</td>
<td>36</td>
<td>588</td>
<td></td>
</tr>
<tr>
<td>Cost of Nursing Staff</td>
<td>$5,289,521</td>
<td>$2,932,294</td>
<td>$2,942,543</td>
<td>$648,095</td>
<td>$11,812,453</td>
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</tr>
<tr>
<td>Number of Clinical Staff</td>
<td>277</td>
<td>185</td>
<td>125</td>
<td>37</td>
<td>624</td>
<td>e, g</td>
</tr>
<tr>
<td>Cost of Clinical Staff</td>
<td>$5,613,274</td>
<td>$3,335,143</td>
<td>$3,079,103</td>
<td>$662,843</td>
<td>$12,690,363</td>
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</tr>
<tr>
<td>Number of Non-Clinical Staff</td>
<td>190</td>
<td>126</td>
<td>113</td>
<td>26</td>
<td>455</td>
<td>e, h</td>
</tr>
<tr>
<td>Cost of Non-Clinical Staff</td>
<td>$2,700,586</td>
<td>$1,845,906</td>
<td>$1,717,718</td>
<td>$433,106</td>
<td>$6,697,316</td>
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</tr>
<tr>
<td>Total Staff</td>
<td>467</td>
<td>311</td>
<td>238</td>
<td>63</td>
<td>1,079</td>
<td></td>
</tr>
<tr>
<td>Total Staff Cost</td>
<td>$8,313,860</td>
<td>$5,181,049</td>
<td>$4,796,821</td>
<td>$1,095,949</td>
<td>$19,387,679</td>
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</tr>
<tr>
<td>Gross Operating Payments</td>
<td>$9,789,935</td>
<td>$6,332,137</td>
<td>$5,921,041</td>
<td>$1,334,304</td>
<td>$23,377,417</td>
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</tbody>
</table>

Source: Annual Returns

*TABLE SIX*
<table>
<thead>
<tr>
<th></th>
<th>BLOOMFIELD</th>
<th>ROZELLE</th>
<th>GLADESVILLE</th>
<th>KENMORE</th>
<th>MORISSET</th>
<th>NEWCASTLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>192,134</td>
<td>184,642</td>
<td>210,939</td>
<td>202,869</td>
<td>214,916</td>
<td>34,284</td>
</tr>
<tr>
<td>Available Beds</td>
<td>665</td>
<td>627</td>
<td>718</td>
<td>596</td>
<td>689</td>
<td>110</td>
</tr>
<tr>
<td>Daily Average</td>
<td>526.4</td>
<td>505.9</td>
<td>577.9</td>
<td>555.8</td>
<td>588.8</td>
<td>93.9</td>
</tr>
<tr>
<td>Occupancy Rate %</td>
<td>79.2</td>
<td>80.7</td>
<td>80.5</td>
<td>93.3</td>
<td>85.5</td>
<td>85.4</td>
</tr>
<tr>
<td>Number of Nurses</td>
<td>313</td>
<td>457</td>
<td>387</td>
<td>290</td>
<td>329</td>
<td>114</td>
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<tr>
<td>Cost of Nursing Staff</td>
<td>$7,139,359</td>
<td>$9,712,286</td>
<td>$8,434,424</td>
<td>$6,246,254</td>
<td>$8,018,127</td>
<td>$2,553,965</td>
</tr>
<tr>
<td>Number of Clinical Staff</td>
<td>330</td>
<td>516</td>
<td>443.5</td>
<td>315.5</td>
<td>352</td>
<td>138</td>
</tr>
<tr>
<td>Cost of Clinical Staff</td>
<td>$7,653,783</td>
<td>$11,572,951</td>
<td>$9,987,179</td>
<td>$6,943,659</td>
<td>$8,696,291</td>
<td>$3,252,389</td>
</tr>
<tr>
<td>Number of Non-Clinical Staff</td>
<td>183.5</td>
<td>361</td>
<td>286.5</td>
<td>215.5</td>
<td>296</td>
<td>74</td>
</tr>
<tr>
<td>Cost of Non-Clinical Staff</td>
<td>$2,708,278</td>
<td>$4,761,009</td>
<td>$4,188,533</td>
<td>$3,294,738</td>
<td>$4,160,642</td>
<td>$1,083,795</td>
</tr>
<tr>
<td>Total Staff</td>
<td>513.5</td>
<td>87/</td>
<td>730</td>
<td>531</td>
<td>648</td>
<td>212</td>
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<tr>
<td>Total Staff Cost</td>
<td>$10,362,061</td>
<td>$16,333,960</td>
<td>$14,175,712</td>
<td>$10,238,397</td>
<td>$12,856,933</td>
<td>$4,336,184</td>
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<tr>
<td>Gross Operating Payments</td>
<td>$12,684,682</td>
<td>$18,664,928</td>
<td>$16,294,727</td>
<td>$12,206,361</td>
<td>$15,216,030</td>
<td>$5,079,832</td>
</tr>
</tbody>
</table>

Source: Annual Returns

TABLE SEVEN
## 1981/82 Statistics

<table>
<thead>
<tr>
<th></th>
<th>MACQUARIE</th>
<th>PARRAMATTA</th>
<th>RYDALMERE</th>
<th>TOMAREE</th>
<th>TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Days</strong></td>
<td>108,122</td>
<td>171,020</td>
<td>152,804</td>
<td>20,774</td>
<td>1,492,504</td>
<td>a</td>
</tr>
<tr>
<td><strong>Available Beds</strong></td>
<td>374</td>
<td>675</td>
<td>556</td>
<td>72</td>
<td>5,082</td>
<td>b</td>
</tr>
<tr>
<td><strong>Daily Average</strong></td>
<td>296.2</td>
<td>468.5</td>
<td>418.6</td>
<td>56.9</td>
<td>4,089.1</td>
<td>c</td>
</tr>
<tr>
<td><strong>Occupancy Rate %</strong></td>
<td>79.2</td>
<td>69.4</td>
<td>75.3</td>
<td>79.0</td>
<td>80.5</td>
<td>d</td>
</tr>
<tr>
<td><strong>Number of Nurses</strong></td>
<td>317</td>
<td>351</td>
<td>282</td>
<td>5</td>
<td>2,845</td>
<td></td>
</tr>
<tr>
<td><strong>Cost of Nursing Staff</strong></td>
<td>$ 6,370,456</td>
<td>$ 7,434,766</td>
<td>$ 6,536,821</td>
<td>$143,899</td>
<td>$ 62,590,357</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Clinical Staff</strong></td>
<td>390</td>
<td>425.5</td>
<td>321.5</td>
<td>5</td>
<td>3,237</td>
<td>e, g</td>
</tr>
<tr>
<td><strong>Cost of Clinical Staff</strong></td>
<td>$ 8,317,908</td>
<td>$ 9,286,742</td>
<td>$ 7,866,331</td>
<td>$143,899</td>
<td>$ 73,721,132</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Non-Clinical Staff</strong></td>
<td>238</td>
<td>238</td>
<td>231</td>
<td>12.5</td>
<td>2,136</td>
<td>e, h</td>
</tr>
<tr>
<td><strong>Cost of Non-Clinical Staff</strong></td>
<td>$ 3,370,232</td>
<td>$ 3,468,944</td>
<td>$ 3,217,431</td>
<td>$211,085</td>
<td>$ 30,464,687</td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td>628</td>
<td>663.5</td>
<td>552.5</td>
<td>17.5</td>
<td>5,373</td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff Cost</strong></td>
<td>$11,688,140</td>
<td>$12,755,686</td>
<td>$11,083,762</td>
<td>$354,984</td>
<td>$104,185,819</td>
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</tr>
<tr>
<td><strong>Gross Operating Payments</strong></td>
<td>$13,751,122</td>
<td>$15,110,774</td>
<td>$12,954,428</td>
<td>$489,091</td>
<td>$122,451,975</td>
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</table>

Source: Annual Returns

TABLE SEVEN (CONTINUED)
### FIFTH SCHEDULE HOSPITALS – FINANCIAL AND STAFFING DATA

#### 1981/82 CUMULATIVE STATISTICS

<table>
<thead>
<tr>
<th></th>
<th>5 D.D.</th>
<th>HOSPITALS</th>
<th>4 NURSING HOMES</th>
<th>10 PSYCHIATRIC HOSPITALS</th>
<th>TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>515,994</td>
<td>409,966</td>
<td>1,492,504</td>
<td>2,418,464</td>
<td></td>
<td>a</td>
</tr>
<tr>
<td>Available Beds</td>
<td>1,601</td>
<td>1,285</td>
<td>5,082</td>
<td>7,968</td>
<td></td>
<td>b</td>
</tr>
<tr>
<td>Daily Average</td>
<td>1,413.7</td>
<td>1,123.2</td>
<td>4,089.1</td>
<td>6,625.9</td>
<td></td>
<td>c</td>
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<tr>
<td>Occupancy Rate %</td>
<td>88.3</td>
<td>87.4</td>
<td>80.5</td>
<td>83.2</td>
<td></td>
<td>d</td>
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<tr>
<td>Number of Nurses</td>
<td>1,012.5</td>
<td>588</td>
<td>2,845</td>
<td>4,445.5</td>
<td></td>
<td>e</td>
</tr>
<tr>
<td>Cost of Nursing Staff</td>
<td>$18,898,337</td>
<td>$11,812,453</td>
<td>$62,590,357</td>
<td>$93,301,147</td>
<td></td>
<td>f</td>
</tr>
<tr>
<td>Number of Clinical Staff</td>
<td>1,085.5</td>
<td>624</td>
<td>3,237</td>
<td>4,946.5</td>
<td></td>
<td>e, g</td>
</tr>
<tr>
<td>Cost of Clinical Staff</td>
<td>$20,701,563</td>
<td>$12,690,363</td>
<td>$73,721,132</td>
<td>$107,113,058</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Non-Clinical Staff</td>
<td>642</td>
<td>455</td>
<td>2,136</td>
<td>3,233</td>
<td></td>
<td>e, h</td>
</tr>
<tr>
<td>Cost of Non-Clinical Staff</td>
<td>$9,023,704</td>
<td>$6,697,316</td>
<td>$30,464,687</td>
<td>$46,185,707</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff</td>
<td>1,727.5</td>
<td>1,079</td>
<td>5,373</td>
<td>8,179.5</td>
<td></td>
<td>f</td>
</tr>
<tr>
<td>Total Staff Cost</td>
<td>$29,725,267</td>
<td>$19,387,679</td>
<td>$104,185,819</td>
<td>$153,298,765</td>
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<td></td>
</tr>
<tr>
<td>Gross Operating Payments</td>
<td>$35,255,833</td>
<td>$23,377,417</td>
<td>$122,451,975</td>
<td>$181,085,225</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE EIGHT**
Notes

a. Bed Days as indicated on the Part A Annual Return (Statement 2).
b. Available Beds as indicated on the Part A Annual Return (Statement 1).
d. Occupancy Rate = (Daily Average * 100)/Available Beds.
e. Number of staff is the actual number employed at 30th June as indicated on the Part A Annual Return (Statement 8). Part-time staff units have been counted as 0.5 of full-time staff units.
f. Cost of staff is the total of all elements of salaries and wages for the year to 30th June as indicated on the Part A Annual Return (Statement 7).
g. Clinical staff are defined as:
   (i) Nursing Services
   (ii) Medical Support Services
   (iii) Medical Staff as indicated on the Part A Annual Return (Statement 8).
h. Non-clinical staff are defined as:
   (i) General Admin. and Clerical Services
   (ii) Hotel Services
   (iii) General Maintenance and Allied Services as indicated in Part A Annual Return (Statement 8).
i. Gross operating payments for the year to 30th June as indicated in the Part A Annual Return (Statement 6A).
### Fifth Schedule Hospitals - Financial and Staffing Data

1981/82 Overtime and Sick Leave Analysis for 19 Establishments

<table>
<thead>
<tr>
<th>Nurses</th>
<th>Clinical Staff</th>
<th>Non-Clinical Staff</th>
<th>Total Staff</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Staff</td>
<td>4,445.5</td>
<td>4,946.5</td>
<td>3,233</td>
<td>8,179</td>
</tr>
<tr>
<td>Cost of staff</td>
<td>$93,301,147</td>
<td>$107,113,058</td>
<td>$46,185,707</td>
<td>$153,298,765</td>
</tr>
<tr>
<td>Cost of Overtime</td>
<td>$8,626,816</td>
<td>$8,650,866</td>
<td>$1,484,392</td>
<td>$10,135,358</td>
</tr>
<tr>
<td>Cost of Overtime/Cost of Staff %</td>
<td>9.2</td>
<td>8.1</td>
<td>3.2</td>
<td>6.6</td>
</tr>
<tr>
<td>Days of Sick Leave</td>
<td>65,015</td>
<td>68,273</td>
<td>47,529</td>
<td>115,802</td>
</tr>
<tr>
<td>Sick Leave as Percentage of Available Staffing %</td>
<td>6.6</td>
<td>6.2</td>
<td>6.7</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Source: Annual Returns

**TABLE NINE**
Notes

a. Cumulative numbers of staff, aggregated from the actual number employed at 30th June 1982, as indicated on the Part A Annual Return (Statement 8). Part-time staff units have been counted as 0.5 of full-time staff units.

b. Cost of staff is the total of all elements of salaries and wages for the year to 30th June 1982 as indicated on the Part A Annual Return (Statement 7).

c. Cost of overtime is one of the elements of the cost of staff (Statement 7) of the Part A Annual Return.

d. \[ \text{Cost of overtime} \times 100 \]
   \[ \frac{\text{Cost of staff}}{} \]

e. Days of sick leave as provided by the former Health Commission of NSW. Data for Lidcombe (Non-Recognised), Strickland and Tomaree not included.

f. \[ \text{Sick leave/230} \] (Adjusted for exclusions as follows)

<table>
<thead>
<tr>
<th>Number of staff</th>
<th>Lidcombe</th>
<th>Strickland</th>
<th>Tomaree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>119</td>
<td>36</td>
<td>5</td>
<td>160</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>125</td>
<td>37</td>
<td>5</td>
<td>167</td>
</tr>
<tr>
<td>Non-Clinical Staff</td>
<td>113</td>
<td>26</td>
<td>12.5</td>
<td>151.5</td>
</tr>
<tr>
<td>Total Staff</td>
<td>238</td>
<td>63</td>
<td>17.5</td>
<td>318.5</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Bloomfield</td>
<td>641</td>
<td>758</td>
<td>610</td>
<td>716</td>
</tr>
<tr>
<td>Rozelle</td>
<td>3657</td>
<td>1017</td>
<td>3425</td>
<td>1017</td>
</tr>
<tr>
<td>Gladesville</td>
<td>1183</td>
<td>795</td>
<td>1110</td>
<td>792</td>
</tr>
<tr>
<td>Kenmore</td>
<td>675</td>
<td>748</td>
<td>685</td>
<td>666</td>
</tr>
<tr>
<td>Morisset</td>
<td>1151</td>
<td>783</td>
<td>954</td>
<td>783</td>
</tr>
<tr>
<td>Newcastle</td>
<td>1652</td>
<td>511</td>
<td>1570</td>
<td>140</td>
</tr>
<tr>
<td>Macquarie</td>
<td>2032</td>
<td>423</td>
<td>2034</td>
<td>414</td>
</tr>
<tr>
<td>Parramatta</td>
<td>2754</td>
<td>742</td>
<td>2536</td>
<td>714</td>
</tr>
<tr>
<td>Rydalmere</td>
<td>1120</td>
<td>616</td>
<td>1160</td>
<td>564</td>
</tr>
<tr>
<td>Tomaree</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
</tbody>
</table>

| TOTAL (excluding Tomaree) | 14865 | 6033 | 14084 | 5808 | 13203 | 5368 | 14591 | 5200 | 14034 | 5103 | 13543 | 5010 |

| % Change from Previous Year | 0.0   | 0.0   | -15.3 | -13.7 | -6.3  | -17.6 | 4110.5 | -3.1 | -13.8 | -1.9 | -13.5 | -11.8 |

Source: Annual Returns
1. Bed capacity: refers to available beds

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tomaree</td>
<td>4110.5</td>
<td>-11.8</td>
<td>15851</td>
<td>5272</td>
<td>14958</td>
<td>5175</td>
<td>13625</td>
<td>5082</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

TABLE ONE
### ADMISSIONS AND BED CAPACITY - FIFTH SCHEDULE MENTAL RETARDATION HOSPITALS

<table>
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<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grosvenor</td>
<td>224</td>
<td>140</td>
<td>163</td>
<td>86</td>
<td>130</td>
<td>92</td>
<td>185</td>
<td>86</td>
<td>167</td>
<td>86</td>
<td>91</td>
<td>86</td>
</tr>
<tr>
<td>Marsden</td>
<td>193</td>
<td>484</td>
<td>218</td>
<td>476</td>
<td>188</td>
<td>476</td>
<td>322</td>
<td>476</td>
<td>368</td>
<td>474</td>
<td>465</td>
<td>443</td>
</tr>
<tr>
<td>Peat Island</td>
<td>309</td>
<td>196</td>
<td>395</td>
<td>174</td>
<td>338</td>
<td>174</td>
<td>334</td>
<td>174</td>
<td>280</td>
<td>174</td>
<td>75</td>
<td>174</td>
</tr>
<tr>
<td>Stockton</td>
<td>105</td>
<td>910</td>
<td>132</td>
<td>902</td>
<td>139</td>
<td>902</td>
<td>138</td>
<td>877</td>
<td>53</td>
<td>871</td>
<td>41</td>
<td>844</td>
</tr>
<tr>
<td>Collaroy</td>
<td>N. A.</td>
<td>N. A.</td>
<td>N. A.</td>
<td>N. A.</td>
<td>N. A.</td>
<td>N. A.</td>
<td>63</td>
<td>60</td>
<td>63</td>
<td>54</td>
<td>107</td>
<td>54</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>831</td>
<td>1730</td>
<td>908</td>
<td>1646</td>
<td>845</td>
<td>1644</td>
<td>1042</td>
<td>1673</td>
<td>931</td>
<td>1659</td>
<td>779</td>
<td>1601</td>
</tr>
</tbody>
</table>

% Change from Previous Year

|                | 0.0              | 0.0                  | 40.3             | -16.9                | -0.1             | +23.3                | 4.118            | --116.31             |

Source: Annual Returns

Excluding 976 1613 868 1605 672 1547

Collaroy 4115.5 H1.9 -116.7 -4.1 -22.6 -3.6

---

**TABLE TWO**
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
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<tr>
<td>Allandale</td>
<td>311</td>
<td>536</td>
<td>313</td>
<td>536</td>
<td>243</td>
<td>536</td>
</tr>
<tr>
<td>Gorrarwarra</td>
<td>243</td>
<td>331</td>
<td>249</td>
<td>331</td>
<td>214</td>
<td>331</td>
</tr>
<tr>
<td>Lidcombe (non-recog.)</td>
<td>324</td>
<td>330</td>
<td>408</td>
<td>310</td>
<td>409</td>
<td>310</td>
</tr>
<tr>
<td>Strickland and TOTAL</td>
<td>237</td>
<td>108</td>
<td>286</td>
<td>108</td>
<td>233</td>
<td>108</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1115</td>
<td>1305</td>
<td>1256</td>
<td>1285</td>
<td>1099</td>
<td>1285</td>
</tr>
</tbody>
</table>

% Change From Previous Year:

- Allandale: 0.0
- Gorrarwarra: 0.0
- Lidcombe: 442.6
- Strickland and TOTAL: 1.5
- TOTAL: -12.5
- Source: Annual Returns

TABLE THREE
### Table Four: Admissions and Bed Capacity - Authorised Private Hospitals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evesham Clinic</td>
<td>499</td>
<td>42</td>
<td>740</td>
<td>42</td>
<td>699</td>
<td>42</td>
<td>644</td>
<td>42</td>
<td>628</td>
<td>42</td>
</tr>
<tr>
<td>Mt. St. Margaret Clinic</td>
<td>624</td>
<td>148</td>
<td>772</td>
<td>149</td>
<td>735</td>
<td>161</td>
<td>793</td>
<td>169</td>
<td>697</td>
<td>150,</td>
</tr>
<tr>
<td>Northside Clinic</td>
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<td>99</td>
<td>1383</td>
<td>98</td>
<td>1543</td>
<td>98</td>
<td>1518</td>
<td>98</td>
<td>1504</td>
<td>98</td>
</tr>
<tr>
<td>St. John of God Sydney Clinic</td>
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<td>800</td>
<td>95</td>
<td>1007</td>
<td>95</td>
<td>1019</td>
<td>95</td>
<td>1001</td>
<td>95</td>
</tr>
<tr>
<td>Chatswood</td>
<td>519</td>
<td>20</td>
<td>472</td>
<td>20</td>
<td>565</td>
<td>20</td>
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% Change from Previous Year: 0.0, 0.0, +121.3, 1.128.4, +12.2, +12.9, +13.0, +4.7, -0.2, 14.1

Source: Annual Returns
The image contains a table showing the bed capacity of various psychiatric units from 1973/79 to 1980/81. The table includes columns for admission years (1973/79 to 1980/81), bed capacity for June of each year, and percentage changes from the previous year. The units listed are Palmerston Hornsby Unit, Banks House, Macquarie Clinic, Liverpool Wrd 20, Wollongong Robinson House, Wagga Wagga Richmond Clinic, Lismore Caritas, St. Vincents P. O. W Unit, Prince Henry Unit, Albury Base, and a total for each year.

The table also includes a source note: "Source: Annual Returns and Inquiry's Investigations."
<table>
<thead>
<tr>
<th></th>
<th>Prior Admissions 1980</th>
<th>Previous Year</th>
<th>Total Readmissions</th>
<th>Total as Percentage</th>
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<th>TOTAL</th>
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<td>378</td>
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<td>175</td>
<td>374</td>
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Source: Morbidity Collection (1980)
## TABLE TWO

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<th>Hospital</th>
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<th>Prior Admissions Previous Year</th>
<th>Total Admissions</th>
<th>Total Readmissions as Percentage all Admissions</th>
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<th>TOTAL</th>
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<td>1</td>
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<td>3</td>
<td>6</td>
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<td>19</td>
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Source: Morbidity Collection (1980)
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<th>Total Readmission as Percentage all Admissions</th>
<th>First Admissions</th>
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</tr>
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<td>18 33</td>
<td>51 68.9</td>
<td>23 74</td>
<td></td>
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<td>199 75.4</td>
<td>65 264</td>
<td></td>
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<td>350 73.7</td>
<td>125 475</td>
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<td>176 85.9</td>
<td>29 205</td>
<td></td>
</tr>
<tr>
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<td>30 64</td>
<td>94 66.2</td>
<td>48 142</td>
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<tr>
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<td>29 44</td>
<td>73 61.9</td>
<td>45 118</td>
<td></td>
</tr>
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<td>Morisset</td>
<td>159 106</td>
<td>265 71.8</td>
<td>104 369</td>
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<td>Newcastle</td>
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<td>67 261</td>
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<td>58.8</td>
<td>199</td>
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</table>

Source: Morbidity Collection (1980)

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**TABLE THREE**
### TABLE FOUR: MAJOR FIFTH SCHEDULE PSYCHIATRIC AND AUTHORISED PRIVATE HOSPITALS

**READMISSIONS FOR PRINCIPAL DIAGNOSIS MENTAL RETARDATION (1980)**

<table>
<thead>
<tr>
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<th>Prior Admissions 1980</th>
<th>Prior Admissions Previous Year</th>
<th>Total Readmissions</th>
<th>Total Readmission As Percentage All Admissions</th>
<th>First Admissions</th>
<th>TOTAL</th>
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<tr>
<td>Rozelle</td>
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<td>22</td>
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<td>71.4</td>
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<td>63</td>
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<td>25</td>
<td>51</td>
<td>78.5</td>
<td>14</td>
<td>65</td>
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<tr>
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<td>38</td>
<td>137</td>
<td>86.7</td>
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<td>158</td>
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<td>64.9</td>
<td>27</td>
<td>77</td>
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<td>11</td>
<td>47</td>
<td>75.8</td>
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**TOTAL**

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<th>Prior Admissions Previous Year</th>
<th>Total Readmissions</th>
<th>Total Readmission As Percentage All Admissions</th>
<th>First Admissions</th>
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Source: Morbidity Collection (1980)
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<th>Prior Admissions Previous Year</th>
<th>Total Readmissions</th>
<th>Total Readmission as Percentage all Admissions</th>
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<th>TOTAL</th>
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<td>1841</td>
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<td>680</td>
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<td>347</td>
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<td>262</td>
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<tr>
<td>Kenmore</td>
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<td>497</td>
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<td>785</td>
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<td>3301</td>
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TOTAL | 6306 | 4884 | 11,190 | 1 | 69.6 | 30.39 | 100.0 |

Total Excluding Auth. Private | 3987 | 3902 | 7889 | 3570 | 11,459 |

% Excluding Auth. Private | 34.8 | 6 | 834.1 | 8 | 100.0 |

Source: Mor Collection (1980)
<table>
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<th>(1) Actual Salaries and Wages 1981/82 Costs</th>
<th>(2) Initial Salaries and Wages Allocation July 1982</th>
<th>(2) Budget Salaries and Wages Allocation October 1982</th>
<th>(3) Salaries and Wages Costs to Implement 1979 Staff Review (Oct 82 costs)</th>
<th>Difference Between Budget Allocation and 1979 Review</th>
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<td>16.4</td>
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### Budget Salaries and Wages Allocation

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<td>$m</td>
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<td>$m</td>
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<td><strong>163.5</strong></td>
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</table>

1. Annual returns costs not adjusted to October, 1982 levels.

2. Finance sections, Regional Offices.

3. Adjusted to include supernumary staff at the hospitals at June, 1982. Excludes overtime, but includes all other staff on-costs. Calculated using October, 1982 salary and wage levels, and allowing 5% award. Does not include the 131 extraneous nursing and 36 extraneous apprentices June, 1982 establishment.