Community Care of the Aged: A Working Model of a Needs-Based Assessment Unit

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by

Ruth Errey, Carole Baker and Sarah Fox

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FOREWORD

Much has been written in recent years about community care, and in the area of services for the aged community care as a preferable alternative to care in residential institutions has figured prominently at the centre of debate on policy, resource allocation, administration and, above all, service delivery. The desirability of community care has been argued on the grounds of cost as well as the quality of life of the aged population.

The case study presented in this report relates the experience of an Aged Referral and Assessment Unit which operated as a pilot project for about 15 months in one part of the Sydney metropolitan area. The report has been written by the people who conducted the project; the role of the Social Welfare Research Centre consisted only of providing consultation on the research aspects of the project and assisting in the analysis of data. What makes this study rather different from other studies in the area of community care is, first, the application in practice of a particular philosophy of assessment of need in community care; and, second, the action research approach used in the Unit's operation and recording of its activities. The holistic, 'needs-based' assessment transcends the 'health/welfare' dichotomy in the care of the aged, as well as the inter-organisational and inter-professional boundaries in service delivery. The action research approach breaks the division between 'research' and 'practice', illustrating that the two activities can be fairly successfully conducted in the process of service delivery.

The report documents the experience of the Aged Referral and Assessment Unit, from the initial formative steps to something approaching a routine operation. The reader can see the problems encountered by the Unit as they arose and how the members of the Unit attempted to deal with them. While some of these problems had a distinct local character, most of them have been identified in research literature in Australia as well as in other countries. The report shows that difficulties in service delivery arising from organisational and professional imperatives, which have been identified in various research reports, indeed constitute the reality of community care. The 'ideal' of community care is somewhat different in practice - people do not find it easy to solve the problems, notwithstanding their commitment to the value of community care. However, the experience of the Aged Referral and Assessment Unit indicates that the 'ideal' is worth pursuing, although the success of such pursuit is far from certain.

This project was funded by the Commonwealth Department of Community Services. I am pleased that the Social Welfare Research Centre has been able to assist in the project, albeit in a small way, and I hope that the readers, especially those interested and/or involved in community care will find this report interesting and useful.

Adam Jamrozik
Acting Director
Social Welfare Research Centre.

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A MODEL OF NEEDS-BASED ASSESSMENT

This report deals with the particular experience of a small multi-disciplinary team which operated as a unit offering holistic assessment to elderly residents of five inner-western municipalities in Sydney who were referred from any source as being in need of information and/or assistance. Post-assessment referrals were made as appropriate, and after discussion of available options.

During its period of operation, from July 1984 to September 1985, many of the issues surrounding community maintenance of very old, frail, disabled, or confused people, which emerge in research findings both in Australia and in other English-speaking countries, were recognised and documented, using an action research approach adopted by the Unit in testing its brief (see Appendix I). Arising from the origin of its brief, which was based on a **non-health** community initiative, the Aged Referral and Assessment Unit differed in its composition and its manner of functioning from models followed by numbers of other similarly funded pilot projects (and already established Community or Extended Care Teams), and differed also from the description outlined in the recommendations of the McLeay Report, which stated,

> Assessment teams are generally seen as multi-disciplinary, comprising a geriatrician or medical practitioner with experience in geriatrics, social worker, nurse, a range of remedial therapists and consultants and an administrator. It is envisaged by the Department of Health that each team would be responsible for a specific region and would have access to the full range of services for the aged, including acute hospital and rehabilitation beds in its region. (1982:95)

The Aged Referral and Assessment Unit was co-ordinated by a social worker with a background in nursing, and included an occupational therapist, a community nurse, and a clerical assistant. Although it was funded as an initiative of the federal Department of Health (later, of Community Services), and was administered through the Inner Western Suburbs Area Health Board (and located in a cottage adjacent to the Western Suburbs Hospital) it had no direct responsibility to a medical practitioner or geriatrician.

While acknowledging that no assessment team could function effectively without access to the full range of geriatric diagnosis and medical care, the Unit operated on the assumption that domination by health professionals may lead to a one-dimensional view of multi-dimensional problems, and also to identification with the sick role of people suffering chronic functional limitations which may, in time, lead to depression and isolation. Irrespective of its point of attachment, it seemed important to the members of the A.R. & A.U. that there was a role for an accessible community resource team which, while offering holistic assessment of elderly people seeking or being referred for assistance or information, was able to assume a position of neutrality which permitted it to bridge existing divisions between health and welfare service systems, and to build co-ordinating and feed-back mechanisms across political boundaries of local government. This model offered the team the benefit of daily contact with elderly people, both in their homes and in various forms of residential care, while at the same time

being in a position to collect and feed regional data to planners and policy-formulators.

Assessment as practised by the Unit was not undertaken without the agreement of the referred individual, and did not take the form of clinical measurement of discrete areas of functioning carried out by a series of practitioners each operating within his/her professional boundaries. Assessment was usually carried out in the normal living situation of the referred person, and concerned itself with the appropriateness of that situation and the ability of the person to function within that environment. Lacks and deficiencies in any area of functioning (or in available support - both formal and informal) were identified by the assessor, and all available remedial options were explored with the elderly person, and, where appropriate, with his or her carers and support networks. Such options might include modification of the immediate environment, the introduction of any one or a mix of community services or aids to daily living, referral for specialist medical diagnosis, the arranging of respite accommodation, or the imparting of information for future reference.

The matching of assessors to the situation as described at the time of referral was based on the recognition of the competence and experience of each team member by her co-workers. Ongoing informal discussion among team members permitted vulnerable elderly people to receive input from a multi-disciplinary team while needing to develop a trust relationship with one worker only. This blurring of professional roles within the team was seen as a move towards securing positive outcomes to the assessment process, and was a conscious endeavour to break down the rigid barriers which have developed with the growing professionalisation of the service-providers.

This report, therefore, offers an alternative model for community assessment teams. The model grew independently out of the Unit's contact with at-risk elderly people in the community, their informal support networks, and with the range of workers and organisations providing services for the aged; but it also has elements outlined by Kendig (1983) in the conclusions put forward by the Ageing and the Family Project.

> One of the most important developments for serving disabled older people is the establishment of multi-disciplinary assessment teams in all regions throughout the country. In addition to providing specialised geriatric care when necessary, these units would refer particular individuals to the most appropriate supports for their particular circumstances. Each team would form a single, highly visible resource centre to which older people, their family, and medical and welfare professionals could turn to find high quality care and advice. Careful monitoring of case loads would assist in developing a profile of unmet needs, and thus identify local priorities for community and institutional services to fill the gaps. (1983:172).

The experience of the Aged Referral and Assessment Unit has shown that while the presence of such a team can generate tensions and anxieties at a local level, and rejection by some centrally based organisations, the possibility of eventual acceptance does exist.

This report is presented as a case study - as such, the experience of the Aged Referral and Assessment Unit needs to be seen in the context of issues which arose out of local characteristics and might or might not exist, in a different form, in another setting. However, when the experience of the A.R. & A.U. is considered in relation to, or in the context of, relevant research literature, it is clear that many of the issues identified and the problems encountered in this case study illustrate those which are of concern in most settings.

ACKNOWLEDGEMENTS

This study was made possible by a grant from the Commonwealth Department of Health, and later, the Department of Community Services, to the New South Wales Department of Health. The Aged Referral and Assessment Unit was one of a number of pilot projects which explored differing approaches to the provision of adequate and appropriate care for elderly people.

The Aged Referral and Assessment Unit was administered by the Inner Western Suburbs Area Health Board (Sydney) through its Area Executive Officer, Mr. Graham Brown, and was responsible, through Antonia Hawkins, Planning Officer, Southern Metropolitan Region, to the Head Office of the New South Wales Department of Health. At the local level the Unit reported monthly to a Steering Committee comprising representation from all five municipalities in Area 5, which included a consumer, and health and welfare workers from government (local and State), non-government, and the private sectors.

The members of the A.R. & A.U. team gratefully acknowledge the strength of the support received from the administration of the Inner Western Suburbs Health Service - from Graham Brown, Denbeigh Garrard and from Anne Holz - and also from Antonia Hawkins in her linking role with the Southern Metropolitan Regional Office.

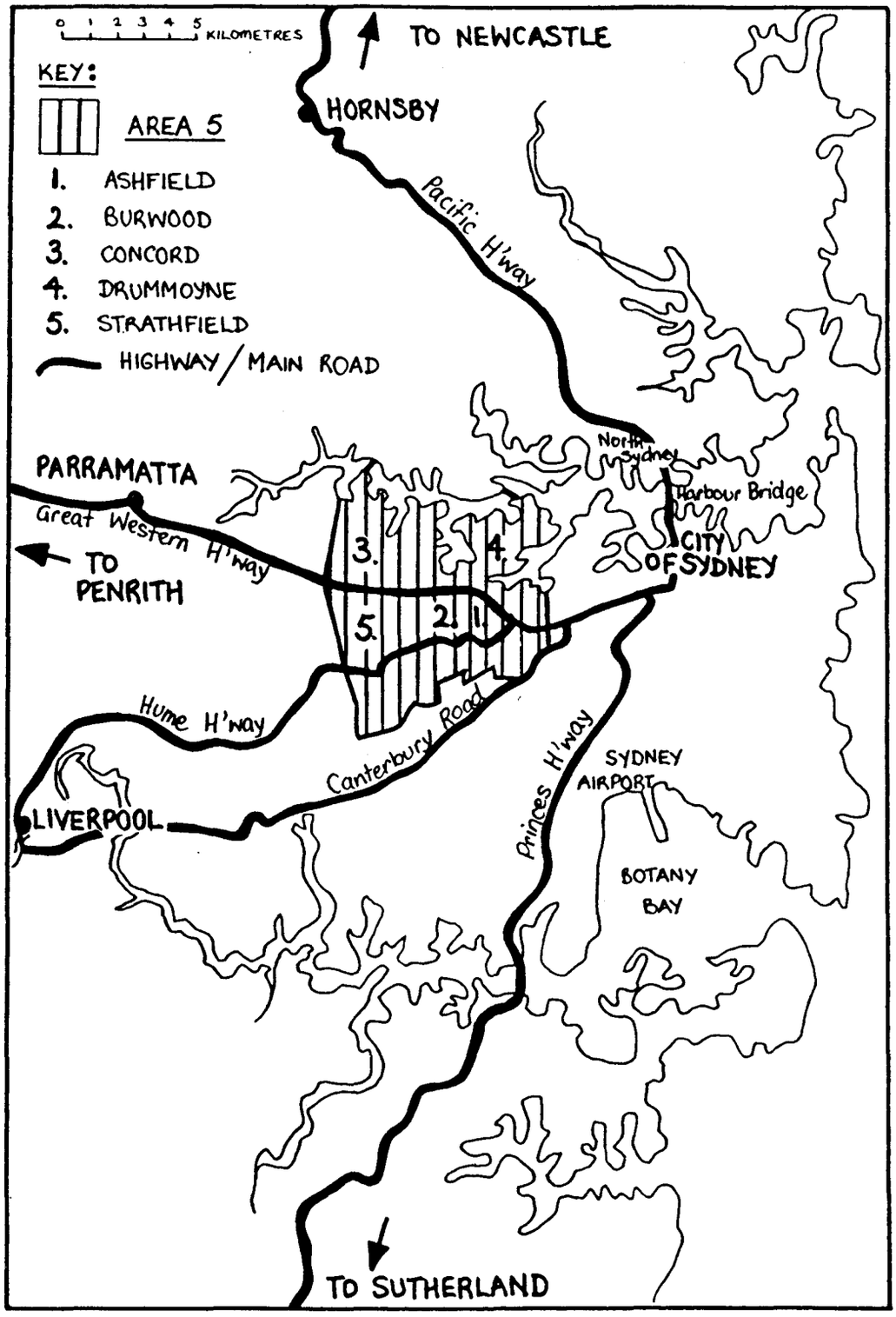
Much valuable advice and assistance in the area of data collection and analysis was received from Adam Jamrozik of the Social Welfare Research Centre, University of New South Wales, and the Team wishes to express its appreciation to the Social Welfare Research Centre for this assistance and for the publication of this report. Thanks must also go to Julie Cruickshank for her contribution as a team member and for typing the original report; and to Jane O'Brien of the Social Welfare Research Centre for her part in typing this revised version and organising the report for publication.

Ruth Errey
Carole Baker
Sarah Fox

LOCATION OF AREA 5

SOUTHERN METROPOLITAN REGION OF THE

NEW SOUTH WALES DEPARTMENT OF HEALTH



CHAPTER 1

CARE OF THE AGED : PERSPECTIVES ON ISSUES AND POLICY RESPONSES

1.1 INTRODUCTION

The issues surrounding aged care have been a subject of concern over the past decade, both in Australia and in other countries. This is evident in the literary output and in the number of research projects and surveys aimed at identifying the extent and nature of the problem and action that should be taken to reach appropriate solutions. It is also evident in the responses of governments, in the health and welfare services, and in the community at large.

As the implications of demographic trends towards an ageing population began to be recognised in the late 1970s and early 1980s, attention of researchers, those working with the aged, and politicians began to focus on the range and cost of services which the aged - these mostly 'unproductive' members of society - would generate.

Most research reports indicated a high degree of consensus of views on the problems in identifying the 'real' needs. Individual variations in levels of available support, and in people's coping abilities made contemplation of service-provision at the level of predictions based on health and welfare status data unattractive, both on economic grounds, and because of the risks involved in pre-judging the willingness of people to accept help.

Other issues which emerged related to complexities in legislation (particularly in Australia) with consequent administrative adaptations which varied from State to State. Organisational rivalries, together with specialisation and professionalisation of the 'helping' occupations, were shown to lead to fragmentation of services at the point of service delivery. Lack of co-ordination and interaction between services sometimes led to a mis-match between needs and services, and gaps and overlaps continued to exist because of absence of uniformity in data-recording and in assessment procedures.

A number of researchers recorded a need for readily accessible comprehensive information so that elderly people could make decisions about their lives in the light of all available options. The need for support and relief for carers and informal networks had been recognised in Australia as in other countries (e.g. in the United Kingdom), and tools for the measurement of stress levels in carers were being developed. Number of studies were concerned with aspects of accommodation for the aged, and most of the research, if not all, was undertaken within a framework which assumed that people should (and would choose to) remain outside of long-term institutional care for as long as possible.

In this rising climate of concern, a sub-committee of the House of Representatives Standing Committee on Expenditure, chaired by Leo McLeay, called for submissions relating to accommodation and home care for the aged. In October 1982 the Committee produced a report titled 'In a Home or at Home', which recommended rationalisation of all legislation affecting aged people, with consequent sweeping changes in administrative arrangements.

At the level of service delivery the Committee expressed concern at the reported incidence of mismatch of services to needs. This included, at the extreme, inappropriate nursing home placement. 'Adequate assessment of the individual's total situation, including personal, social, economic, psychological and physical conditions' (McLeay 1982:94) was seen to be a mechanism by which the most effective use could be made of service provision. The report recommended the appointment of multi-disciplinary teams comprising 'a geriatrician...social worker, nurse, a range of remedial therapists and consultants and an administrator', operating within specific regions, and having access to the full range of services for the aged, including acute hospital and rehabilitation beds in that area. The Committee saw these teams as hospital-based, but 'active in the community'. Additional roles for such teams would be the identification of gaps and overlaps in services, and the co-ordination of all aged-related services to the advantage of elderly residents. In particular, it was envisaged that no person should be admitted to a nursing home without prior assessment by such a team.

In the Federal budget 1983/84 funds were released to the Commonwealth Department of Health to initiate a number of pilot projects, to test the effectiveness of a range of differing models. The Aged Referral and Assessment Unit (A.R. & A.U.) was one such pilot project.

1.2 RESEARCH FINDINGS

A review of the literature shows that whilst in some Continental European countries (e.g. Holland and Denmark) the ageing of the population had been recognised some years ago, in the United Kingdom and in the United States of America the process of defining the parameters of the demographic change occurred later, approximately at the same time as in Australia. Resource allocation and organisation of services differs from country to country, but many of the issues which have been identified in Australia have also been the focus of studies in other industrialised countries. Although some pilot projects which are offering a generalist client-based service are underway in the United Kingdom, no final evaluation of these projects appears to have been recorded.

United Kingdom

Data relating to the health and welfare status of people aged 65+ years indicates that, with the exception of the level of income, which at the lower end of the scale compares unfavourably with the income maintenance program implemented in Australia by the Department of Social Security (Lloyd:1985),

issues needing to be addressed were not dissimilar to those which had emerged in Australia. Despite the localised organisation of service provision, there appeared to be an absence of predictability in the range, levels and quality of assistance available between one area and another (Macleod and Smith:1985). There was uncertainty as to how needs could be quantified, taking into account individual attitudinal differences towards the ageing process, functional limitations and personal independence.

The subjective nature of assessment received comment in Rowlings (1985), quoting a Grampians (Scotland) study which indicated that the assessment procedure frequently reflected the professional orientation of the assessor, or of the availability of one service over another. Assessments by social workers proved the most diverse; home help organisers saw the immediate need of the client almost exclusively in terms of whether or not home help services were required, while occupational therapists recognised needs other than aids and adaptations in only four cases out of the twenty-four cases recorded as receiving OT assessment.

Information - advice, guidance, counselling - also emerged as an issue in the findings of the Gruen report on the **Needs of the Elderly in the Scottish Borders** (1975), where it was estimated that 58 per cent of people aged 65+ were in need of contact with a 'social worker'. Lack of available information was also one of the aspects explored by Paul Chapman in a study conducted in Pimlico, U.K., in 1971-72, which looked at two main areas: the disconnection between expressed needs and the services provided; and the efficacy of maintaining a central register of elderly people in a given area. The study involved interviews with 536 elderly people in 1971/72 and the fact that the report was published in 1979, and was quoted in a number of papers and research reports in the early 1980's suggest that this was one of the few which addressed community care of aged people from the point of view of the needs and satisfaction/dissatisfaction of members of the 'target group'.

(i) there was a failure on the part of services to provide help needed (in particular, a voluntary body);

(ii) eligibility criteria excluded some people needing help;

(iii) circumstances changed between the time of the interview which established the need and when the service became available (waiting list);

(iv) the client rejected the service.

The notion of a central register of elderly people was dismissed by Chapman as creating dependency and stigmatising the old, although in final paragraphs of the report Chapman conceded that there might be a need for a form of monitoring people aged 75 and over, and those living alone.

In confronting needs which were specific to the individual but general, multi-faceted and overlapping in nature (as occurs with greater frequency with advancing years) the tendency towards specialisation in the helping professions and for prescription of service-limits with consequent multiplication of the agencies and workers involved received attention from a number of writers. Anthony Hopkins, writing in **The Lancet** (June, 1984),

deplored the multiplicity of support agencies, and said that the needs of clients were specific and individual. He suggested that the self-interest of agencies and individual service providers often overrode those of the client, and he regretted the over-professionalisation and specialisation of the helping professions, suggesting a one-year training course with a common-core curriculum for 'helpers' who would provide the practical help which aged individuals usually needed.

The Kent Community Care Project was reviewed in the **British Journal of Social Work** in 1980 (10-1, Spring) by Challis and Davies. This Project was introduced to a seaside town in Kent in 1977 after a careful study of the problems associated with the need for, and provision of, aged care in the community. Challis and Davies made the following observations about the situation in the town in which the Project was to be launched.

- need was growing faster than resources (including residential care beds)
- patterns of need were changing
- the obverse of the increasing frailty of people seeking admission to nursing home beds was a high probability of relatively frail old people having to cope in the community
- a higher proportion of those living alone were very old and incapacitated, and a lower proportion of those saw relatives regularly

Problems cited were:

- existing domiciliary services were not available at times when they were needed and often did not perform the tasks desired
- the home help service lacked the management structure and the personnel to secure the rapid and flexible redeployment of resources for the care of the most vulnerable elderly
- consumers were becoming more sophisticated in expressing their dissatisfactions, and powerful national pressure groups were developing to represent their interests.

Challis and Davies concluded that a new approach was needed which would achieve care at a lower average cost for each person helped, and in a way which satisfied the old person better. The approach should also aim to interweave with existing carers rather than replacing them.

The Kent Community Care Project was planned as an innovative accountable undertaking which involved the administration by social workers of a budget at two thirds the cost of residential care for each client admitted to the project. Careful negotiation had to occur at several organisational levels before the Project commenced, and its credibility had to be satisfactorily established.

Seventy people in the most vulnerable category were admitted to the program - 35 in an experimental group and 35 as controls. Workers were able to make antonomous decisions in arranging the most appropriate sources of help. This

included, in a number of cases, contracting assistance with local community members. An advantage from such arrangements was the opportunity for relationships to develop which went beyond the contractual agreements. Evaluation after 12 months showed more positive outcomes in the experimental group than in the control group, although the overall decrease in numbers remaining in the community showed the time-limited nature of intervention in the lives of these most vulnerable people. Unit cost differences were relatively small between the two groups, but were regarded as having the potential to make a substantial impact in service cost in the long term.

In relation to the issues discussed in **this** report, the value of the Kent Project lies not so much in any revolutionary mode of care provision, but rather in the model it provides for the building of a conceptual framework after consideration of the nature of the task, and the careful preparation which preceded its launching. The evaluation techniques employed could also be used as a guide for other projects requiring equivalent measurement.

This concern also underpinned the establishment of the Ecclesfield Neighbourhood Support Unit in Sheffield, which, after 14 months of operation, was reported on by Kristina Cooper in **New Society**. Funding was directed to this project as an alternative to an allocation for a 42-bed 'old people's home and day care centre'. The report said,

> By breaking down the conventional job demarcation barriers between staff, replacing them with community support workers the unit is adapting its services to meet old people's changing needs ... (**New Society**, 29-11-1985)

According to the report, each worker arranges his/her schedules flexibly to meet the needs of five clients and provides whatever assistance seems useful at that time. The worker's close interaction with each client allows for recognition of, and referral on, for any more specialised intervention or treatment. The support Unit was reported to be available 7 days per week x 13 hours per day, and at that time was servicing 140 people who were visited (as required) up to a maximum of 4 times per day.

United States of America

The Pride Institute **Journal of Long Term Home Health Care**, (U.S.A.) devoted its Winter 1985 edition to reports on two demonstration projects providing Community Long Term Care. In each case, multi-disciplinary teams were employed with access to all services which were likely to be required.

While the 'user-pays' orientation of the U.S.A. medical/welfare system made for some differences, the basic approach of these projects and their funding bears relevance to some feasibility studies carried out in Australia, such as the Aged Referral and Assessment Unit which is the subject of this report.

Blackman et al (1985) reported on a 4-year Community Long Term Care Project mounted in South Carolina where people classified as eligible for nursing home placement were given the option of remaining at home with the granting of

additional medical options on the use of community services. The aim was to relieve the pressure on nursing home beds and to work towards more cost effective home maintenance of disabled people. Findings in that report, although not expressed in money terms, suggested that home care as provided under the demonstration project was 'no greater than the cost of the current, more restrictive, institutional-biased Medicaid programme'.

Weiss et al (1985) conducted a 5-year project in San Francisco, looking, in particular, at the matching of services to needs. The typical project participant was 79 years old, female, not employed, widowed and living alone. The commonest physical problem was cardiovascular disease. The demonstration group were seen to have received more appropriate services, and the cost saving for this group, compared with a control group, was 15 per cent; most gains occurring in the first 6-18 months, and most arising out of reduced hospitalisation. It was also found that the activities of the project workers did not displace informal support networks. The conclusions suggested that the initial co-ordinating effect of such a team was time-limited, and that once participants had settled into the services, a client-monitoring process by a paraprofessional would be able to detect a need for further intervention.

Australia

A research problem which received comment from a number of writers arose out of the maze of Federal and State legislation which governed the provision of aged services, and the lack of uniformity between administrative arrangements from State to State. Studies of organisations providing 'the same' community services across Australia were thwarted by differences in the conceptual framework of their sponsoring bodies, which influenced data-collection, referral requirements, assessment procedures, etc. For example, domestic assistance arising from the Federal States Grants (Home Care) Act, 1969, was provided by a separate statutory authority in New South Wales, by local governments in Victoria, by State Health Department's Geriatric Division in Queensland, through Community Health in Tasmania, by the South Australian Health Commission domiciliary care package in that State, and through the Silver Chain non-government organisation in Western Australia (Bowman, 1985). In general, services, particularly in New South Wales, were seen to be patchy, fragmented, often stretched to beyond the limit of usefulness, delivered by a confusion of Federal, State and local government bodies, by workers from non-government agencies, and by volunteers. With no effective co-ordination at the interface of delivery, and with the growing tide of professionalism and specialisation among care-givers, demarcation squabbles had tended to rigidify and make even less effective those services which purported to provide care and support for elderly people in the community. With very few exceptions, studies were service-based (frequently dealing with one service only), and gave little information of interaction among services (or of the networking among individual workers) in effectively meeting the identified or expressed needs of elderly community members. Kendig et al (1983) of the Ageing and the Family Project (Australian National University) provided the most comprehensive study in Australia to that date of the condition of elderly people at home, reporting on a survey of 1050 people in urban New South Wales. The study considered family structure, health status, the use of medical and paramedical services, as well as community care and those who provided it.

Reports and Proceedings of the Social Welfare Research Centre have looked at the confused elderly (Carter, 1981); at Australian Home Help Policies (Keens et al, 1983); at the role of Carers (Kinnear & Graycar, 1982; Rossiter et al, 1984; Rossiter, 1984); at Meals on Wheels in New South Wales (Smith, 1984); and at Accommodation after Retirement (Graycar, 1984).

A useful contribution was the Position Paper produced by the Victorian Council on the Ageing which summarised, compared and contrasted contents of the major reports on aged care from 1977-1984.

The report of the Ageing and the Family Project was titled **Health, Welfare and Family in Later Life** and reported on its survey findings in terms of 'the circumstances of the older Australians in the community, with particular attention to the vulnerabilities and resources which influence their need for health and welfare services'. This led to an examination of what was likely to affect the independent status of elderly people, and who cared for them when they could not care for themselves. Both informal and formal support systems were considered and Kendig ranked the needs into low level areas such as transport and home upkeep; middle levels such as household tasks; and high level which was personal care. Kendig also addressed the question of unmet needs. He stated, 'While the unmet needs of the non-institutionalised aged reduce their quality of life, and pre-dispose them to risk of earlier institutionalisation it is not possible to argue that additional services are currently required to enable them to stay out of institutions' (1983:124).

Gibson, in the same report, and looking at the health status of elderly people, offered among others, the following statistics:

AGEING AND THE FAMILY PROJECT

1050 persons over 60, surveyed in October-December, 1981

Self-Rated Health

Good	Fair	Poor
61%	26%	14%

Self-Acknowledged deficiencies in

Eyesight	Fair 30%	Poor 10%
Hearing	Fair 29%	Poor 5%
Foot Problems	Some 27%	A Lot 7%

20% could not use stairs alone without difficulty
16% were unable to use public transport freely
12% could not go out alone
4% had difficulty in getting out of bed, and
1% could only manage this with help
4% could not take a bath or shower without difficulty and
3% could do this only with help or not at all
51% had problems of the musculo-skeletal system
37% had problems with heart and circulatory system
20% had problems with sensory and nervous systems (half blindness)
15% had suffered from respiratory disease

(Kendig et al, 1983)

In his conclusions Kendig looked at limitations which induce vulnerability, and identified as significant (a) physical disability, (b) low income, and (c) living without a spouse. Where all these were present, Kendig described the elderly person as in 'triple jeopardy', and went on to typify as most likely to need care those people aged 75 years or over, suffering all three of these limitations, or 18 per cent of the people in this age group.

In commenting on services, he deplored the way in which programmes were fragmented into separate services and under different auspices, and concluded that

> If community services are to provide alternatives to institutions for any older people, they will need to have the capacity to provide more flexibly. This would enable older people to have the particular mix of services appropriate to their individual circumstances. (Kendig et al, 1983:168-169)

Kendig saw that one of the most important developments for serving disabled older people was the establishment of multi-disciplinary assessment teams which would be 'a single, highly visible resource centre to which older people, their family, and medical and welfare professionals could turn to find high quality care and advice'. He suggested (as also did the McLeay Report) that in the context of their work such teams would develop a 'profile of unmet needs', which would enable local priorities to be formulated for community and institutional services to fill gaps.

He concluded that the target groups for community care 'in the more important and intensive tasks' were a specific and small proportion of the older population - probably little more than 10 or 15 per cent. Only 7 per cent receive any community services (figure quoted by Senator Grimes in March, 1985 at H.A.C.C. conference conducted by the New South Wales Council of Social Service was 8%). Kendig observed,

> Some services have long waiting lists, are not available in all areas, and in any event do not help with such necessities as shopping, errands and transport. The sobering conclusion is that the most vulnerable older people can remain in the community only if they have substantial amounts of informal support. (Kendig, 1983:126-127)

In the same report D.T. Rowland stated the following:

> just under 5 per cent of persons aged 50 years and over are long-term residents of institutions including hospitals, nursing homes and homes for the aged. The proportion in institutions increases with age from less than 1 per cent at 60-64 to over 34 per cent at ages 85 and over. (Rowland, 1983:19)

Rowland quoted survey results indicating that 7 per cent of the elderly never married and 17 per cent had no children. Informal support care by relatives, if they were living in the household or living nearby, was recognised as being the most common source of support. However, 'symptoms of gaps in the support network' were indicated by findings that 60 per cent of the aged living alone in Sydney had no sons or daughters living within 8 kilometres, 17 per cent had no living children, more than a third had no daughters, and 44 per cent had no spouse.

John Hemer, another contributor to the Kendig Report, writing in the **Australian Journal of Ageing** (1984, 3(1):24-26) presented an extremely perceptive commentary on assessment procedures which identified numerous issues which became evident in the day-to-day working of the Aged Referral and Assessment Unit.

The Social Welfare Research Centre of the University of New South Wales has published a number of relevant research findings in its Reports and Proceedings (R. & P.s) beginning in January, 1981 and continuing until 1985. The reports were prepared by various members of staff of the Centre, and covered a range of subjects relating to elderly people and their care.

Three reports related to surveys of people providing care at home for elderly relatives. The first, published in 1982, by Kinnear and Graycar, was based on samples surveyed in Sydney and Hobart. The other two reports related to surveys conducted in an outer local government area in Sydney, in Adelaide, and in the general metropolitan area of Hobart (Rossiter, Kinnear and Graycar, 1984; Rossiter, 1984). All three reports supported the assumption that most care of elderly people occurred within the family, but they also looked at the effects which caring could have on the lives of individual carers and on families providing care. The need was outlined for Day Care, Respite Care and Home Visiting Services - services which aimed at supporting and easing the burden of care by families.

In another report entitled **Options for Independence - Australian Home Help Policies for Elderly People**, Keens, Staden and Graycar, (1983) looked at the provision of home help services. The report covered an attempt to elicit data on home help services across Australia. This endeavour was partly thwarted by the inability of the services in a number of States to produce information in

the form requested. However, a thumbnail sketch was drawn of the manner in which the service was provided in each State, with a separate and major section concerned with the replies to questionnaires received from 47 New South Wales branches of the Home Care Service of New South Wales*

After looking at the issues underlying the need for formal systems of care of elderly people at home, the report considered some basic principles of service provision, e.g. whether or not there should be a fee-for-service and whether such services should be administered by government or non-government agencies, or be contracted out to commercial enterprise. Volunteerism was also considered.

The authors suggested that **for a service to be effective it must not only be efficient, but also flexible, comprehensive, accessible, acceptable and accountable** (Keens, Staden and Graycar, 1983:28). These attributes were looked at in terms of the receiver of the service. The authors also concerned themselves with the need for integration and co-operation of services and what this might mean to local branches. The latter proved to be an issue in **this** feasibility study, and is addressed elsewhere in this report.

Accommodation of older people in the community did not emerge in these reports as a major issue adversely affecting people aged 65+ years. Australian Bureau of Statistics data from the Income and Housing Survey (I.H.S.) 1982 quoted in a number of studies (Graycar ed, 1984; Rossiter, 1985) showed a housing owner-occupation rate of close to 73 per cent, reflecting the high rates of home-ownership among older people in Australia. Only 6.4 per cent were quoted by Graycar (1984) as occupying places in various forms of institutions, but these did not indicate the level of long-term 24 hour care being provided, as the figure also included, a range of non-private living arrangements e.g. hostels, 'homes for the aged' etc.

As the ABS Income and Housing Statistics refer only to privately owned accommodation (either owner-occupied or rented), the sanguine picture emerging from these data, while excluding residents in non-government administered hostels and self-care units, also failed to give an indication of the hardest-to-house group in Kendig's state of 'triple jeopardy' - those people on fixed low incomes, no societal supports, and with functional limitations both physical and cerebral (sometimes developmental and sometimes alcohol-induced) who live transient lives in boarding and/or rooming houses.

A study conducted in Sydney in 1984 (Freytag;1986) sought the views of sixty residents of boarding-houses, hostels and self-care units. Among the conclusions arising from their responses is this observation,

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* It was, perhaps, unfortunate that this work preceded major changes for the better in home help funding in New South Wales (an increase of 187 per cent in three years of which 107 per cent occurred in 1983/84). By the time the report was published a sudden growth in both the volume and range of services made some of the observations included in the report rather out of date.

> a common and disturbing thread which ran throughout the types of accommodation studied ... was characterised by a lack of choice, a lack of freedom, lack of flexibility, diminished rights, a subordination of individual needs to that of the institution and a lack of security of tenure. (Freytag;1986:62)

This suggests that these forms of 'care in the community' need to come under further scrutiny.

The Meals of Wheels Service in New South Wales was also reviewed by Randall Smith in a report produced in March, 1984 (SWRC R & P No.39). This report offered a picture of ad hoc arrangements for the provision of home-delivered meals, organised at a local level, with no central co-ordination and with major differences in quality, cost and delivery across municipal boundaries and between country centres.

Other reports covered in the literature review included a report of the Evaluation Committee of the Victorian Meals on Wheels Service (June, 1984) which concerned itself with service delivery rather than organisational matters, but nevertheless showed a willingness to tackle a State-wide (Victorian) review.

Margaret Bowman (1985) in an **Occasional Paper in Gerontology** traced the history of the appointment of Welfare Officers for the Aged under the States Grants (Home Care) Act, 1969. In placing this program in its historical context she has made a brave attempt to locate the three major home care services - home care, meals on wheels, and home nursing - and the uses to which Senior Citizens Centres have been put in each State, and to classify them in one of four systems of care, i.e. Decentralised Integrated Welfare, Dispersed Welfare, Centralised Health Care, and Mixed Systems. As mentioned earlier in this report (p.6) the problems associated with such an undertaking rendered it almost useless, other than to indicate the existing degree of organisational chaos and the need for some form of rationalisation of both legislation and administration.

Bowman also considered the philosophical basis of the divisions between health and welfare service systems. Because the bridging of these divisions was central to the position taken by the Aged Referral and Assessment Unit her argument is quoted below at length. Bowman says,

> The issue is not simply one of tension between central control by State government and devolution to the third sphere of government. The lines of conflict also tend to coincide with the different philosophies and styles characterising health and welfare service systems. The former tends to be more sympathetic to top-down planning by professionals for categories of treatment whereas the latter is more concerned with fostering individual autonomy in making choices to promote well-being, and encouraging community development.

> In terms of services delivery, the main issues are the extent to which welfare service systems should be integrated into care of the sick and targeted on the frail and disabled and how far they should be generally available to support those with social needs. One current minor dispute ... illustrates the tensions. Should home helpers be encouraged to extend and elaborate their role as providers of personal care, or as professional nurses argue, should giving personal care be restricted to aides specifically appointed and responsible to the domiciliary nurse? Such professional boundary disputes take on a particular sharpness when they are seen to reflect deeply held and competing philosophies. On the one hand, health carers emphasise the value of professional judgement and training as guaranteeing high standards of service provision. On the other hand, welfare workers mistrust the paternalism of the medical professions, and question that the quality of service provision to the old person can be measured by the certification of the care giver. People are not just 'patients' they are equally importantly social beings, with social needs which health professionals are not always trained to meet. The administrative separation of domiciliary nursing from other 'home care' service systems does nothing to bridge the gap. (1985:32)

The position paper prepared by the Victorian Council on the Ageing (**Care of Older People in Victoria,** 1984), reviewed the major reports on aged care from 1977 to 1984, in which it made clear the substantial involvement in Victoria of local government in the organisation and administration of community services, and highlighted a major difference between Victoria and New South Wales service delivery. In commenting on service provision the writer stated

> older people often have to accept what is offered, in the way it is provided, with little thought having been given to their real personal needs. This occurs sometimes because their needs are perceived only on the basis of services that are available. People are made to 'fit' services ... (1984:26)

A hierarchy of needs was presented in the paper diagramatically and levels were explored from 1 to 5, commencing with the requirement of an adequate income and moving through assistance given by the family or modified extended family to neighbourhood support systems (including G.P.s) At Level 4 'local services' may be needed, and in this regard the following statement was made

> Every person in need of assistance could have a regular contact with one local worker to take responsibility for co-ordination of services to that person. (1984:34)

Level 5 was seen to require the intervention of services organised at State or regional levels, most of which related to health (including mental health) and/or accommodation, e.g. nursing homes, hostels, etc. and specialised services such as for the deaf or blind.

Repeatedly, the report called for greater co-operation between health and welfare workers and across professional boundaries, so that users of services

received the best and most appropriate attention to their needs. In six out of ten of the reports summarised, emphasis was placed on the need for comprehensive assessment. This was usually seen as the responsibility of a multi-disciplinary team, placed at regional level, and given sufficient autonomy to make independent decisions which may cross health/welfare demarcation lines.

1.3 POLICY RESPONSES

There have been a number of policy responses to both the demographic trends, revealed in particular by the 1981 Census figures, and to the research that these trends have engendered.

The McLeay Report

In 1981 a sub-committee of the Expenditure Committee of the House of Representatives was set up to inquire into accommodation and home care of elderly people. Its report - known as the McLeay Report - was released in October, 1982. This report looked at the development of services concerned with the health and welfare of aged people - the evolution from care within the family, through care by the voluntary sector, to government involvement at Commonwealth, State and local levels. It considered the policies which impinged upon aged people, and it looked, in particular, at the relative advantages of caring for the elderly in the community or in institutions such as nursing homes. The report focused attention on the nature and effectiveness of those community services which were already working to maintain aged people in their homes, and consideration was given to ways in which these services could be co-ordinated into providing less fragmented, needs-based care.

The McLeay report recommended that all programmes providing home care and accommodation for the aged be brought under the control of one Minister, and that negotiations should be undertaken with State governments to develop more effective cost-sharing arrangements. The report also recommended that there should be an Extended Care Program which would incorporate benefits and subsidies currently being provided under six different Acts, and that planning and delivery of the program should be conducted at the regional level. As a mechanism to assist in such regional planning, multi-disciplinary teams should be set up, with access to the full range of services for the aged. These teams would assess the needs of elderly people and refer the people appropriately to community services or to residential care. It was assumed that by this means there would be a matching of needs to services and that teams could assist in the co-ordination of service provision, thus contributing to the well-being of the elderly.

In August, 1983 a joint press statement was released by Senators Grimes and Gietzelt and Dr. Blewett (Minister for Social Security, Veterans Affairs, and Health, respectively), stating that 'some 50 assessment teams' would be established across Australia at an approximate cost of $200,000 each. This

statement indicated that assessment by such teams 'would be a pre-condition for aged persons receiving future admission to nursing home care or for receiving community care in their home or hostel'. There was a clear indication in this statement that assessment teams were going to be a feature of services for the aged in the future and this was re-iterated by the then Secretary of the New South Wales Department of Health in the Dick Gibson Memorial Lecture given to the Hunter Valley Chapter of the Australian Association of Gerontology in September, 1983.

As has been stated previously, eight such projects were funded in New South Wales out of an Australia-wide allocation made in the Federal Budget for 1983/84. As most of these arose from locally-based submissions, they differed in character and emphasis. Not all were service-oriented, and three were lone positions concerned with ethnic aged populations in specific areas. The Aged Referral and Assessment Unit was one of the New South Wales initiatives.

In August, 1984, a joint press statement by the Ministers for Social Security, Health, and Veterans' Affairs announced 'a new cost-shared program with the States and Territories - the **Home and Community Care (H.A.C.C.) Program'**. The program was presented as offering 'new directions in care for aged and disabled people, providing realistic alternatives to institutional care and expanded assessment services to help aged people and their relatives choose the most appropriate care for their needs'.

Subject to Federal/State agreement, new legislation was to be developed to replace existing legislation affecting a number of community care programs. The Federal Department of Community Services was to be formed, subsuming those parts of Departments of Social Security and Health which were concerned with the legislation mentioned above, and coming under a Minister for Community Services. A number of areas were singled out for increased or new funding, and there was a special mention of those services which contributed to the care of elderly people at home. Respite care was to be provided in both nursing homes and hostels.

The establishment of an Office for Aged Care, and an Office of Disability, together with a Co-ordination Unit, was also announced and senior appointments were made early in 1985. The Directors of these Units are responsible to the Minister for Community Services.

The cost-sharing arrangements which were basic to the implementation of the H.A.C.C. program required separate agreements to be signed between each State and the Federal Government. South Australia, having appointed the first Commissioner for the Ageing early in 1985, was the first Australian State to sign the H.A.C.C. agreement. In February 1986, New South Wales was the last to sign the agreement. Because of marked divisions between Health and Welfare, government and non-government, consultation between present providers/deliverers of services to disabled and aged people has been protracted and fraught with anxieties arising from professional and territorial imperatives.

As at April 1986 legislation relating to the H.A.C.C. Program (which incorporates relevant sections from other Acts) has not yet progressed through

Parliament. However, State offices of the Department for Community Services have been operating for the past 12 months.

1.4 REGIONAL GERIATRIC ASSESSMENT TEAMS

As can be seen from the foregoing overview of policy announcements and/or initiatives, multi-disciplinary regional assessment teams were seen as being central to the provision of more effective needs-based services to elderly people living in the community.

Some confusion existed as to the degree of their attachment to hospital-based services, and to the service-specific limits of their responsibilities, but it was generally agreed that they would have the potential to provide:

- multi-disciplinary assessment of elderly people
- appropriate referral to services/accommodation/treatment
- qualitative and quantitative information about services provided
- the identification of unmet needs
- a co-ordinating mechanism for regional service provision
- gatekeeping entry of people to residential care

Depending to an extent on professional bias, some policy advisers saw these as health-based and treatment-oriented, while others envisaged a community-based model with strong information/contact aspects but which also combined referral and assessment.

Policy makers and researchers acknowledged that there were already numbers of assessment teams functioning across Australia, but there was nothing to suggest that these assessment teams had been reviewed in the light of the requirements mentioned above.

There was little recognition of the political nature of such teams, with their potential for threat to the territorial rights of existing services and the power inherent in their position of neutral evaluation, and no research appears to have been undertaken as to how (or if) these difficult areas had been addressed by the already existing teams.

Some awareness of those problems was shown by Keens et al (1983:30), who suggested that 'one must not assume that integrated local service delivery ... can be achieved without administrative anguish'. Hemer (1983) acknowledged that there may be many potential areas of dispute, and Bowman (1985) writing primarily about Welfare Officers for the Aged, described in some detail the 'lines of cleavage' compounded by the different interests and priorities of spheres of government and between the public sector and voluntary agencies.

1.5 CONCLUSION

The foregoing brief overview of research literature gives an indication of the complexities surrounding the planning, co-ordination and delivery of services for the aged which come under the name of 'community care'. As will be seen in this report, most of the issues and problems identified in the research literature have been encountered in the experience of the Aged Referral and Assessment Unit during the fourteen months of its operation. The reality of these complexities and problems need to be recognised by policy makers, administrators and people involved in service delivery, if the services for the aged are to meet the needs of elderly people in a way which will enable them to experience a reasonable quality of life while remaining outside of institutional care.

CHAPTER II

CHARACTERISTICS OF AREA 5: SOUTHERN METROPOLITAN REGION (N.S.W.)

The Southern Metropolitan Region of the New South Wales Department of Health is divided into seven administrative areas. Area 5 (see Map.p.18) was chosen for the location of a central referral agency for aged services because of the high incidence of aged residents in that area.

2.1 DEMOGRAPHY

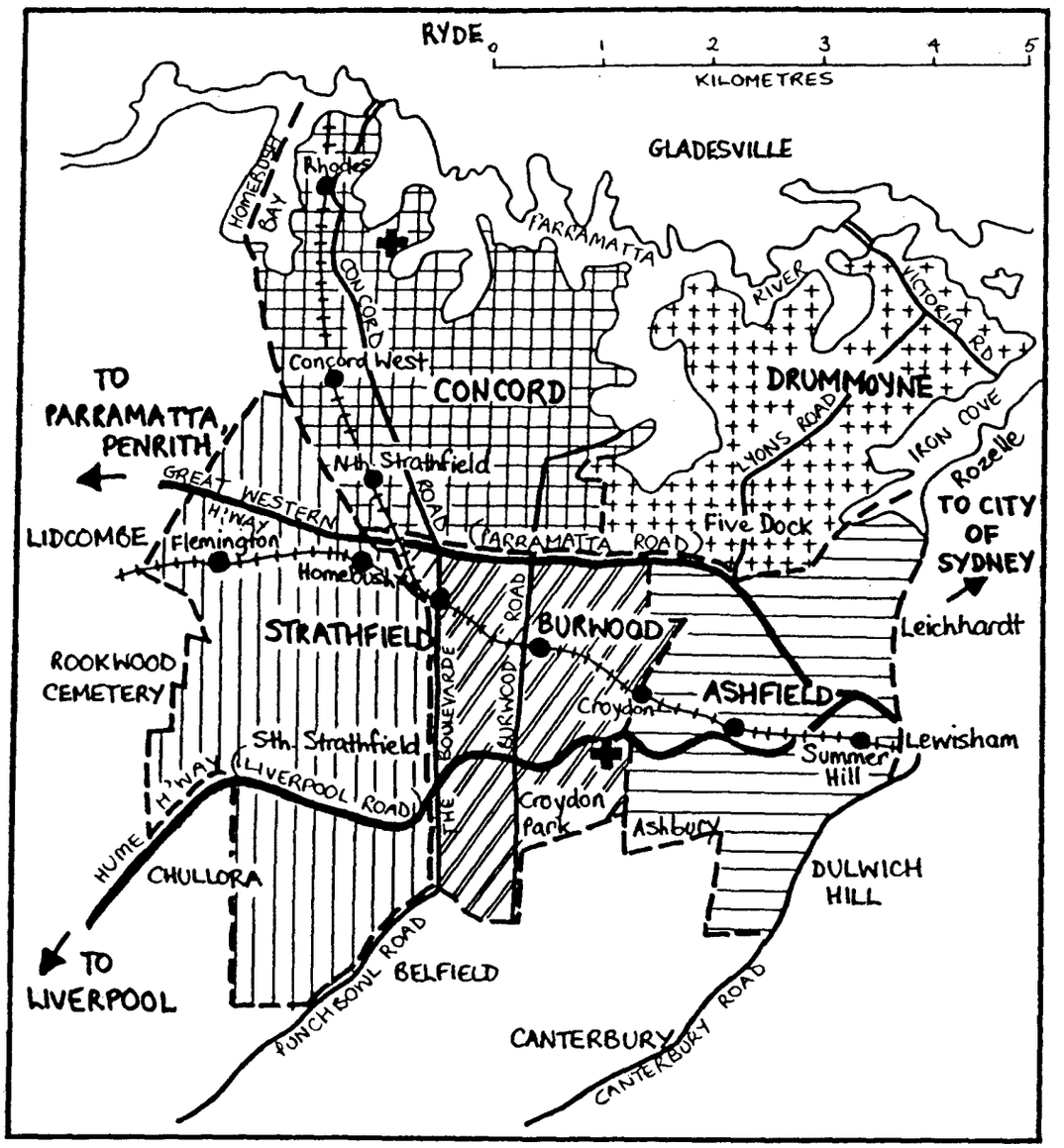
Health Area 5 consists of five small municipalities located in the inner western suburbs of Sydney. Reference to the demographic statistics shown below (Table 2.1) indicates that, of these, Concord has the lowest population figure (23,926) while the highest figure is in Ashfield (41,253). Strathfield (25,882), Burwood (28,896), and Drummoyne (30,961) follow in that order. The municipalities are all served by rail, and also have bus services, some of which are interlinking, as well as providing transport to the city.

All five municipalities are long-established - those of Burwood and Strathfield having a history of past high status which is handed on in a somewhat attenuated form until today. Each of the latter, however, has suburbs which house a more transient, less affluent population representation and this is carried over to Ashfield which, as the municipality closest to the city, tends to attract more renters and a higher level of non-Anglo people. The suburb of Haberfield in Ashfield has a well-established Italian community, while Strathfield houses a colony of Russians who have come to Australia via China. Many of these people are now old.

Concord is perhaps the most homogeneous of the five municipalities, having a fairly settled population of comfortable rather than wealthy means, and a strong notion of local identity. The municipality of Drummoyne is located on a peninsula and runs the gamut of struggling young families at the southern end to more established residents with views of the Parramatta river at the northern extremity.

There appears to be a high incidence of home ownership, particularly among the older and established residents. There are numbers of large old houses in Ashfield, Burwood and Strathfield, and many of these have been utilised as private schools, nursing homes, hostels, and, particularly in Ashfield, as boarding houses.

Over 3,000 of the total population of Area 5 (150,918) are occupying nursing home beds or are residents of hostels (Tables 2.2 and 2.3). More than half of these have come from outside of the area. In general the municipalities house an ageing population with 14.3 per cent aged 65 years and over. This compares with an average of 10.1 per cent for the Sydney Statistical division, and brings Area 5 into the range of New South Wales Department of Health planning units for the provision of regional health services. Of those aged 65 years and above, living in the area, 19.58 per cent are of non-Anglo origin.



THE MUNICIPALITIES OF AREA 5

KEY:
- Municipal boundary
- Highway
- Main Road
- Railway Station
- Acute public hospital

TABLE 2.1 POPULATION 55 YEARS AND OVER IN FIVE LOCAL GOVERNMENT AREAS

(from 1981 A.B.S. Census of Population & Housing)

MUNICIPALITY/ TOTAL POPULATION	AGE GROUP (YEARS)					
	55 - 64		65 - 74		75 +	
	NO.	%	NO.	%	NO.	%
ASHFIELD 41,253	4,247	10.3	3,279	7.9	2,581	6.3
BURWOOD 28,896	3,122	10.8	2,469	8.5	1,749	6.1
CONCORD 23,926	2,758	11.5	2,074	8.7	1,427	6.0
DRUMMOYNE 30,961	3,706	11.5	2,654	8.6	1,695	5.5
STRATHFIELD 25,882	2,849	11.0	2,204	8.5	1,413	5.5
TOTAL 5 LGAs 150,918	16,682	11.1	12,680	8.4	8,865	5.9
SYDNEY STATISTICAL DIVISION 3,204,696	304,331	9.5	205,079	6.4	118,393	3.7

MUNICIPALITY	ALL PEOPLE 55 & +		ALL PEOPLE 65 & +		ALL PEOPLE 75 & +	
ASHFIELD	10,107	24.5	5,860	14.2	2,581	6.3
BURWOOD	7,340	25.4	4,218	14.6	1,749	6.1
CONCORD	6,259	26.2	3,501	14.6	1,427	6.0
DRUMMOYNE	8,055	26.0	4,349	14.0	1,695	5.5
STRATHFIELD	6,466	25.0	3,617	14.0	1,413	5.5
TOTAL 5 LGAs	38,227	25.3	21,545	14.3	8,865	5.9
TOTAL SYDNEY	527,803	19.6	323,472	10.1	118,393	3.7

TABLE 2.2 NURSING HOMES IN AREA 5 (as at August, 1985)

Municipality	Total	Deficit Non Profit	Public Nursing Home	Private Nursing Home
ASHFIELD				
Number of Nursing Homes	19	6	-	13
Number of Beds	1139	401	-	738
BURWOOD				
Number of Nursing Homes	20	-	-	20
Number of Beds	710	-	-	710
CONCORD				
Number of Nursing Homes	4	1	-	3
Number of Beds	187	34	-	153
DRUMMOYNE				
Number of Nursing Homes	3	1	-	2
Number of Beds	138	36	-	102
STRATHFIELD				
Number of Nursing Homes	12	-	1	11
Number of Beds	697	-	205	492
TOTAL AREA 5				
Number of Nursing Homes	58	8	1	49
Number of Beds	2871	471	205	2195

TABLE 2.3 AREA 5 - HOSTELS (as at August, 1985)

ASHFIELD

4 Hostels	-	28	beds
	-	149	beds (including 3 respite)
	-	59	beds (including 2 respite)
	-	58	beds (buy into hostel)
TOTAL BEDS	=	296	including 5 respite for community use

All attached to complexes with nursing home

BURWOOD

3 Hostels	-	32	beds (including 2 respite)
	-	20	beds
	-	9	beds
TOTAL BEDS	=	61	including: - 2 respite
			- 32 visually impaired
			- 9 female, German speaking

CONCORD

2 Hostels	-	19	beds
	-	42	beds
TOTAL BEDS	=	61	

- Nil attached to complexes with nursing homes
- No respite beds

DRUMMOYNE

2 Hostels	-	40	beds (including 1 respite)
	-	68	beds (including 2 respite)
TOTAL BEDS	=	108	including: - 3 respite for community use
			- 68 beds attached to complexes with nursing home

STRATHFIELD

3 Hostels	-	31	beds (including 1 respite)
	-	28	beds (Legacy Widows)
	-	40	beds
TOTAL BEDS	=	99	including: - 1 respite for community use
			40 beds under United Nations Charter taking only Russians from China
			1 respite - Russian speaking

TOTAL AREA 5

* NUMBER OF HOSTELS = 14
* NUMBER OF HOSTEL BEDS = 605
  (including 12 respite beds)

2.2 SERVICE PROVISION

The division of Area 5 into five municipalities complicates the provision of services, as does the plethora of bodies whose policies impinge upon service provision. Difficulties also arise out of differing service boundaries, as is the case within Sydney Home Nursing Service (S.H.N.S.). The following brief overview of service provision presents the situation as it was at the time the Aged Referral and Assessment Unit was in operation, that is, July 1984 to September 1985.

Youth and Community Services Department (Y.A.C.S.): Policies adopted by this statutory body affect a number of services and local workers with the aged. Y.A.C.S. administers subsidies for the council-employed Welfare Officers for the Aged, and, in some cases, co-ordinators of Meals on Wheels branches.

Local Government Welfare Officers for the Aged: As Y.A.C.S.-subsidised, local government employees, these Welfare Workers are often in a position to spear-head the establishment and co-ordination of aged services **within council areas**, but some councils were uneasy about, and resistant to, time spent on planning and organising across council boundaries, particularly where adjoining councils did not employ Welfare Officers of their own. Through the Welfare Workers, Local Government had a strong influence on provision of services to the aged in all five municipalities - both in terms of assistance given and assistance with-held. For example, after some unsatisfactory experiences in the past, Strathfield Council had distanced itself from any welfare role for a period of some seven years. Many of the Strathfield groups had arisen out of educational imperatives, and there had been an emphasis on the satisfying of individual rather than community needs. During the period of the functioning of the A.R. & A.U. there had been no community worker employed by the Council, but a worker was employed in February 1986. A situation had arisen whereby the provision of Meals on Wheels (prepared by Our Lady of Loreto Hospital) had been limited by the voluntary co-ordinator to 40. (Population figures for that municipality show 1,413 people aged 75+ years.)

Home Nursing: In Area 5, home nursing services were provided mainly by the Sydney Home Nursing Service (S.H.N.S.) eighteen nurses served Strathfield, Burwood, Concord and Ashfield municipalities, but also crossed the boundary into parts of the Municipality of Canterbury. The Lewisham Branch had 2 nurses working in Drummoyne but also served municipalities outside of Area 5.

In two municipalities in Area 5 home nursing services were provided by council-employed nurses as well as by the Sydney Home Nursing Service, and a deficit-funded nursing home situated in Ashfield also offered a 'user-pays' home nursing service to people within a wide geographic area.

Home care: The Home Care Service of New South Wales had a Burwood Branch which served Burwood, Strathfield and Concord, and a branch at Five Dock (Ashfield/Drummoyne Branch) which served those two municipalities. Whilst branches of the Home Care Service responded to local Management Committees they were also responsible to a central executive based in Parramatta for administration and policy.

Meals On Wheels: Services in New South Wales have tended to be organised by local management committees based within local government boundaries. Some acted with almost complete autonomy, while others were linked to councils by aldermanic representation on the committees of management.

Co-ordination at regional level, therefore, involved co-operation between local autonomous voluntary bodies which, in the case of Meals on Wheels, provided 'the same' service at varying prices, product standards, eligibility criteria, delivery arrangements and management conditions. Efforts by the New South Wales Council on the Ageing to bring about an agreement to work towards standardisation has so far been less than effective.

Podiatry: A service, which is free to Pensioner Health Benefit card holders, was available at the Western Suburbs Hospital and, by arrangements with local councils, at Concord, Burwood and Drummoyne (including a domiciliary service in that municipality), with negotiations under way in Ashfield. Strathfield Council had deferred consideration of the matter until such time as a local welfare officer was appointed. (The Aged Referral and Assessment Unit was involved in liaising between Councils, community workers, and the Senior Podiatrist at Western Suburbs Hospital in extending previously existing services in Concord, and the establishment of services in Drummoyne.)

Audiology and Dental Treatment were also available at the Western Suburbs Hospital with some transport provided.

Physiotherapy and Occupational Therapy were available by medical referral at Croydon Community Rehabilitation Service. Waiting times could be as long as eight weeks, although a priority system was maintained. A surprisingly high proportion of the patients seen at this centre were nursing home residents.

Five Dock Community Mental Health Team offered a mental health service across the whole of Area 5. The team consisted of a psychiatrist, social workers, a psychologist and psychiatrically trained community nurses. One psychiatrically trained nurse offered a service to aged clients. This team was a useful resource for second opinions when assessing confused or psychiatrically disturbed individuals. Attempts to utilise the worker for the aged to provide a general ongoing monitoring service were unsuccessful, because his priority was inevitably towards those of the elderly who were suffering from psychiatric disorders, and his caseload prohibited him from offering a more generalist service.

Social Groups for elderly people were present in all municipalities. A total of 23 were located in Area 5. Comparatively active nursing home residents formed a significant section of participants. One reason for this was the ease in moving groups (rather than individuals) by minibuses from A to B, so that numbers could be maintained and the value of the organisation validated. An added incentive to the gathering in of nursing home residents was the contribution made by diversional therapists employed by nursing homes who accompanied them.

Groups offered activites such as craft, bowls, bingo and outings. Some were conversational groups for elderly non-Anglo people. Some included the lunch period, either providing a light meal, or requesting each person to bring food. Most of these groups catered for the marginally active aged. Their

activities did not appear to attract men in any great numbers. There were **R.S.L. Day Care Clubs** in Ashfield, Concord and Drummoyne. These were auspiced by the Department of Veterans Affairs, had a more highly organised infra-structure, and drew larger attendances, including some people with quite severe physical limitations. Men were often prepared to attend R.S.L. Day Care Clubs.

Senior Citizens Centres existed in each of the municipalities. These varied in the level of activities, numbers attending and style of management.

A number of **specialist organisations** supported groups in Area 5. These included the Legacy Widows Club, the Royal Blind Society (although philosophy now espoused by that society follows the notion of integration of blind people into 'normal' community activities), Blind Citizens Association, A.D.A.R.D.S., and the Straight Talk and Stroke Club (the only source of speech therapy for post-stroke people in Area 5).

Community (Aid and) Information Centres existed in Ashfield, Burwood, Concord, Drummoyne and Five Dock. Some of these (e.g. Ashfield, and Five Dock) were staffed by voluntary workers, while others had one or more paid co-ordinators. Some offered a limited information service while others had strong attachments to local councils and were the hub of much activity e.g. classes, case-work, community service/development.

Branches of the **Combined Pensioners Association** were active in Burwood, Ashfield and Drummoyne, and representatives from this Association served on a number of committees of management etc. giving input from consumer groups.

(Buses from Western Suburbs Hospital are utilised by many of these community groups.)

2.3 MODELS OF OPERATION

In four of the five municipalities under review (Strathfield being the exception) workers were employed by Council to look after the interests of aged residents. These workers form part of the Commonwealth Welfare Officer for the Aged programme which was introduced under the States Grants (Home Care) Act 1969, and which, in New South Wales, is administered by the Department of Youth and Community Services (Y.A.C.S.) The salaries of these workers are subsidised by federal money, directed through Y.A.C.S.

In three of the municipalities (Burwood, Drummoyne and Concord) salaries are also paid under the Delivered Meals Subsidy Act, 1970, for part time co-ordinators of the Meals on Wheels service. In Ashfield the role of the Meals on Wheels co-ordinator had been assumed by the Community Arts Officer. However, in April 1985, a Welfare Officer was employed to look after all matters pertaining to the aged (including co-ordination of Meals on Wheels). As this worker was still settling in to her position, no model was available for consideration while the Aged Referral and Assessment Unit was functioning.

In the remaining three municipalities where Welfare Officers for the Aged were employed, their manner of working was discernibly different from one another. Elements which emerged as an outcome of these differences have allowed for the following classification of the operating models:

- a volunteers model (Burwood)
- a community model (Concord)
- a centre-based model (Drummoyne)

Burwood - A Volunteers' Model

Burwood tends to be the commercial centre of Area 5, and was seen as a central location for those activities which had reference to the Area as a whole. The Burwood Council had considerable input into community and welfare initiatives through its association with Burwood Aid Services which is a charitable organisation with a Management Committee of local residents and councillors. Most activities were centred on the Burwood Community Information and Aid Centre. This Centre also provided a location for a Red Cross Worker,* and the part-time Meals on Wheels co-ordinator.

The close association of most of these services with the Council, while giving them status in the community, also tended to limit their activities to within municipal boundaries. The Burwood Community Worker (Aged Services) broadened her role to include the convening of the Inner West Aged Services Task Group, which looked to provide a forum for regional planning and co-ordination of aged-related services in the whole of Area 5.

Burwood Aid Services also had building-space available to accommodate a wide range of groups as well as serving as a venue for a podiatry service for pensioners funded by the Inner Western Suburbs Area Health Services. The Senior Citizens Centre was one organisation which was not allied with Burwood Aid Services.

Volunteers were seen as an integral and important part of the functioning of Burwood Aid Services, and many of the services auspiced by that organisation were run by voluntary workers. As at the end of May, 1985 (and excluding those solely for Meals on Wheels) Burwood Aid Services had 40 volunteers listed as available to give services of various kinds.

A significant amount of the time and energy of the paid co-ordinator and staff of the Burwood Community Information and Aid Centre went into the training, support and direction of volunteers, and the organization enjoyed a high profile, bringing together as it did Council members, paid workers, voluntary workers, and people with needs ranging from information or social interaction to financial assistance (e.g. through the Welstat Scheme).

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* (This service discontinued in August, 1985).

Inevitably where there is such a large voluntary contribution, the services provided tend to vary with individual capabilities. It was perhaps unfortunate that members of the Aged Referral and Assessment Unit had little success in tapping into what would appear to be the kind of volunteer network which was seen as the ideal by numbers of parliamentarians and policy-makers. Enquiries for services (which were advertised as available) e.g. emergency transport, friendly visits to housebound people etc. were met with 'this service is not functioning just at present'. Enquiries to the Information Centre switchboard for specific information (e.g. details about groups meeting in the building, or about the podiatry service) had either been unproductive (the volunteers taking calls did not seem to be able to locate the information and appeared reluctant to put the enquirer in touch with those members of the organisation who could furnish it), or entailed a wait of some days before a return call brought the information desired.

The Meals on Wheels co-ordinator was located in the Burwood Community Information and Aid Centre building. Meals were provided from two sources - St. John of God Hospital, and Western Suburbs Hospital - and were delivered by volunteers. Early in June 1985, 80 meals were being provided at a cost of $1.50 per meal.

The Social Worker who was employed as the Welfare Officer for the Aged, saw her role to be that of a developer of community services, and, as a Council employee, gave strong support to the Burwood Aid Services. She stated that case-work with individual aged people formed 1 per cent of her workload.

Concord - A Community Model

Concord is, with Strathfield, one of the smaller municipalities of Area 5. It is an attractive suburb with many parks and open spaces. The population is stable and economically comfortable. There is a strong sense of community, and people are prepared to watch over the interests of neighbours when this is necessary. As older residents die out some houses are being bought by established people of non-Anglo background - often extended families of three generations.

The Welfare Worker for the Aged working in the municipality had been in the position for eleven years. He saw himself as a Council employee, but was trusted by Council to act autonomously. The Meals on Wheels Co-ordinator, besides fulfilling her part-time obligation to co-ordinate delivered meals, worked as an assistant to the welfare worker. The Welfare worker and the Meals on Wheels co-ordinator were housed in a centrally located office which is attached to the library and is readily accessible to local residents.

These two people were community workers, in that they had sufficient knowledge of 'their' community to be able to meet almost any need from the resources at hand. For instance, if a resident was in need of domestic assistance, these workers would know who, from within the community, would be happy to provide this service and at what cost. If transport was needed to, for instance, Concord Hospital, the workers would know (without the

employment of the label 'volunteer') who would be available and willing to make the trip.

Each of the workers spent time maintaining contact with housebound elderly people in the area. If a garden needed cleaning up, the Welfare Worker would supervise men performing community service while on probation and parole. If a grab rail was required to ensure the safety of an elderly resident, the Welfare worker knew of a community member who would provide this, and the Welfare worker would see that is was installed.

The Council also employed three nurses who between them visited about 24 people each week, charging $1 per call. (Sydney Home Nursing Service also provides a service to Concord.) Messages for these nurses were taken by the Council switchboard, but they were based at the Council Works Depot, which is at some distance from the Council chambers. Contact with the Welfare Worker was maintained, allowing for co-ordination of services. Podiatry sessions had for some time been conducted on a monthly basis (or more frequently as required) at a nearby hall. This service was extended (with funding provided through Inner Western Suburbs Area Health Service) to a regular twice-monthly service. Meals on Wheels were cooked at Concord Hospital, and there was no shortage of helpers to provide delivery. As at first week in June 1985, 65 meals were being delivered at a cost of $1.40.

Concord has a Senior Citizens Centre which operated in the same complex of Council/Library/Welfare Worker's Office. It was run by its own committee, and served a young and active group of people aged 55+.

When asked about his relationship with local General Practitioners the Welfare worker said that he kept them up-to-date with services available, and tended to receive personal phone calls when any elderly person was seen to be in need of follow-up or a community service.

Although team members of the Aged Referral and Assessment Unit felt some anxiety about the capacity of these workers to recognise early symptoms of health breakdown or stress in carers (and there was some evidence of this in the few cases which were referred from Concord municipality), as working relationships developed, useful instances of consultation occurred. The position of trust and the wealth of local knowledge enjoyed by such community workers can be invaluable to teams offering a particular service on a regional basis.

With Concord Hospital within the municipality and with easy and dependable access to services through their local workers it seems likely that elderly people living in Concord feel a security which is not common to aged people in general.

Drummoyne - A Centre-Based Model

The model depicted below seemed likely to be about to undergo radical change; however, during the life of this (Aged Referral and Assessment Unit) project, Drummoyne's aged services were based on the Senior Citizens Centre.

The Centre has a sizeable kitchen and this was the only municipality in Area 5 in which meals for delivery were cooked on Centre's premises. This gave the Centre a focus, allowing for the provision of meals at the Centre for mobile people to eat in company with others (a practice advocated by policy-makers) and encouraging them to stay on for other activities such as craftwork or bowls. In addition, this arrangement introduced a social component for the Meals on Wheels volunteers, many of whom were also elderly, who often sat and had a meal when they returned from the delivery runs. (110 meals were being delivered as at early June, 1985 at a cost of $1.90) Most of the people attending this Centre were from the 'old old' group.

Through the Aged Referral and Assessment Unit the Inner Western Suburbs Area Health Service was able to introduce a podiatry service into this Centre - 2 sessions per month being centre-based and one session being a domiciliary service for the housebound.

The co-ordinator of the Centre (the Welfare Officer for the Aged employed by the Council) was primarily centre-based, while the Meals on Wheels co-ordinator had been an active visitor of the housebound and other elderly residents of Drummoyne. This had given a fair coverage of both the mobile and frail aged. The co-ordinator had had a background in entertainment and this permitted him to lead in social activities and in the arranging of occasional afternoon concerts which drew large numbers of elderly residents.

The extent of the 'good works' carried out by this co-ordinator, and the contribution made by him to the quality of life enjoyed by numbers of elderly people with whom he made contact was not immediately apparent, but emerged in the context of assessment and intervention by the A.R. & A.U. (see case studies, appendix VI)

Although this model seems to have been the one which was described by the Minister in announcing the Capital grants for the establishment of Senior Citizens' Centres in 1969 (Bowman, 1985:8), there now appears to be a change in policy with a different role ascribed to Welfare Officers. The implications of this are discussed later in this report.

2.4 Problem Areas

Individual problem areas have been identified earlier in this Chapter. However, some difficulties of a more general nature need consideration. Among these are the Program of Aids for Disabled People (P.A.D.P.) the Home Care Service, rehabilitation as it is offered in Area 5, and the general area of transport for frail and disabled people with individual needs (i.e. unable to use either public transport or minibuses, and needing to attend medical centres or hospitals for appointments or treatment, or to visit institutionalised spouses).

It is not the view of the authors of this report that the provision of more funds would necessarily improve services, but rather that changes in operating modes might bring about more effective provision.

Program of Aids for Disabled People (P.A.D.P.)

This program was launched by the Health Department in February 1982 to ensure that people with particular needs would not be precluded, by money or lack of knowledge, from a whole range of aids which would assist their daily functions. Examples include ongoing necessities such as disposable syringes for diabetics and once-only requirements such as electric wheelchairs for people suffering paralysis. A central distribution centre (usually a hospital) was nominated in each area, and money was granted on a per capita basis for the purchase of aids. Referral was to come from General Practitioners, or in some cases, specialists.

No funds were allocated for administration of the program, so that hospitals tended to regard the provision of aids as a clerical exercise, usually performed by a clerical worker who had no knowledge of either the aid or of the appropriateness of its allocation. This has led, in cases known to the Aged Referral and Assessment Unit team members, to the issuing of unsuitable but expensive equipment to people with no idea of its best and efficient use. Meanwhile funds for provision of aids have run out each year, months before the allocation period had elapsed. As oxygen is included in this program, the non-availability of this commodity can be a serious problem to people who have become dependent upon having it freely available. The employment of a person with an interest in and knowledge of such aids could lead to a more effective and cost-efficient service.

Home Care Service of New South Wales

This service is obviously extremely difficult to administer. Inevitably regular subsidised domestic assistance is seen as desirable by elderly people with diminishing energy resources and with physical and functional limitations, and is therefore unlikely to be relinquished willingly (unlike the more intermittently used services - Meals on Wheels or the Home Nursing Service) once it has commenced. The Home Care Service is therefore faced with an elastic demand which is seen to be relentlessly stretching beyond the capacity of the public purse to pay. (An alternative view was expressed by MacLeod and Smith writing in the Scottish context; 'the provision of home help for an hour per day to a family to enable them to continue caring for the further twenty-three hours ... is a very small price to pay in comparison to admission to a residential home' (1985:66).

Some of the reservations directed by the Home Care Service at projects such as the Aged Referral and Assessment Unit have arisen out of determination of the Home Care Service to make its own service-specific assessments, and it would seem that any containment of the present service explosion devolves upon the process of initial assessment and regular re-assessment. As things stand at present, the Home Care Service, at least as it operates in Area 5, cannot be relied upon as one of the services which can respond at short notice (in circumstances of crisis, or near crisis) to stave off a move to residential placement or institutionalisation. The pressures engendered by the need to juggle available 'hours' and to make decisions about service entitlement in relation to need, (**and** to cope with complaints and

dissatisfactions which arise from these decisions) have led to the adoption of attitudes in some administrators which are counter-productive to open interaction with other community workers.

To its credit, the Burwood branch of the Service, having no 'available hours', was often willing to put applicants in touch with workers (therefore vouched for by the Home Care Service) who were prepared to make 'private arrangements'. This was often taken up, and proved satisfactory as an ongoing arrangement (either because the applicant had sufficient means, or because finance was made available through the applicant's support network).

This situation has arisen with sufficient frequency for the question to be asked - is there a need for a vouched-for 'user-pays' service, which could be run in tandem with the Home Care subsidised service, which, while not yielding any profit to its administrators, would take pressure off the subsidised service as it currently operates?

Rehabilitation

Rehabilitation for stroke patients and for others needing physical re-education in Area 5, was limited by the capacity of the Croydon Community Rehabilitation Service. This Centre took medical referrals from the community, and identified patients admitted to Western Suburbs Hospital who were in need of rehabilitation. Outpatient treatment was conducted at the Day Hospital. A significant number of its community patients were from nursing homes and there were waiting times of up to 8 weeks for treatment, although a system of assessment and priority establishment was in operation.

The Centre had no inpatient beds but theoretically had at its disposal 25 beds at Our Lady of Loreto in Strathfield. This is a Schedule III Hospital with 205 beds whose official description is 'long term care/nursing home'. Presumably the 50 rehabilitation beds (25 for Croydon Community Rehabilitation Service and 25 for Canterbury Rehabilitation Unit) are not included under this category. On the occasions when the Aged Referral and Assessment Unit assessment had suggested the need for inpatient rehabilitation, some disquiet was felt by the Unit about the passive nature of this process. The only physical therapist employed at Our Lady of Loreto Hospital was a physiotherapist, and it did not seem that the nursing staff have been educated to the notion of active rehabilitation. For example, patients undergoing rehabilitation did not take responsibility for their own daily living functions (e.g. bathing) during their stay. No home visits were made either by staff members (to ascertain the nature of the environment to which the patient would be discharged e.g. need for grab rails, training for negotiating stairs etc.) or to trial the patient before final discharge.

No Health Department-employed speech pathologist was available to treat post-stroke patients suffering from aphasia in Area 5

The above observations would indicate that people needing rehabilitation in Area 5 (and not eligible for admission to Concord Hospital as 'community patients') are disadvantaged.

Transport

The transport needs of frail and disabled people have long been recognised as presenting major difficulties. The Disabled Taxi Service established by the Urban Transport Authority in November, 1981, was soon swamped, and now employs such stringent criteria as to be inaccessible to new applicants.

A quick and fashionable solution has been the provision of mini-buses, often paid for by local service clubs, and usually controlled by Municipal Councils. While these meet the needs of the more active aged in the community and can be employed for group transport (e.g. for shopping, outings etc.) if voluntary drivers can be located, mini-buses tend to have characteristics which may make them no more accessible than public transport to frail and disabled aged people. Elderly people with problems of the lower limbs find difficulty in entering any but the front passenger seat of cars. Where wheel-chairs or walking frames must also be accommodated, the ideal vehicle is a station wagon.

In the past, use was made of ambulances to carry such people to hospitals or to other health-related appointments. This was an unwieldy and costly practice, but its discontinuation has made great problems for elderly people in the community (particularly those who are paying rent, and are therefore unable to consider the frequent use of taxis).

In Area 5, as has been indicated earlier (p.27) some workers with the aged have managed to overcome this problem when it is presented to them, by the use of volunteers. However, in three municipalities the problem had still to be solved.

Day Care for Frail and/or Confused Aged People

Day respite for carers was not available in any organised form in Area 5. In some of the municipalities volunteers could be located for this purpose, but this was dependent upon the goodwill and availability of individual residents.

There was no Day Centre which provided regular and predictable respite for carers, nor one that offered social contact for frail people who lived alone. A Day Hospital was available at the Croydon Community Rehabilitation Centre, where some social contacts were fostered, but the requirement of a medical referral, and the focus of the Centre on physical therapy suggested that this was limited to people with identifiable rehabilitation needs.

2.5 CONCLUSION: OBSERVATIONS AND COMMENTS

A discerning reader of this report will have noticed that the feature of the services provided for the aged in Area 5 is a wide diversity of approaches, attitudes, and modes of operation. As will be seen in the next chapter, members of the A.R.& A.U. located and visited all facilities, agencies, aged service-providers and social groups in Area 5. This included visits to nursing homes and hostels, which, despite regulatory controls exerted by relevant government bodies, show individual characteristics which need to be taken into consideration when it is necessary for elderly people to move into a supervised environment.

The diversity was especially evident in services provided in the community. Here again, although the policies emanating from centralised funding bodies underpin the activities of the workers in the field, inevitably community work attracts practitioners who prefer an unstructured environment and this leads to a lack of uniformity and predictability of services across council boundaries. That this has its effect is demonstrated by the three models of service delivery described in this chapter.

In an area which is not geographically extensive, such diversity seems not only costly in terms of financing administration and organisation, but must also be confusing for residents and/or consumers of services.

Another feature is the lack of any form of non-service-specific monitoring or even of ongoing casework with individuals with problems of a general nature.

The focus of this study was on the factors involved in maintaining people **outside** of hostels or institutional care. As will be seen in Chapter IV of this report, the A.R & A.U. team made contact with numbers of elderly people living at home whose independent status was marginal, but whose limitations did not bring them within the prescribed limits of any of the established community services. (It should also be acknowledged that some elderly people, when presented with options, refused possible asistance for a variety of reasons.) Some form of monitoring/contact service (which was acceptable to the person being visited) emerged from this feasibility study as an essential component in any integrated community care program.

This account of special accommodation, services and social groups for aged people in the five municipalities in Area 5 suggests the need for a central point of contact for information, and also indicates a need for planning and co-ordination which transcends municipal boundaries in the interests of providing a responsive integrated support service for the growing number of elderly residents.

CHAPTER III

THE AGED REFERRAL AND ASSESSMENT UNIT

This chapter is concerned with the background to the establishment of the Aged Referral and Assessment Unit, the development of its brief, and the method adopted for the testing of the brief's feasibility.

3.1 BACKGROUND

The historical background to this project had a strong influence on subsequent events and must therefore be given in some detail. Some years prior to 1984 a move had been initiated by a number of 'non-health' workers in Burwood for the establishment of a Central Referral Agency for aged services incorporating a single generalised assessment procedure. Whether this was to provide a service for Burwood only, or for a number of surrounding municipalities is not certain. Nor is it clear whether consultation had occurred with all of the agencies which might have been expected to utilise a system organised in this way.

A submission was prepared, but was shelved for lack of suitable funding at that time. However, in late 1983/early 1984 when Federal funds were released for the establishment of pilot projects for regional assessment units, an approach was made by a representative of the New South Wales Department of Health for the submission to be brought up to date in the light of Federal funding requirements. It was suggested that the group of workers who prepared the original submission be the nucleus of a steering committee, but that the funds be channelled through the New South Wales Department of Health, and administered under the Inner Western Suburbs Area Health Services. At a subsequent meeting called to discuss the submission which had been hurriedly revised and submitted by a small group of the workers originally involved, the meeting rejected the revised concept (seeing it, among other things, as 'Health dominated') withdrew their support, and disbanded their group. As a consequence of exchanges at this meeting the Medical Director of the Croydon Community Rehabilitation Service also disengaged himself from further involvement. Nevertheless, it was decided by Health representatives at State, regional and local level that the project should go ahead. It was recognised that the lack of support from service-providers in Burwood would be a factor, but as four other municipalities were involved, and with continuing support from the Administration and Board of the Inner Western Suburbs Area Health Service, it was believed that some value might emerge from the project. A team of four people was therefore sought to undertake the feasibility study. (For brief, see Appendix I).

3.2 THE TEAM : MEMBERSHIP AND ADMINISTRATION

The team consisted of a Co-ordinator-Assessor, who was a social worker with previous nursing training and experience, an Occupational Therapist, a

Community Nurse, and a Clerical Assistant with computer experience. With the exception of the latter, all members had previous experience with working in a team which was concerned with the maintenance of the frail aged in the community. This had involved the building up of working relationships with service providers both in the community and in institutions. The team members had good understanding of legislation and policies affecting care of the aged, and, in the case of the Community Nurse, a wealth of knowledge of the Health system as it affected aged individuals. The Co-ordinator began work on 9 July 1984, followed a week later by the first Assessor. By early August the full team had commenced duty.

The team was based in a cottage adjacent to, but not in the grounds of, the Western Suburbs Hospital, in Croydon, in Sydney's Inner Western Suburbs. Funds were channelled through the Inner Western Suburbs Area Health Services, and were administered by the Area Executive Officer. The Unit's chain of responsibility was through a planning officer at the Southern Metropolitan Regional Office of the New South Wales Department of Health, to a three-member team at Head Office of that Department, and ultimately to an Inter-government Steering Committee.

The project undertook to cover the five municipalities which made up Health Area 5 (Ashfield, Burwood, Concord, Drummoyne and Strathfield - for demographic data see Chapter 2).

3.3 PROJECT GUIDELINES/WORKING BRIEF

Guidelines for the project were derived from the original submission prepared by the Burwood workers. The guidelines were formulated in general terms and were open to interpretation. In the light of developments in some services in the intervening years since they were first produced, the guidelines were, in themselves, provocative in their assumptions about the scope of the project and were no longer realistic.

A letter from the Secretary to the Department of Health (N.S.W.) outlined the following working brief.

> This project aims to establish a central referral agency for a variety of domiciliary support services including Home Care, Home Nursing, Red Cross, Paramedical Services, Delivered Meals, Social Activities and Counselling. All references for these agencies will be made to a single agency where a comprehensive assessment will be made, and referral made to the appropriate mix of services. This project will be evaluated through the establishment of a client record system. Analysis of records will reveal:
>
> (a) number of clients requiring more services than on the original referral;

(b) number of clients unable to receive recommended range of services;

(c) primary reasons for (b)

(Letter from B.V. McKay, Department of Health, 9th April, 1984.)

(See Appendix I)

3.4 METHOD OF OPERATION

An action research model was adopted for the conduct of the project. Such a model involved the setting of short term objectives which evolved progressively on the basis of achieved goals. A research design was drawn up and offered as a groundplan upon which further modes of action would be based within the action research model.

In working towards the testing of their brief, the project workers saw the need to obtain standardised information from:

(a) all undertakings in Area 5 which could be seen as providing support for, or services to, people aged 60+; this was to include residential care

(b) the users/recipients of the services, and their informal support networks.

In order to meet the brief, it was considered necessary to identify the needs of elderly people through direct contact with them, and also to test the level of their satisfaction with any services they were receiving. For this to occur, a point of contact (a central referral agency) needed to be established. However, there were some doubts about the feasibility of achieving this aim.

In the face of hostility towards the project being voiced by a section of the local service providers at the time of its launching, there seemed to be no certainty that the team would receive referrals for assessment. The research design therefore proposed that, while the Unit would be open for referrals once its initial information gathering stage was concluded, a possible means of contacting people would be by instituting a survey. This was seen as a fall-back plan, which, as referrals began to come in, was not necessary to put into practice.

3.5 ACTION RESEARCH MODEL - IMPLEMENTATION

The implementation of the action research model called for development of a program of activities which would allow for a general direction of the

project's conduct, but with a provision for re-assessment of progress at regular intervals. Two steps were taken from the outset: establishment of contact with centralised organisations which provided services for the aged in the community; and formulation of a steering committee. Other activities followed in a logical sequence; some of these were concentrated in the early stages of the Unit's operation, others became part of a regular routine once the initial collection of information had been completed.

Contact with Centralised Organisations

In recognition of the centralised organisations of two of the major providers of community services, contact was immediately sought with senior officers of the Sydney Home Nursing Service and the Home Care Service of New South Wales. Subsequent interviews, and presentation of information about the project to executive committee, drew from the Sydney Home Nursing Service limited support at a level which was within the capacity of local workers (nurses) to provide. The representative of the Home Care Service of New South Wales indicated that Service's opposition to the project, and no word was received from the executive of the Home Care Service, either at that time, or in response to a later request for a position statement.

Steering Committee

On 7th August 1984 a meeting was convened in a Burwood church hall to which workers and residents of Area 5 were invited. The meeting was chaired by the Chairman of the Inner Western Suburbs Area Health Board. This meeting offered an opportunity for team members to be introduced, for the proposed project to be presented and discussed, and for the nucleus of a Steering Committee to be appointed. All five municipalities were represented on the Steering Committee, and the eleven members included a resident who represented the viewpoint of consumers, and of the Combined Pensioners Association, co-ordinators of both health and welfare services for the aged, a nursing home matron, and the Planning Officer from the Southern Metropolitan Regional Office of the New South Wales Department of Health. A general practitioner from Drummoyne who rang, asking to be a member of the Committee did not ever attend a meeting, but received minutes.

The first meeting of the Steering Committee was held on 23rd August 1984, at which the Area Executive Officer of the Inner Western Suburbs Area Health Service was elected to the chair. Meetings continued thereafter at monthly intervals. From November 1984 to May 1985, meetings were attended by a representative from the Aged Services Policy Unit of the Department of Youth and Community Services (Y.A.C.S.).

Initial and Routine Activities

In the framework of the action research model the activities of the Aged Referral and Assessment Unit can be divided into the following areas.

Information (information in and out)

Education

Co-ordination and Planning

Community Service Development

Assessment

Referral (in and out) (see Chapter 4)

Recording/Data Collection

Outcomes of Assessment

Identification of service gaps and other related findings, and action and suggested action towards the filling of these gaps

These areas of activity should not be seen as discrete functions, as often more than one activity would be carried out at the same time.

3.6 INFORMATION

Information was seen to be central to the activities of such a Unit - both in terms of making appropriate referrals, and in providing a point of contact for aged people, their relatives, or for workers from within a given area or from outside, seeking advice or information on any matter relating to the aged living in that area.

The gathering and dissemination of information needed to occur within an understanding of the ageing process and all that was implied by that statement. The Unit's first task, therefore, was to gather and record, in standardised form, information regarding all available resources for the aged existing in, or impinging upon, Area 5.

Two separate schedules were designed (See Appendix II, III) to compile standardised information about

(a) community service providers and social groups
(b) residential care - nursing homes/hostels

Included in (a) were the three major providers of communtiy services - Sydney Home Nursing Service, Home Care Service, Meals on Wheels - but also services provided through local government in each municipality, voluntary

organisations (both subsidised and independent), and local social groups. Clinical services provided through hospitals were included as were the services provided in Area 5 under the Area Health Board.

The Unit made its presence known in Area 5 by:

- personal contact during the information gathering process
- handing out pamphlets to workers at Interagency meetings*
- contacting doctors' surgeries and writing letters to General Practitioners (Appendix V)
- publication of items in three local newspapers

In the initial process of collecting and distributing information the team members visited social groups, agencies, clinical services, nursing homes and hostels, and general medical practitioners.

Agencies

In all, the Team visited 49 social groups and social welfare agencies in Area 5 as well as a number of other organisations involved in the provision of services for the aged. They were:

23 community groups
3 R.S.L. Day Clubs
5 Co-ordinators of Meals of Wheels
4 Local Government Welfare Officers for the Aged (or persons acting in that capacity)
5 Community Information (and Aid) Centres
7 Specialist organisations (Royal Blind Society, Blind Citizens Association, Legacy, A.D.A.R.D.S.,* Technical Aid for the Disabled, Tech. Help, and the Straight Talk & Stroke Club)
1 Red Cross Worker
1 Combined Pensioners Association Branch,

Numbers of Senior Citizens Centres

Libraries (gathering information about Home Library Services, large print books and books in languages other than English)

Communtiy Activities Centres such as Woodstock (Burwood) and Ella (Ashfield)

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* See Appendix IV
* A.D.A.R.D.S. - Altzheimers Disease and Related Disorders Society

Clinical Services

Contact was made with co-ordinators of services provided under Inner Western Suburbs Area Health Services. These included:

Five Dock Mental Health Team

Croydon Community Rehabilitation Service (including hydrotherapy)

Program of Aids for Disabled People

Audiology

Dental Service

Free Denture Scheme

Podiatry

Names and location of agencies/social groups etc. were used as the basis for directory of aged services in Area 5, which was compiled by the Ethnic Aged Health Worker concurrently with the Unit's operation, for eventual distribution to all agencies working with the aged and to General Practitioners.

Nursing Homes/Hostels

Visits were made to 56 nursing homes and 14 hostels in the Area. In devising the schedule, team members contributed their individual past experience with nursing homes and their particular areas of interest and expertise. (See Appendix III). No request to visit nursing homes was refused and in almost every case the visiting team member was conducted over the building.

In gathering information, team members looked at the physical, financial and social aspects of each establishment, including the interests of non-English speaking people. Although it was acknowledged that such information related to situations which were not static, physical surroundings are slow to change and changes are usually foreshadowed, and attitudes often persist beyond individual staff changes, e.g. some nursing homes are more open than others to post-stroke victims, to smokers, or to people classified as being 'burnt out psychs'.

From their past experience team members believed that such information could be valuable in matching individuals to residential care, either as an outcome of Unit assessment, or as an information resource for elderly people, their carers/supporters, or workers with the aged either inside or outside of Area 5. For instance, an individualistic person coming from unsalubrious surroundings would not be likely to settle well in a clinically clean nursing home where eccentric behaviour was not tolerated. A heavy smoker would experience difficulty if placed in home which forbade smoking. Placing a man

in a nursing home where the only other males were unable to communicate would be equally unsuitable.

The information gathered was used as reference material by numbers of workers (particularly hospital social workers) in Area 5 and beyond, and was passed on in an abbreviated form to the then recently appointed social worker in the Residential Care Section of the Department of Community Services.

Contacts made at the time of initial visits to the 14 hostels in the area had proved to be particularly rewarding - this in the light of the release of information in November, 1984, regarding the allocation of beds for respite care (See Appendix VI). Some of the hostels in the area have limited intake arrangements e.g. Legacy widows, Russian-speaking people from China, German-speaking Catholics, visually impaired people.

General Practitioners

To older people living at home (particularly those living alone) the General Practitioner is often the primary care-giver. It therefore seemed essential for the team to make its presence, and possible usefulness, known to General Practitioners in Area 5.

Exploratory telephone calls were made to the surgeries of almost 200 doctors who were listed as practising in the Area. Some of these proved to be specialists and were therefore excluded from the list for contact by mail. Telephone contact was followed by a letter and a pamphlet explaining the Unit and the assessment role it was offering. (Appendix IV, V). In all cases of telephone contact, enquiries were made as to languages spoken other than English (this was with the interests of the Ethnic Aged Health Worker in mind). This information was recorded, and has been much sought after by local workers.

The data relating to doctors speaking languages other than English was subsequently used by the Ethnic Aged Health Worker to survey doctors of non-Anglo backgrounds.

In the early life of the project it was anticipated that all of the above information would be computerised but, as the computer had not been introduced during the life of the project, alternatives were developed for the storage and handling of these data. Updating of data and the recording of additional data was maintained throughout the duration of the project.

3.7 ASSESSMENT

The project workers believed that within a team which was to offer information and assessment there was a need for knowledge and competence in the areas of health, social functioning and the practicalities of daily living, so that the minimum components of any such team would need to be members of the three professions comprising the Aged Referral and Assessment

Unit. There would also need to be an understanding of the inter-relationships of community agencies and workers, and a recognition of the need for co-operation and feedback so that services which reached the individual could be co-ordinated in the best and most meaningful way.

The dignity and independence of the individual was held to be of primary concern, and his/her right to self-determination (having been given sufficient relevant data to make an informed choice) was respected, even where the risk factor involved was extremely high.

At the time of referral a filtering system in terms of stated need suggested which of the three professional assessors should accept responsibility, and an introductory phone call to make an appointment for a visit usually occurred within twenty-four hours of receipt of the referral. Assessment was carried out by one team member only. Informal discussion followed each assessment, allowing input from the expertise of all team members. This meant that elderly people, stressed and sometimes confused, were required to relate to only one new person while receiving the consideration and attention of an inter-disciplinary team.

(It should be said at this point that the team was small, self-selected and particularly cohesive. Members had worked together previously in a setting which was not dissimilar to that prevailing while working in the Unit, and each had a high regard for the professional competence of the other members. Such cohesion allowed for a recognition of the strengths within the team and for the testing of opinions and decisions, and contributed to the quality of assessments and the follow-up work involved in carrying out the team's recommendations.)

Team members shared the view that assessment should not take place without the prior agreement of the referred person, and that it should be holistic in nature, having regard to physical, psychological, social and environmental aspects.

Assessments took place wherever the referred person was located at time of referral. This could be at home, in an acute hospital, in a private hospital, in a nursing home or in a hostel. (In the case of people in acute hospitals the first contact was often an introductory one, and follow-up visits were made post-discharge.) Initial visits usually took not less than one hour, but the process of assessment (including telephone contacts with members of the support network, General Practitioners and other workers) often took many hours, and there were only seven cases where follow-up visits were not required.

Early in the contact, permission was usually requested to contact the General Practitioner and, wherever relevent, family members, friends or neighbours who gave informal support. A summary of the findings of the assessment was forwarded to the General Practitioner within a few days, although telephone contact often ensued at the time of the first visit. Single-person contact was also maintined with members of the support network - family, relatives, neighbours, friends. This aspect of the work often took as much or more time than that spent with the referred person, and was commonly crucial to the functioning capacity of the person being assessed.

It was soon found that assessment was not a 'one-off' activity (Hemer, 1984, p.25). A trust situation needed to be established for a meaningful exchange of information, and this applied as much to relatives and friends as to the referred person. In the latter case there was often a very real fear of institutional placement which had to be dealt with before the assessor could be accepted as a reliable reference person.

Referrals were often made at times of crisis, or imminent crisis (e.g. on the departure from the scene of a carer, prior to discharge from hospital following a fall or an acute episode - either of which may have challenged the patient's confidence in his/her capacity to manage independently - or refusal of a communtiy service by an apparently at-risk elderly person) when those involved were is a state of disequilibrium. In such cases it was often necessary to provide short term (sometimes intensive) support, or to arrange for respite care (e.g. live-in housekeeper, or hostel respite) until the situation settled, and a more realistic assessment and referral process could be set in motion. Contact could then be made at lengthening intervals until the situation had settled into a new equilibrium.

This process of short term intervention was to become a point of issue between the team and some members of the steering committee. The team was of the opinion that, even if experienced case-workers **had** been available in Area 5, the introduction of new people as an immediate sequel to assessment would be neither kind nor optimally effective, and that the form of assessment/intervention undertaken by the team members provided opportunity for the best interests of all involved to be served, and a more 'successful' and acceptable outcome to eventuate.

For the purposes of this study re-assessments were made as required by the brief, i.e. at maximum of three monthly intervals. Where assessment had involved the provision of physical aids, there seemed little point in retaining contact once it had been established that the new owner could manage the aid to its best advantage.

This was also the case where the enquiry came in the form of a simple request for accommodation. At the time the books had been closed (31st May 1985) for statistical analysis, direct or indirect reports on all contacts were obtained.

Almost invariably, the process of assessment involved exchanges of information - personal information on the part of the referred person and the informal support system, and relevant factual information imparted by the assessor. As will become apparent in the data (Chapter IV), the imparting of appropriate information by the Unit was the major form of intervention.

3.8 DATA COLLECTION/RECORDING

Records were maintained on sheets in normal use by health workers in the Inner Western Suburbs Area Health Service. Personal information was recorded in computable form, and coding conformed with that used in the Southern Metropolitan Region of the New South Wales Department of Health.

It had been anticipated that, as the Aged Referral and Assessment Unit was to function as central referral agency, case statistics would be maintained on computer within the Aged Referral and Assessment Unit along with data pertaining to aged services, etc.

Team members found that recording of initial assessments and maintenance of files (e.g. when information was fed back regarding hospital admissions, nursing home placements, deaths etc.) occupied a significant proportion of their time.

Assessments were first recorded in descriptive form, and were later quantified on data sheets developed for the purpose (See Appendix VII). Some limitations were revealed in this instrument at the time of data-analysis and, if such a Unit were to be re-established in future, some refining of the original instrument would be required.

A system was also developed to monitor attendance at Casualty Department, Western Suburbs Hospital, of all people aged 70+ years. This was commenced as a mechanism for the picking up of at-risk people, e.g. those who had frequent falls, overdosed with prescribed drugs, or attended frequently with non-specific symptoms.

The monitoring at the Casualty Department also led to constructive contact with Casualty staff, raising the awareness of the need for enquiring before discharge about available support, and also leading to the practice of referring appropriately to the Aged Referral and Assessment Unit where support was likely to prove to be a problem.

Additional gains arising from this action were:

(a) knowledge of admission to hospital of people already known to the Unit, and
(b) a growing awareness of the numbers of nursing home residents attending Casualty either for on-the-spot treatment and discharge, or being admitted to the Western Suburbs Hospital for acute care. (See Chapter 5, p.89)

In the case of the former, a visit was usally made to the ward, and the Aged Referral and Assessment Unit's involvement was recorded on the medical notes. Relevant information could be passed to the Ward Sister, or to the hospital Social Worker or Welfare Officer, and the Aged Referral and Assessment Unit could have input into planning for discharge, or, if necessary, nursing home placement best suited to the needs of the individual and his/her support network.

Interaction such as reported above, demonstrates the way in which a team with an understanding of hospital systems (and with access to hospital facilities and personnel) can interpret social needs of people to 'institutional' workers. This not only worked to the advantage of patients but was also effective in sensitising hospital staff to the need to look beyond the diagnosed condition or injury.

3.9 EDUCATION

As there appeared to be some anxiety about the notion of geriatric assessment in the community, and a lack of understanding, not only of the role of assessment teams but also of the roles of the individual professionals in the team, it seemed that there was a need to speak out about assessment in general and about this team in particular.

Where possible, this occurred with groups of older people themselves - Senior Citizens Groups, Combined Pensioner Association Branches, and non-Anglo speaking groups (this was done through interpreters). Members also spoke to 'hands-on' workers such as trainee nurses, at Western Suburbs Hospital, and community nurses employed by Sydney Home Nursing Services. Letters were written to the Council on the Ageing, and to a number of local private hospitals, giving an indication of what the Unit could offer.

Much of the education process arose out of the day-to-day work of the Unit, by its contact with Steering Committee members, with members of the Inner West Aged Services Task Group, attendance at Inter-agency meetings, and by contact with, and summaries sent to, General Practitioners during the process of assessment. In interaction with staffs in hospitals, in other residential institutions and with community workers, both paid and voluntary, team members had consciously presented the needs of the frail, disabled (and particularly the house-bound) members of the aged population. In particular the team had worked hard to break down the divisions between 'health' and 'welfare' and to have all those involved take a more holistic view of aged people in the context of their lives.

3.10 CO-ORDINATION AND PLANNING

Regional assessment teams are seen in the literature as a focal point for the co-ordination of all services for the aged in a prescribed area. Input from knowledge and experience of team members of the A.R. and A.U. was sought with growing frequency in the funded life of the Unit.

As was described in Chapter 2 the composition of Area 5, with its five municipalities and the resulting duplication and complexity of service-provision made for particular difficulties in addressing co-ordination and regional planning. The team was also disadvantaged by the tension surrounding its establishment, and the scepticism with which it was initially regarded in some quarters.

It should also be noted that in order for co-ordination to occur, there was a need to influence policies established by centrally-organised bodies, by five local governments, and by autonomous locally-based agencies.

During the information-gathering stage of the Unit's activities, some useful contacts were made.

In August 1984 there was a reactivation of a lapsed group of Burwood workers with the aged, and the co-ordinator of the Aged Referral and Assessment Unit

saw this as having potential as a forum for regional planning, integration and co-operation. After preliminary discussion, this group was broadened to accept workers from other municipalities, and was formalised under the title of Inner West Aged Services Task Group, with a voluntary worker from Strathfield as chairperson. It was established that this group would identify gaps in services and would consider possible avenues for filling them - drawing them to the attention of planners/policy-makers, or, where appropriate, collecting data, writing submissions, etc. The Task Group was seen as capable of taking an advocacy role on behalf of individual residents, local workers or agencies/services where indicated. Meetings, which would occur monthly, would allow for information exchange. It was hoped that such exchanges might lead to the extension of working networks, allowing for the development of feedback systems, and, eventually to more integrated service-provision.

The Aged Referral and Assessment Unit brought to this Task Group data obtained in its information gathering stage. Some gaps were identified, and working parties were established to address these issues.

They related to:-

Transport
Day Centres/Relief for Care
A caseworker service for frail aged people living at home.

The Aged Referral and Assessment Unit was represented on each of these working parties.

In April 1985 an approach came from the Chairperson of the Management Committee of one of the two Home Care Branches operating in Area 5 for a team member of the A.R.& A.U. to join the Committee. The Occupational Therapist/Assessor has since served on this Committee. (Although this was seen as a major breakthrough, it did little to reduce the distance maintained by the administrative staff of the Branch. Similar difficulties did not occur in relationships with the other Branch.)

Aged Referral and Assessment Unit team members served on an Area Health sub-committee planning for the possible purchase of a nursing home, in the provision of palliative care in the area, and in rationalisation of the Program of Aids for Disabled Persons (P.A.D.P.).

The Co-ordinator became a member of a small regional planning group which was formed at the request of the Professor of Geriatrics, University of Sydney. The group considered the feasibility of incorporating geriatric services planned for Concord Repatriation General Hospital in a model of integrated service provision in Area 5.

Towards the end of the Unit's functioning life the Community Nurse/Assessor became involved in the consultation and planning for the implementation of the Home and Community Care Program, and was subsequently elected to be the Co-ordinator, Inner West Sub-Regional H.A.C.C. Forum.

3.11 COMMUNITY SERVICE DEVELOPMENT

Some funds became available early in 1985 for the establishment or extension of community-based podiatry services. Negotiations were set in motion with the Councils of all five municipalities. A new service providing 2 centre-based sessions per month and one domiciliary session was commenced at Drummoyne, operating from the Senior Citizens Centre. Two other Councils extended their services by one session per month (i.e. from one to two).

Strathfield Council elected to defer any decision until its Welfare Officer for the Aged was appointed. Ashfield was in the process of introducing one session per month.

In December, 1984 the Co-ordinator was advised that a sum of money might be available from a Burwood service club for services to the aged. She began to explore the possibility of introducing sessional speech therapy. Discussion with the Medical Director of the Croydon Community Rehabilitation Service and a number of speech pathologists, in both the private and public sector, led to a decision that, in consideration of the limited funds available, the most practical use of any such money would be to look for means of supporting the Straight Talk and Stroke Club, which met weekly at Concord, and was the only access to a speech pathologist available to those people in Area 5 who were not eligible to attend the Concord Repatriation Hospital.

The president of the Straight Talk and Stroke Club attended and addressed a meeting of the service club. This resulted in both badly needed monetary support and the promise of a voluntary driver to provide transport for people (some experiencing varying degrees of disablement as a result of strokes) to attend the weekly meetings. Western Suburbs Hospital released the Aged Referral and Assessment Unit bus for regular use by the Straight Talk and Stroke Club. Attendance at meetings has since doubled.

3.12 IDENTIFICATION OF SERVICE GAPS IN AREA 5, AND OTHER RELATED FINDINGS

In the course of the Unit's operation described above major service gaps have been identified as follows:-

(a) One or more day centres for the frail aged and the confused. These to meet the dual purpose of providing opportunities for socialisation as well as carer relief.
(b) Carer in-home relief.
(c) Access to a Geriatric Assessment Unit (Concord Repatriation Hospital) with inpatient admission so that causes of physical and mental conditions, sudden behavioural changes etc. can be explored by specialist geriatric health workers.
(d) Beds to which elderly people in temporary need of 24 hour care (but not holding private health insurance) can be directed e.g. while awaiting nursing home placement, during the absence of a carer, or when suffering from a malady which does not require the service of an acute hospital.

(e) A comprehensive in-patient rehabilitation service for people with this requirement in Area 5, including speech pathology.

(f) Contact workers to provide human contact and a monitoring service to housebound aged people and their carers.

(g) A transport service which takes into account the physical limitations of elderly people, and has sufficient flexibility to meet a wide range of individual needs.

(h) Improved administration of the Program of Aids for Disabled People (P.A.D.P.) so that a cost-effective and aids-appropriate service is available across the full 12 months of each financial year. Such administration to allow for purchasing a pool of aids for people able and willing to pay, but physically unable to locate and obtain appropriate aids.

(i) Revision of assessment priorities in the allocation of assistance by the local branches of the Home Care Service allowing hours to be available for immediate help in times of genuine crisis.

(j) Flexibility in accessibility of meals so that short term assistance with meals available at times of particular need e.g. on discharge from hospital, absence of a carer, etc.

(k) Development of a system aimed to reduce the trauma inherent in the transition from an acute hospital to home, ensuring that, where required, support (formal, informal, or a mix of both) is available, and there is an understanding of the health status, drug regime, and (where applicable) the effective use of aids and equipment. Monitoring of periods between re-admissions could be used to support any deployment of resources.

CHAPTER IV

THE AGED REFERRAL AND ASSESSMENT UNIT IN OPERATION

4.1 SOURCES OF DATA AND METHOD OF ANALYSIS

This chapter contains the data collected from the intake records of people seen and assessed by the Aged Referral and Assessment Unit. The data refer to all intake records from the time the Unit began operation (August, 1984) to the end of May, 1985, and refer to 120 persons seen and assessed by the Aged Referral and Assessment Unit over that period.

For the purpose of comparison two forms of analysis were undertaken: the independent variables being, first, the Local Government Areas/Municipalities in which the referred persons lived; and second, the source of referral. This was done to ascertain, first, any differences in the characteristics of the people referred from each municipality, and, second, any difference in the characteristics of the people referred from any particular source. It will be seen from the data in the Tables below, that the differences in the characteristics of the people from any of the five municipalities in relation to sex distribution, age, marital status, the presence of children and of support networks were relatively minor. Given the small size of the sample, these differences may be discounted and it may therefore be assumed that there was a considerable degree of homogeneity among the population from all five municipalities.

The differences were more pronounced when the characteristics of the population were related to the sources of referral.

It is pointed out that a more extensive analysis of data might have revealed some as yet unknown relationships among the recorded variables. Unfortunately, because of the non-availability of computing facilities, and the short time available for analysis, this was not possible to achieve. However, despite these limitations of analysis, the data allow for some valuable and interesting observations about the characteristics of the people seen and assessed by the Aged Referral and Assessment Unit, and, by inference, on the complexities of service provision to the aged population in Area 5.

As will be seen in this chapter, it may be considered particularly noteworthy that while almost all the persons referred to the Unit had previous contact with health and health-related services (the General Practitioners being the most prominent among these), over one-half had no previous involvement with any of the formal community services for the aged operating in the area.

4.2 DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF PERSONS REFERRED TO AND ASSESSED BY THE AGED REFERRAL AND ASSESSMENT UNIT

Age Group

Data relating to age show that the Unit has had contact with the 'old old' group, with 63.3 per cent aged 75 years and above. This is again indicative that the Unit has reached people whose age signifies a probability of physical limitations which lead to a restricted lifestyle, and a gradual decline in activities, social contacts, and feelings of selfworth.

As has been pointed out in other sections of the report, this 'old old' group (particularly those whose financial status takes them outside of the public health system) in many cases do not receive the attention of the formal community services. They are also excluded, by lack of suitable transport, from the social contacts enjoyed by the younger and more active aged (including some of those in nursing homes). It is for these reasons that the Aged Referral and Assessment Unit sees the necessity for some form of monitoring service, especially for the aged persons living in the community.

As shown in Table 4.1 and Figure 4.1, the percentages of people referred to the Aged Referral and Assessment Unit were not much different from those of the population 60 years and over in each of the five municipalities, except for Concord, where referrals were minimal. However, while in the population of the five municipalities, 45.1 per cent of people over the age of 60 years were in the age group 60-69 years, and 54.9 per cent were 70 years or over, in the Aged Referral and Assessment Unit referrals only 12.5 per cent were under the age of 70 years, 63.3 per cent were over the age of 75 years, and 39.1 per cent were over the age of 80 years.

Sex Distribution, Marital Status, Children

Of the 120 persons assessed by the Aged Referral and Assessment Unit from August 1984 to May 1985, there were 80 women and 40 men - a ratio of 2 to 1 which is the same as that in the population 60 years and over in Area 5 (1981 Census - see Table 4.1). Over two thirds (85 persons, or 69.8 per cent) were without a spouse, although some of these had other in-home supports. The percentage (17.5 per cent) of people who had never married was well above the 7 per cent in that age group shown for Sydney in the 1981 Census. This high number of people without a spouse supports the view expressed by Kendig et al (1983) that the presence of a spouse is a good insurance against depending upon community services in the later years of life.

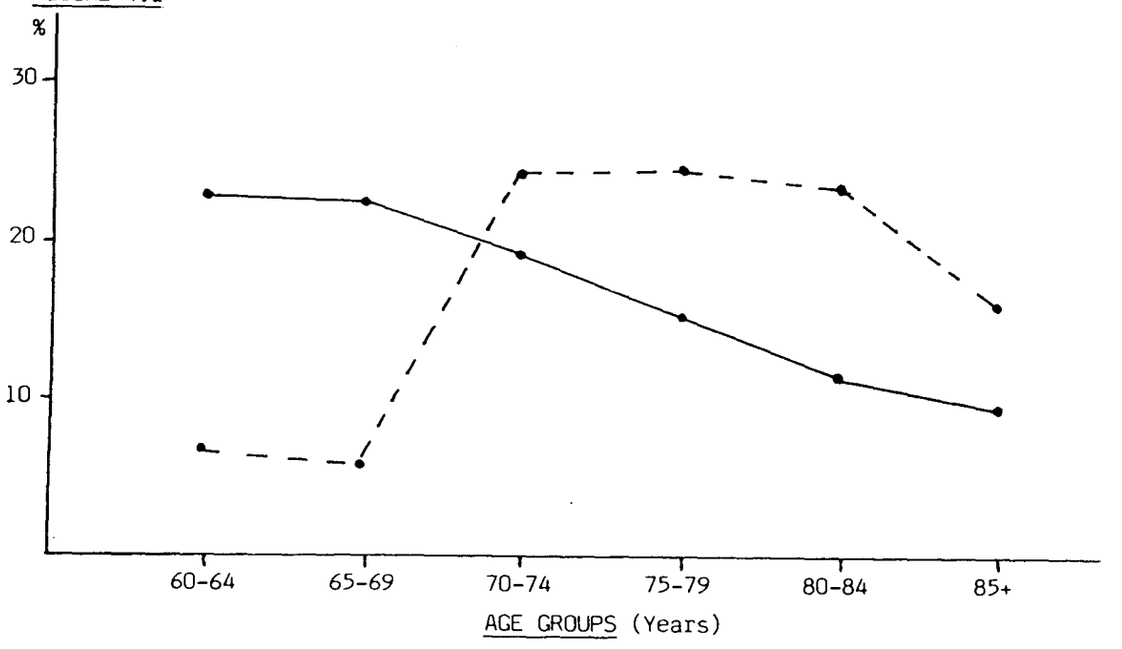
Close to one-half of the people seen (43.3 per cent) had either no living children or no children playing an effective part in their lives. For the purposes of this project 'children' were seen as offspring who were alive and

TABLE 4.1 POPULATION REFERRED TO THE AGED REFERRAL & ASSESSMENT UNIT FROM THE FIVE MUNICIPALITIES

	Municipalities							
Age Group (years)	Ash-field N	Bur-wood N	Con-cord N	Drum-moyne N	Strath field N	Total N	Total %	Population in 5 LGAs * %
60-64	3	-	-	2	3	8	6.7	22.9
65-69	-	2	1	3	1	7	5.8	22.2
70-74	15	7	1	3	3	29	24.2	19.1
75-79	5	5	1	11	7	29	24.2	15.2
80-84	7	11	1	7	2	28	23.3	11.1
85+	4	4	-	9	2	19	15.8	9.5
Total (N)	34	29	4	35	18	120	(100)	(100)
Total (%)	28.3	24.2	3.3	29.2	15.0	-	100	
Population 60 years + 1981 Census (N)	4914	3424	2709	3753	3052	-	-	17852
(%)	27.5	19.2	15.2	21.0	17.1	-	-	(100.0)

* Data from the 1981 Census of Population and Housing

FIGURE 4.1



were of significance to the person being assessed. Where children had died,or where they had been 'mislaid' along the way (as was often the case with elderly men with a history of heavy alcohol intake), the assessor did not press for any detailed information. No discrimination was made as to whether 'children' were the children of both partners, or of the most recent marriage where there had been more than one. For example, one 90-year-old widower who had married late in life, lived with his wife's son from a previous marriage.

By comparison, respondents to the Ageing and the Family Survey (Kendig et al, 1983) revealed 17 per cent as being childless. It seems probable that, because referrals were often made to the Aged Referral and Assessment Unit for reasons of vulnerability to nursing home placement, the incidence of genuine childlessness could be expected to be above that in the aged community at large.

TABLE 4.2 SEX, MARITAL STATUS AND PRESENCE OF CHILDREN

Demographic Characteristics	Municipalities: Ash-field N	Bur-wood N	Con-cord N	Drum-moyne N	Strath field N	Total N	Total %
All Referrals	34	29	4	35	18	120	100
Sex							
Males	15	8	1	8	8	40	33.3
Females	19	21	3	27	10	80	66.7
Marital Status							
Married	13	9	-	8	5	35	29.2
Widow(er)	14	14	2	18	9	57	47.5
Divorced/ Separated	2	1	1	2	1	7	5.8
Never married	5	5	1	7	5	21	17.5
Children							
None	16	9	1	18	8	52	43.3
Yes	16	19	3	16	10	64	53.3
Not known	2	1	-	1	-	4	4.3

Living Arrangements

In the process of assessment the referred individual was asked about his/her living arrangements - whether the accommodation was owned or rented, and by whom, and whether or not the premises were shared with others.

Accommodation, in terms of a satisfactory roof overhead, did not prove to be a problem in any significant number of cases. As can be seen in Table 4.3, the majority of people lived either in their own (owned) home, or in the home of relatives. This is, of course, a reflection of the strong thrust towards home-ownership which was present when these people were establishing themselves. It is also a demonstration of the high levels of home-ownership in the five municipalities in Area 5.

'Other arrangements' and 'other' accommodation mostly referred to those people who lived in rooming- or boarding-houses.

A high proportion (47.5 per cent) of those seen by assessors lived alone, signifying again, that the referrals received reflected the factors (advanced age, absence of close family, living alone) which put individuals at risk.

The determination of elderly people to remain at home was seen by the Aged Referral and Assessment Unit team members as legitimate, and was fostered in every way possible. This sometimes involved time spent in redefining the situation for anxious friends or relatives who were convinced that the individual 'would be much better off in a nursing home'. It was sometimes necessary to point out that, quite apart from the rights of the referred individual to determine his/her future accommodation, there was no means, other than 'scheduling'* by which the person could be moved.

It is appropriate to note here that Robbie Lipsman writing on 'Housing for the Elderly: A discussion of Options', in the **Pride Institute Journal** (1985), stated the following

> as the elderly lose so many of the guideposts of life - jobs, friends, loved ones - their homes may prove to be last bastions of reality and competence (1985, 4 (1):31)

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* **'Scheduling'**: (Situation as of August, 1985)
A doctor signs a form (Schedule II) placing the person involuntarily in a Schedule V (Psychiatric) Hospital. This can involve a police escort. After a few days in the Schedule V Hospital the person is brought before the magistrate. Appropriate hospital staff, relatives, or on occasions, workers from outside the hospital who have been involved with the person may be requested to attend. A decision is made as to whether the person returns to live in the community, is placed in residential care (e.g. a nursing home) or remains in the Schedule V system. If placed in residential care the person may or may not be placed on 'Long Leave' from the hospital, meaning the hospital doctor monitors the person for up to twelve months and responds accordingly.

TABLE 4.3 ACCOMMODATION AND LIVING ARRANGEMENTS

Characteristics	Municipalities: Ash-field N	Bur-wood N	Con-cord N	Drum-moyne N	Strath field N	Total N	Total %
All Referrals	34	29	4	35	18	120	100
Type of Accommodation							
Own house/flat	24	19	1	26	13	83	69.2
Rented Housing Commission	-	3	-	3	-	6	5.0
Rented Private	5	1	-	3	1	10	8.3
Hostel	-	1	-	-	-	1	0.8
Nursing Home	3	1	-	-	-	4	3.3
House of family member	-	3	1	3	1	8	6.7
Other	2	1	2	-	3	8	6.7
Living With							
Alone	14	13	1	19	10	57	47.5
With husband/ wife	10	5	-	6	5	26	21.7
With children	3	4	1	3	2	11	9.2
Husband/wife + children	-	1	-	2	-	3	2.5
With sibling	-	2	1	4	-	7	5.8
With other family member	1	1	-	-	-	2	1.7
Other arrange-ments	6	5	1	1	1	14	11.7

Support Networks and their Location

The presence of strong and empathic support networks was seen by the Aged Referral and Assessment Unit team as crucial to the ability of the very aged and frail to remain in their own homes. The form of support necessary was not always material or physical in nature, but often took the form of a reference person or an emotional link. For example, one 92-year-old lady depended for support and advice on a nephew who lived in Adelaide, with whom she spoke on the telephone at least weekly. Another 90-year-old lady became quite desperate when she found that neighbours on both sides were going away for Easter (see Appendix VI)

Because of the significant role played by informal support networks, team members often spent at least as much time working with relatives, friends and neighbours as with the referred individuals.

TABLE 4.4 SUPPORT NETWORKS AND THEIR LOCATION

Characteristics	Ash-field N	Bur-wood N	Con-cord N	Drum-moyne N	Strath-field N	Total N	Total %
All Referrals	34	29	4	35	18	120	100
Support Networks							
None	3	4	-	2	2	11	9.2
Marriage Partner	9	2	-	3	4	18	15.0
Children/ Relatives	13	15	4	13	7	52	43.3
Friends/ Neighbours	5	3	-	7	1	16	13.3
More than one type	3	5	-	9	1	18	15.0
Other	1	-	-	1	3	5	4.2
Nearest Location of Support							
Not appl.(None)	3	4	-	2	2	11	9.2
At home	14	8	1	14	9	46	38.3
In LGA	4	4	1	11	2	22	18.2
Outside LGA <5km	3	1	1	3	-	8	6.7
Other Metrp Area	6	11	1	5	2	25	20.8
Outside Metrp Area	4	1	-	-	3	8	6.7

Figures presented in Table 4.4 may be somewhat misleading because they do not indicate adequately the extent or variety of support available or used. The strongest support did not always come from the nearest source. For instance, where an elderly couple or a pair of siblings lived together, an assumption could be made that mutual support was available 'at home'. This may have been far from the case, when the person assessed was the provider rather than the receiver of support. Cases were also seen where an elderly lady was intermittently shoring up a wayward son or a 'feckless' brother.

Where elderly people were dependent either emotionally or for physical assistance on siblings, this became more and more problematic as their matching ages advanced and their capacity to assist was reduced. In some instances there could be as much an interdependence as a leaner/leaned-on situation.

The relatives providing support often came from a person's extended family. Team members were surprised at the number of nieces or nephews who were giving a considerable amount of physical assistance (shopping, cleaning, bringing meals, etc.) to their ageing aunts and uncles. Where relatives in country areas or interstate were the reference persons for the aged people, contact with the Unit was often sought by them when it was known that the situation was being assessed. In such cases, the involvement of the Aged Referral and Assessment Unit, and the giving of local information was acknowledged by this distant source of support as being of value. This indicates that where assessment teams are ongoing, they could be seen as a contact point for such people, advising when their presence was needed, or when any major change in the situation warranted reporting (e.g. admission to hospital with the possibility of eventual nursing home placement).

Income and Ethnicity

For the purposes of this research no discrimination was made between the Aged Pension and the Repatriation Pension. Disability Pensions such as Blind Pensions, however, were listed under 'Other' as these are distinct in not being subject to means testing.

It can be seen that over 85 per cent of those assessed were in receipt of a pension or a part pension. Included in 'other' income was a grandmother who had come to Australia under the Family Reunion Scheme, and was awaiting the granting of residential status.

As has been stated elsewhere the percentage of the population of the five municipalities aged 65+ years who were of non-Anglo origin was 19.58 per cent. During the early stages of the project, the percentage of non-Anglo people referred was close to the percentage of non-Anglo residents in the area. However, from March 1985, the number diminished.

TABLE 4.5 INCOME AND ETHNICITY

Characteristics	Municipalities: Ash-field N	Bur-wood N	Con-cord N	Drum-moyne N	Strath field N	Total N	Total %
All Referrals	34	29	4	35	18	120	100
Income							
Pension	32	23	3	29	15	102	85.0
Private	2	3	1	4	3	13	10.8
Pension +	-	1	-	1	-	2	1.7
Other	-	2	-	1	-	3	2.5
Ethnicity							
Anglo	27	24	4	31	16	102	85.0
Europe	5	4	-	3	2	14	11.7
Asia	1	1	-	-	-	2	1.7
Middle East	1	-	-	-	-	1	0.8
Oceania	1	-	-	-	-	1	0.8

When the re-assessment was made in May 1985 it was found that there was also a significantly higher death rate among non-Anglo people who had previously been referred to the Aged Referral and Assessment Unit. A possible conclusion to be drawn from this is that referrals for non-Anglo people were made at a time when the outcome of the person's state of health was already determined and no preventive measures could be effective. This could also be seen as illustrating the barriers impeding access to accurate information and appropriate referral for people with English language difficulties.

4.3 REFERRALS TO THE AGED REFERRAL AND ASSESSMENT UNIT

The first referrals received by the Unit (i.e. those received before October 1984) arrived almost accidentally through the switchboard of the Western Suburbs Hospital or through enquiries to Community Health.

At the completion of the information-gathering stage when the Unit advised other workers (through Interagency) and General Practitioners that its service was available, the first major referral source was the social worker at Western Suburbs Hospital. Her referrals usually involved follow-up assessments to ensure that elderly people had appropriate aids and supports to manage after discharge from hospital. The practice of conferring with General Practitioners and sending them an assessment summary gradually established the Unit with those General Practitioners with whom team members came in contact, leading to referrals from some doctors.

Sources of Referrals: Services and Municipalities

Referrals from General Practitioners often took the form of 'Would you please visit Mrs. X and see if there is anything more that can be done for her? She is determined to remain in her own home, and I am limited (by risk of being charged with over-servicing) in the number of calls I can make, and what I can do'.

Such calls reflected the risk factor recognised by the Aged Referral and Assessment Unit team members as being a significant burden to those closely concerned with elderly people who remained in the community - particularly those living alone. This risk factor would sometimes become intolerable to relatives (and, in some cases, neighbours) who could not provide 24-hour care. The Aged Referral and Assesssment Unit team members believe that one of the important roles of assessment teams could be the objectifying and sharing of this risk factor so that networks (including General Practitioners) could continue to offer support until such time as an acute episode or a major accident brings irrevocable changes to the situation - or the elderly person him or herself feels able to decide that the time has come for full nursing care. General Practitioners frequently mentioned the need for some form of monitoring for the many vulnerable people with whom they came in contact.

In some referrals a specific need was mentioned as a reason for assessment, e.g. requesting a review of bathing facilities, or suggestions regarding suitable social groups, or, less often, accommodation.

Staff members from the Sydney Home Nursing Service began to drop in to discuss cases, sometimes requesting information about community resources, but also looking for a broader perspective on some of their more troubling cases. These discussions led to assessment visits where appropriate. Referrals from other community services were patchy, often dependent upon the rapport established between team members and individual workers. The history of the Unit's establishment led to reticence on the part of some services, (e.g. an informal 'boycott' by Burwood Aid Services and by the Home Care Service). Other workers, while apparently supporting the Unit, were not able to see its relevance to services which they provided (e.g. Concord Council Workers).

Table 4.6 shows clearly that more than half of the referrals (53.4 per cent) came from 'medical' sources. To this can be added those from Community services which emanated from contact with the Sydney Home Nursing Service.

Among those received from self, family and friends were those which were deflected by services both in and outside the area. Sources known to have directed such calls have been Council on the Ageing, Department of Community Services, Total Living Foundation, and Social Workers from out-of-area hospitals. On two occasions people reached the Aged Referral and Assessment Unit via talk-back radio.

The scatter of referrals across municipalities was by no means random, and had obviously arisen from a complex mix of circumstances and interactions, some of which have been mentioned above. For instance, the Unit was used

from very early in its funded life by the Social Worker at Western Suburbs Hospital, leading to requests for assessment in Ashfield, Burwood and Strathfield. Concord Repatriation Hospital, which accepted 'community' patients (i.e. non-veteran) from Concord and Drummoyne, did not make use of the Unit. The Meals on Wheels co-ordinators in Ashfield and Drummoyne made appropriate use of the Unit, while only 2 referrals came from community services in Strathfield which had no paid welfare workers. (One of the Strathfield referrals came from a voluntary Home Library visitor who reached the Unit after three other calls).

Sources of Referral: Age Groups of Referred Persons

Definite relationships emerged between the ages of referred persons and their sources of referral, as shown in Table 4.7 and Figure 4.2.

While illustrating once again the extreme age of a significant proportion of those people referred to the Unit, Figure 4.2 also shows that General Practitioners were the most frequent source of referral for the 'old old'. Other data collected by the Aged Referral and Assessment Unit suggest that General Practitioners were the primary care-givers to these people, many of whom lived alone in their own homes and were not recipients of community services. Their isolated position often arose out of their own wish to remain independent, combined with the General Practitioner's respect for this. However, as has been previously mentioned on a number of occasions, somewhat desperate requests were received from General Practitioners for assessments of situations where the vulnerability of very old people had begun to outweigh their capacity to function without assistance.

Such situations required delicacy and understanding in introducing 'outside' assistance into the lives of proud old people. Often there was a need to 'colour' the perception of the service-givers (e.g. Home nurses, Meals on Wheels co-ordinators) so that the most empathic attention posssible could be given. This form of client-centred intervention was regarded by team members to be an important function of an assessment team.

Hospital referrals differed from others in that they were concerned with sick people rather than those experiencing difficulties in daily functioning. It seems probable that some of those people who were suffering from acute conditions between ages 65 and 70 would not be among the survivors who were referred at a much later age. Among those who were referred at 80+ years would be a number whose short-term memory loss was of concern to hospital staff, and whose capacity to remain at home required regular re-assessment.

The last mentioned group of people also featured among those referred by Community services.

Referrals from elderly individuals, their family and friends often came with specific enquiries for aids, or for information about services or residential care. Such enquiries often masked anxiety about future outcomes or abilities to manage. General discussion and information-giving at this time often gave those involved the confidence to continue without immediate assistance, but

with the knowledge of services available (and how to contact them) should some form of support become necessary.

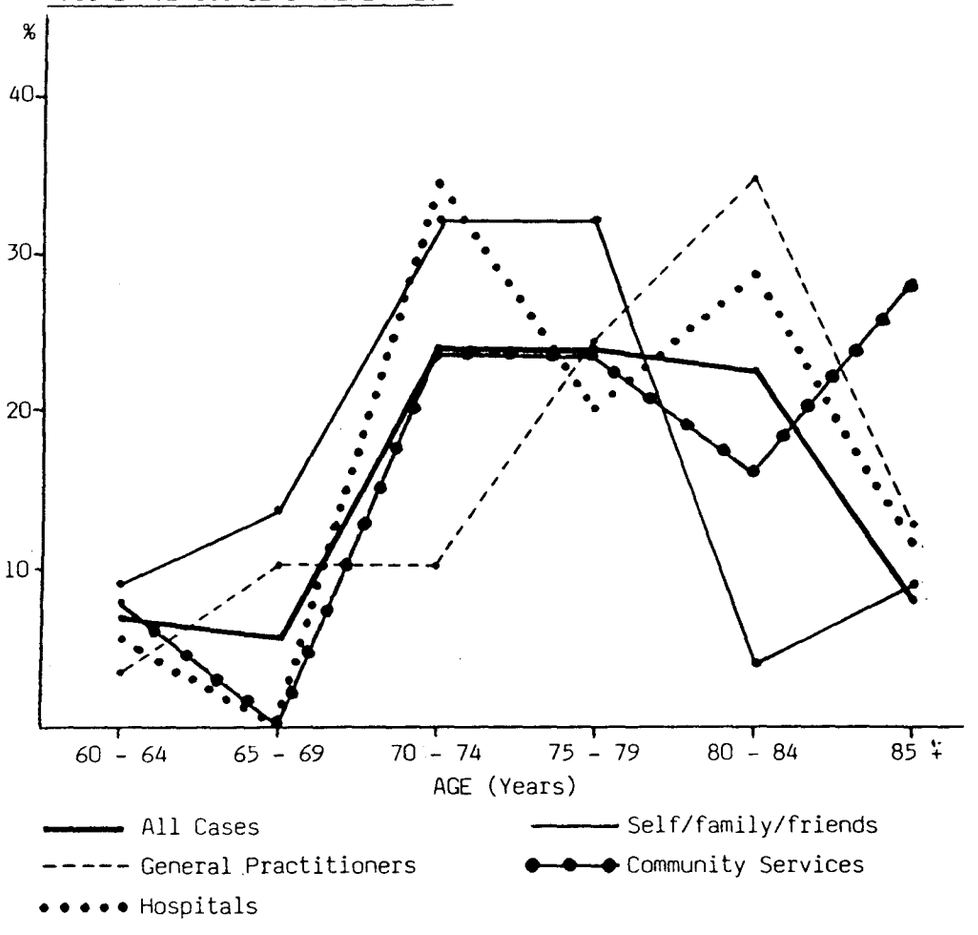
TABLE 4.6 SOURCES OF REFERRAL, SERVICES AND MUNICIPALITIES

Characteristics of Referrals	Sources of Referrals: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total %
All Referrals	22	29	35	25	9	120	(100.0)
% of each source	18.3	24.2	29.2	20.8	7.5	-	(100.0)
Months of first Contact							
Aug 84 - Oct 84	2	-	6	2	1	11	9.2
Nov 84 - Jan 85	7	9	17	12	4	49	40.8
Feb 85 - May 85	13	20	12	11	4	60	50.0
Municipality of Referred Person							
Ashfield	5	5	10	11	3	34	28.3
Burwood	6	7	13	1	2	29	24.2
Concord	1	3	-	-	-	4	3.3
Drummoyne	6	14	4	11	-	35	29.2
Strathfield	4	-	8	2	4	18	15.0

TABLE 4.7 SOURCE OF REFERRAL: AGE GROUPS OF REFERRED PERSONS

Age Group (years)	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total %
All Referrals	22	29	35	25	9	120	(100.0)
60-64	2	1	2	2	1	8	22.9
65-69	3	3	-	-	1	7	22.2
70-74	7	3	12	6	1	29	19.1
75-79	7	7	7	6	2	29	15.2
80-84	1	10	10	4	2	27	11.1
85 +	2	5	4	7	2	20	9.5

FIGURE 4.2 SOURCE OF REFERRALS



Referrals: Reasons for Referrals and Sources of Concern* (M)

The following table (Table 4.8) categorises the reasons given for requesting assessment, and the people expressing concern at the time.

TABLE 4.8 REFERRALS: REASONS FOR REFERRALS AND SOURCES OF CONCERN *(M)

Characteristics	Sources of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Reason for Referral								
Information	6	3	2	3	-	14	10.5	11.6
Assessment	11	23	24	15	7	80	60.1	66.7
Specific Need	8	5	10	5	2	30	22.6	25.0
Condition (health)	2	1	1	2	1	7	5.3	5.8
Other	-	-	1	1	-	2	1.5	1.7
Total Reasons	27	32	38	26	10	133	100.0	-
One Reason	-	-	-	-	-	109	-	90.8
More than One	-	-	-	-	-	11	-	9.2
Source/Cause of Concern								
Self	3	1	4	2	1	11	7.4	9.2
Family/ Friends	18	1	5	2	1	27	18.1	22.5
G.P.	-	28	1	-	-	29	19.5	24.2
Other Professionals	-	1	20	8	3	32	21.5	26.7
Post-accident	1	1	2	1	-	5	3.4	4.2
Post-hospital	2	1	17	-	2	22	14.8	18.3
Personal/ emotional	1	-	3	-	-	4	2.7	3.3
Other/not known	-	1	-	14	4	19	12.8	15.8
Total Sources/ Causes	25	34	52	27	11	149	100.0	-
One source/cause	-	-	-	-	-	98	-	81.7
More than One	-	-	-	-	-	22	-	18.3

* (M) In this table and in most of the statistical tables to follow (marked *(M) multiple answers have been recorded, and the percentages indicate the frequency of the answers as well as the proportion of the referred population (N=120) to which a particular answer applied. Thus the percentages in the extreme right-hand column (marked "% of persons") total more than 100% in most cases.

Some telephone enquiries for information were considered to be inadequate contact for an appropriate response and home visits were made to assess the situation and to advise accordingly.

The majority of General Practitioners' referrals were requests for overall assessment, suggesting that, while doctors felt adequate in making judgements about the health care of the aged person, they recognised a need for a more comprehensive appraisal of the individual and his/her living and support arrangements. In some instances the community nurse/assessor's many years of experience in working with aged people in the community led her to identify factors relating to health or to specialised geriatric care which she was then able to discuss with the General Practitioner. At such times the lack of access to a specialist geriatric inpatient unit within Area 5 was keenly felt.

Hospital referrals were usually in the form of requests for follow-up post-discharge visits. Such contacts were usually short term in nature as the person recovered from an acute episode, but illustrate the need for some form of overview during the transition period from institution to community.

Referrals for specific needs often involved the provision of aids to daily living, and were handled by the O.T./Assessor, who would identify what was most appropriate. While P.A.D.P. funds were available, aids were obtained (depending upon eligibility) through Croydon Community Rehabilitation Service, otherwise advice would be given about where such aids could be obtained. The assessor would always ensure that any such aids were adjusted for the elderly person's use, and that the referred person was able to put them to optimum use.

On a number of occasions the community nurse was able to educate people in the use of nebulisers, or to alter oxygen apparatus to make living easier for people suffering from respiratory diseases.

Conditions of Person Referred to Aged Referral and Assessment Unit and Expressed Need

Team members, in looking at the overall situation referred for assessment, identified those conditions which were threatening to the individual's capacity to function independently. Also recorded was the area(s) seen by the elderly person as presenting the greatest difficulty (See Table 4.9)

TABLE 4.9: CONDITION OF PERSON REFERRED TO AGED REFERRAL & ASSESSMENT UNIT AND EXPRESSED NEEDS *(M)

Characteristics	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Condition of Person								
Confusion	3	4	6	-	1	14	8.5	11.6
Self neglect	2	3	5	2	1	13	7.9	10.8
Mobility/balance	2	9	10	9	2	32	19.4	26.7
Difficulties managing	7	7	10	4	-	28	17.0	23.3
Current arrangements	5	4	13	7	3	32	19.4	26.7
Other	8	11	12	11	4	46	27.9	38.3
Total reported conditions	27	38	56	33	11	165	100.0	-
One reported condition	-	-	-	-	-	85	-	70.8
More than one	-	-	-	-	-	35	-	29.2
Expressed Needs								
Aids	4	7	8	4	1	24	17.5	20.0
Accommodation	4	2	3	7	4	20	14.6	16.6
Support	10	8	20	7	2	47	34.3	39.2
Social interaction	4	7	2	1	2	16	11.7	13.3
Other	4	9	7	8	2	30	21.9	25.0
Total Needs for	26	33	40	27	11	137	100.0	-
None	-	-	-	-	-	8	-	6.7
One	-	-	-	-	-	89	-	74.2
More than one	-	-	-	-	-	23	-	19.2

More than a quarter of those assessed (29.2 per cent) suffered from more than one condition which complicated their lives. A comparatively significant number suffered difficulties resulting from conditions which were not among the categories identified, but included such things as deafness, leg ulcers, and incontinence of varying degrees.

Needs expressed at the time of assessment included various kinds of support, e.g. supervision with bathing, delivered meals, home library service (including talking books), domestic assistance. Numbers of people expressed (directly or indirectly) the need for human contact. In some areas this was among the most difficult things to provide (see Models of Operation, Chapter II), and pointed to the need for some form of contact/monitoring service.

The process of assessment sometimes led to the mutual redefining of situations so that needs which were expressed at the time of first contact were either no longer relevant in the light of options presented by the assessor, or were seen to be of lesser importance than the needs which were revealed by assessment. For example, an elderly person or his/her relatives (or even General Practitioner) might have felt that an immediate move to a nursing home was the only solution to the many problems facing the referring or referred person. The assessor, on the other hand, might have offered respite in a hostel (with personal care) or in a private hospital (if the elderly person had health insurance cover) while all those concerned had a break of, say, 6 weeks. At the same time where appropriate, modifications could be made to the house to make things easier and safer. Home Care could be considered to take over some of the routine cleaning on the person's return home, and, if necessary, the home nursing service could supervise bathing on a twice weekly basis. Any or all of these alternatives could be introduced on a trial basis, on the understanding that nursing home placement was still a solution when all other avenues had been explored. Such a process might not only stave off nursing home placement for months or even years, but might make placement more acceptable to all concerned, when or if it eventually occurred.

Another example might be where an elderly person living alone was reported by neighbours as being confused and acting strangely, and in need of twenty-four hour care. Assessment might have revealed that the person had become careless in his/her drug-taking regime. This had had a cumulative effect, leading to confusion and self-neglect, all of which were reversible once the primary cause had been established.

Difficulties Experienced by Referred Persons

The following tables seek to identify particular areas of difficulty, taking into account a number of the broad aspects of living, and then developing these in more detail.

TABLE 4.10: DIFFICULTIES EXPERIENCED BY REFERRED PERSONS *(M)

Characteristics	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Type of Difficulties Experienced								
Functional	15	17	24	18	5	79	28.6	65.8
Personal (Health)	19	24	26	21	6	96	34.8	80.0
Environmental	6	9	10	8	4	37	13.4	30.8
Social	11	17	14	10	4	56	20.3	46.7
Other	-	1	4	2	1	8	2.9	6.7
Total reported difficulties	51	68	78	59	20	276	100.0	-
One reported difficulty	-	-	-	-	-	32	-	26.7
More than one	-	-	-	-	-	88	-	73.3
Functional Difficulties								
Personal Care	10	10	21	15	3	59	40.1	49.2
Domestic Tasks	8	12	14	13	1	48	32.7	40.0
Other tasks/ other	5	9	15	8	3	40	27.2	28.3
Total functional difficulties	23	31	50	36	7	147	100.0	-
None reported						41	-	34.2
One difficulty	-	-	-	-	-	33	-	27.5
More than one	-	-	-	-	--	46	-	38.3

Continued Over Page

TABLE 4.10 Continued

Characteristics	Source of Referrals: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Personal(Health)								
Memory	3	3	6	3	-	15	9.4	12.5
Incontinence	-	1	1	1	1	4	2.5	3.3
Confusion	2	4	8	1	-	15	9.4	12.5
Mobility/balance	3	10	9	11	1	34	21.3	28.3
Gradual deterioration	1	6	7	5	1	20	12.5	16.7
Emotional	8	13	8	7	4	40	25.0	33.3
Alcohol/other substance	1	1	-	5	2	9	5.6	7.5
Other	8	5	5	4	1	23	14.4	19.2
Total Personal (Health)	26	43	44	37	10	160	-	100.0
None reported	-	-	-	-	-	21	-	17.5
One	-	-	-	-	-	58	-	48.3
More than one	-	-	-	-	-	41	-	34.2
Environmental Difficulties								
No accommodation	2	-	-	-	-	2	5.3	1.7
Accommodation unsuitable	3	3	4	2	3	15	39.5	12.5
Other	1	6	5	7	2	21	55.3	17.5
Total Environmental	6	9	9	9	5	38	100.0	-
None reported	-	-	-	-	-	82	-	68.3
Social Difficulties								
Family/relatives	5	6	5	6	-	22	30.6	18.3
Social isolation	6	12	4	3	3	28	38.9	23.3
No support	-	2	2	-	-	4	5.6	3.3
Support inadequate	4	3	2	3	-	12	16.7	10.0
Other	-	2	2	1	1	6	8.3	5.0
Total Social difficulties	15	25	15	13	4	72	100.0	-
None reported	-	-	-	-	-	61	-	50.8
One	-	-	-	-	-	47	-	39.2
More than one	-	-	-	-	-	12	-	10.0

Consideration of data in these tables reveals the importance of health (good or bad) in the coping ability of aged people. The data also show that a significant number of the people assessed were experiencing multiple difficulties, and that this was evident not only in the aggregate, but also in the more explicit information sought.

Only a third of those assessed reported having no functional problems. These included those with spouses or live-in carers/supporters who were able to compensate for any deficits. It also included people who were already in nursing homes.

As has been stated earlier, accommodation was seldom the over-riding problem. In only two cases, the Unit received direct requests for accommodation. One of these related to an elderly widower who was sleeping in his car outside of the home of his daughter and son-in-law, after family relations had become strained. This referral reached the Aged Referral and Assessment Unit after nine fruitless phone calls by the son-in-law to other agencies and services. The man was successfully placed in a hostel within four days, and has remained there to the satisfaction of all concerned. The other instance involved a lady in her seventies who had been moving from the home of one family member to another. Her only income was the pension. She was seeking unit accommodation to which she could take her own furniture, which was close to shops, and which was within her capacity to pay (i.e. no bond or donor contribution). Despite her somewhat unreal expectations, accommodation was found for her in a divided cottage in the grounds of a hostel complex in Drummoyne, and she soom became happily established.

Referrals emanating from nursing homes usually underlined inappropriate placement, e.g. people capable of functioning in hostel accommodation with personal care, or a mentally alert comparatively young man who was the sole male resident of a nursing home.

Doctors and hospitals were sometimes concerned about the coping capacity (i.e. suitability) of people living alone at home who were in the early stages of dementia and it was in circumstances such as this that the risk factor had to be weighed against the sometimes competing interests of the individual and his/her support network.

Social isolation was also identified as a significant difficulty. Where people were able and willing to embark on social interaction outside of their homes, team members were able to offer appropriate information. For those with a greater degree of disablement this was a continuing problem, underlining the need for (a) a day centre for the frail and disabled aged (including suitable transport arrangements) and (b) a reliable home monitoring service - either by paid contact workers or by well co-ordinated volunteers.

Medical Diagnosis of Referred Persons

In most cases (if this had not been furnished with the referral) information regarding the medical diagnosis and medication regime was sought from the

referred individual at the time of assessment. These were often significant factors which could not be overlooked. The effect of confusion over drug-taking was present in a number of cases, requiring either a simplification of the drug regime (achieved in consultation with the General Practitioner) or arrangements with relatives or neighbours, working in co-operation with the home nurse.

TABLE 4.11: MEDICAL DIAGNOSIS OF REFERRED PERSONS

	Source of Referral							
Medical Diagnosis	Self Family Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	% of answers	% of persons
All Referrals	22	29	35	25	9	120	-	100.0
C.V.A.	3	1	4	3	-	11	5.9	9.2
COAD/Emphysema	5	3	5	2	2	17	9.1	14.2
Cardio-vascular	2	12	13	3	4	34	18.3	28.3
Rheum/arthritis	-	11	3	4	1	19	10.2	15.8
Trauma	1	1	5	2	-	9	4.8	7.5
Confusion	4	4	8	1	1	18	9.7	15.0
Sensory Loss	4	5	4	5	-	18	9.7	15.0
Other/not determined	7	18	15	16	4	60	32.3	50.0
Total reported condition	26	55	57	36	12	186	100.0	-
One reported	-	-	-	-	-	74	-	61.7
More than one	-	-	-	-	-	46	-	38.3

Forty-six (38.3%) of the people assessed suffered from more than one diagnosed condition. The most frequently appearing diagnosis was Cardio-Vascular disease. This co-incides with the findings of Weiss et al (1985) in the San Francisco Project OPEN. This condition was mentioned almost twice as often as the next group of diagnoses - Rheumatism/Arthritis, Confusion,

Sensory loss (sight, hearing etc.) and respiratory conditions such as COAD (Chronic Obstructive Airways Disease) and Emphysema.

Trauma, such as Colles Fracture, was sometimes a presenting problem which, upon home assessment, proved to be a manifestation of an accumulation of difficulties which made the person's ability to cope with daily living problematic, e.g. failing eyesight, balance problems, and confusional states. Contact at this time with both the individual and his/her support networks allowed for the giving of information which might begin the (sometimes slow) process of realisation of the referred person's limitations.

Confusion, always difficult to accommodate, was made more of a problem in Area 5, because of the absence of either an outpatient or inpatient diagnostic service, day centre, day relief or respite for carers. Very few of the local nursing homes were able to provide adequate care and supervision (See Appendix VI).

4.4 SERVICES ALREADY INVOLVED WITH THE REFERRED PERSON

At the time of assessment, information was sought regarding services already in use and/or workers involved with the referred person (Table 4.12). 'Services' included medical and hospital services, community-based services, and residential care. The services were first classified according to one of the above types and then were dis-aggregated so that specific services involved could be identified.

In Table 4.12 the first set of data (Type of Service involved) gives the aggregate numbers of the type of service involved with the referred person, and each type includes more than one service. In the remaining parts of the Table each type of service has been disaggregated into the specific services involved. Thus for example, the type of service classified as 'medical/hospital' includes General Practitioners, specialists, hospitals etc. giving an aggregate percentage of 121.7 per cent. This disaggregated data then show which services of that type were used and to what extent.

Types of Services Involved and Extent of Involvement

As may be ascertained from Table 4.12, in close to one-half of referrals (49.2 per cent) there was already a multiple involvement of services. No existing involvement of services was recorded in only five referrals. The most frequent involvement was with medical/hospital services, the General Practitioners being, by far, the most frequently involved (92.5 per cent of referrals).

The involvement of community services was less frequent, and over one-half of the referred persons (55.0 per cent) had no involvement with these services. Of those who were already using community services (45.0 per cent) one-half were using more than one service. Home Care Service of New South Wales and

the Sydney Home Nursing Service (S.H.N.S.) were each involved with 21.7 per cent of the referred persons and Meals on Wheels with only 13.3 per cent.

TABLE 4.12: SERVICES ALREADY INVOLVED WITH THE REFERRED PERSONS *(M)

Services Already Involved	Source of Referral: Self Family Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Type of Service Involved								
Medical/ hosptial	23	32	50	31	10	146	56.2	121.7
Community	6	20	26	32	2	86	33.1	71.7
Residential	3	-	3	1	5	12	4.6	10.0
Other	-	4	7	5	-	16	6.2	13.3
Total Services involved	32	56	86	69	17	260	100.2	-
None reported	-	-	-	-	-	5	-	4.2
One	-	-	-	-	-	56	-	46.7
More than one	-	-	-	-	-	59	-	49.2
Medical/ Hospital Services								
G.P.	14	27	29	21	5	96	65.8	80.0
G.P. & specialist	4	2	6	2	1	15	10.3	12.5
Hospital	4	3	14	4	3	28	19.2	23.3
Rehab Centre	1	-	1	3	1	6	4.1	5.0
Other	-	-	-	1	-	1	0.7	0.8
Total Medical/ Hospital	23	32	50	31	10	146	100.0	-
None involved	-	-	-	-	-	6	-	5.0
One involved	-	-	-	-	-	87	-	72.5
More than one	-	-	-	-	-	27	-	22.5
Community Services								
S.H.N.S.	2	5	9	10	-	26	30.2	21.7
Home Care	3	7	9	7	-	26	30.2	21.7
Meals on Wheels	-	4	4	8	-	16	18.6	13.3
Other	1	4	4	7	2	18	20.9	15.0
Total Community Services	6	20	26	32	2	86	100.0	-
None involved	-	-	-	-	-	66	-	55.0
One involved	-	-	-	-	-	27	-	22.5
More than one	-	-	-	-	-	27	-	22.5

TABLE 4.12 Continued

Already Involved	Source of Referrals: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Sources N	Total N	Total % of answers	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Residential Services								
Hostel	-	-	2	-	1	3	25.0	2.5
Nursing Home	1	-	1	1	2	5	41.7	4.2
Other	2	-	-	-	2	4	33.3	3.3
Total residential	3	-	3	1	5	12	100.0	10.0
None Involved	19	29	32	24	4	108	-	90.0
Other Services Involved	-	4	7	5	-	16	-	13.3

TABLE 4.13: RESPONSES/INTERVENTION BY AGED REFERRAL & ASSESSMENT UNIT *(M)

Response/ Intervention	Source of Referral: Families Friends N	G.P. N	Hospital N	Community Services N	Other Sources N	Total N	Total % of responses	Total % of people
All Referrals	22	29	35	25	9	120	-	100.0
Interpretation of Ageing Process	5	1	2	1	2	11	3.8	9.2
Counselling as necessary	10	8	11	10	7	46	16.0	38.3
Information re aids/services	17	20	23	17	7	84	29.3	70.0
Education in use of aids	3	3	1	-	-	7	2.4	5.8
Monitoring	8	8	14	11	3	44	15.3	36.7
Offer A.R.A.U. services in future	13	17	16	11	4	61	21.3	50.8
Other	6	11	11	3	3	34	11.8	28.3
Total Responses Intervention	62	68	78	53	26	287	100.0	98.3
No intervention	-	-	1	-	1	2	-	1.7

These data fit in well with the picture given earlier (p.52) of the very old people living alone in their own homes, with any support coming only from informal contacts - relatives, neighbours, friends - and an occasional contact with the local General Practitioner.

In all, of the 120 persons assessed by the Aged Referral and Assessment Unit only five individuals reported no contact or involvement with services of any kind. Thus it appears that most aged people use some formal services, the most frequent use being made of health and health-related services.

4.5 RESPONSE/INTERVENTION BY AGED REFERRAL AND ASSESSMENT UNIT

The process of assessment as it was practised by the Aged Referral and Assessment Unit included the imparting of information and various forms of short term intervention. Table 4.13 gives some indication of the service given.

A persistent thread throughout this report has been the value placed on equiping elderly people and their support networks with information appropriate to their situation and their current and potential needs. It is therefore not surprising that the categories 'information', 'counselling' and 'interpretation of ageing process' together accounted for close to one-half (49.1 per cent) of all methods of Aged Referral and Assessment Unit intervention and were used in almost all referrals. A further 2.4 per cent of methods was directed to education in the use of various aids. The most frequent information provided (in 70.0 per cent of referrals) was about aids and/or services.

The short-term monitoring role (which would also reasonably be described for the purposes of this project - as 're-assessment') was seen to be an essential part of the assessment process, in that the services introduced, or the outcomes of advice given, resulted in changes in functioning patterns. Sometimes support was necessary during the transition period.

In accordance with the philosophical approach adopted by the Unit, the imparting of appropriate information made people aware of options open to them, not only at the time of initial contact, but as an outcome of developments which occurred (or might still occur) subsequently. Team members made a practice of leaving a card with a phone number for future contact, should this be needed. During the funded life of the Unit such contacts had occurred in some 10 per cent of cases.

Services Introduced or Modified by Aged Referral and Assessment Unit

One of the major fears expressed by both community-based services and the clinical services provided through Western Suburbs Hospital and Inner Western Suburbs Area Health Service was that the Unit would generate demand which

would seriously embarrass already hard-pressed services. **That this has not been the case, illustrates that needs which emerged from holistic assessment often did not fit into the categories identified by services providers,** but, nevertheless, were often of primary concern to elderly people in the community and their supporting groups.

TABLE 4.14: SERVICES INTRODUCED OR MODIFIED BY AGED REFERRAL & ASSESSMENT UNIT*(M)

Services/ Introduced Modified	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Sources N	Total N	Total % of Introductions	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Medical/ hospital	4	3	8	2	1	18	16.4	15.0
Community formal	16	13	13	12	3	57	51.8	47.5
Community informal	1	4	1	1	-	7	6.4	5.8
Family/friends	-	-	-	-	1	1	0.9	0.8
Accommodation	2	-	1	-	-	3	2.7	2.5
Hostel/Nursing Home	1	1	4	1	3	10	9.0	8.3
Commercial	-	1	1	-	-	2	1.8	1.7
Other	2	1	7	1	1	12	10.9	10.0
Total	26	23	35	17	9	110	100.0	56.6
No services introduced	7	11	16	15	3	52	-	43.3
No of Services introduced/ modified								
One	7	15	8	5	4	39	57.4	32.5
Two	5	2	7	4	1	19	27.9	15.8
Three	3	-	3	-	1	7	10.3	5.8
Four	-	1	1	1	-	3	4.4	2.5
Total introduced/ modified	26	23	35	12	9	110(68)*100.0		56.6
No services introduced/ modified	7	11	16	15	3	52	-	43.3

Continued Over Page

TABLE 4.14 Continued

Services Introduced Modified	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of Introductions	Total % of persons
All Referrals	22	29	35	25	9	120	-	100.0
Outcome								
Accommodation arranged/ modified	3	4	10	1	2	20	10.7	16.7
Family/friends support obtained	1	-	2	-	-	3	1.6	2.5
Aids provided/ modified	5	4	8	2	1	20	10.7	16.7
Accepted by community formal	8	8	11	8	1	36	19.3	30.0
Accepted by community informal	2	1	-	-	-	3	1.6	2.5
Treated by G.P./hospital	1	1	7	3	1	13	10.0	10.8
Information given to client	15	17	13	6	4	55	29.4	45.8
Monitoring	4	2	11	4	-	21	11.2	17.5
Other	2	-	7	4	3	16	8.6	13.3
Total Outcomes	41	37	69	28	12	187	100.0	81.7
No Change	2	6	6	6	2	22	-	18.3

* The total of 110 in the part of Table "No. of Services introduced" refers to the total number of services introduced/modified. The number (68) refers to the number of persons referred to services. The percentages in first column ("% of introductions") refer to the frequency of introducing one, two, etc. services.

In 52 referrals (43.3 per cent) no services were introduced or modified, the other forms of intervention such as information, monitoring, etc. having been considered to be sufficient. Of the 68 referrals (56.6 per cent) where services were introduced or modified, in 39 cases (57.4 per cent) one service was introduced/modified, and in 19 cases (27.9 per cent) two services were introduced/modified. Introduction of more than two services was relatively rare, amounting to 14.7 per cent of individuals referred to services.

Referral to formal community services included not only such services as Home Care, Home Nursing and Meals on Wheels, but also community-based podiatry,

mobile dentistry, and home library services. A major proportion of formal community referrals would have been to Croydon Community Rehabilitation Service as this service required a pro forma referral when aids were issued, even though delivery, adjustment and education in use were carried out by team members of the Aged Referral and Assessment Unit.

Services Assessed as Needed but Not Introduced

In 50 cases (41.7 per cent of all persons assessed by the Aged Referral and Assessment Unit) the need for services was indicated, and the most frequent need (24.2 per cent of cases) was for formal community services (Table 4.15). The assessment of need for certain services did not always result in the introduction of such services for use by the elderly people who needed them.

The reasons for non-introduction of services varied widely, the most frequent reason (14.2 per cent of cases) was non-availability of the services. However, refusal of people to accept the service, or deferment of decision to accept were the two other most frequent reasons for non-introduction of services, although in the opinion of the Aged Referral and Assessment Unit team members the need for such services were indicated.

During a period from late October 1984 to early December 1984 (and later in the case of Sydney Home Nursing Service) the Home Care Sevice of New South Wales closed its books to new referrals in order to bring the attention of funding bodies to difficulties it was experiencing. At the same time the Western Suburbs Branch of Sydney Home Nursing Service was forced, by over-loading, to take a similar step. During this period (as also at other times when waiting lists were long) the Home Care branches were prepared to offer contacts which would lead to a 'user-pays' arrangement between some of its home aides and people needing the service.

Home nursing services could be (and were) arranged by the use of the Council-employed nurses in Concord and Ashfield municipalities, and by the Chesalon nurse who was prepared to travel throughout Area 5. In the latter two cases some charge were involved. These arrangements led to some tensions when the Sydney Home Nursing Service reopened its books in January 1985, and its service once more became available.

Waiting lists for Home Care varied over the funded life of the Aged Referral and Assessment Unit. The longest period noted was four and a half months, and, at least on one occasion, a person died between the referral and when the service became available. Tensions generated by the stand taken by the Home Care Service of New South Wales against the introduction of regional assessment teams were reflected in the interaction between local branches and the Aged Referral and Assessment Unit, so that, until the latter months of its operation, Aged Referral and Assessment Unit team members were not always able to establish the time lapse between referral and commencement of service.

Difficulties were also experienced in arranging for delivered meals in Strathfield, where the Meals on Wheels Service restricted its provision to 40 meals at any one time. In the later stages a re-arrangement of the service

TABLE 4.15: SERVICES ASSESSED AS NEEDED BUT NOT INTRODUCED *(M)

Services and Reason for Non-Introduction	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	% of service	% of persons
All Referrals	22	29	35	25	9	120	-	100.0
Type of Service								
Medical/hospital	1	-	-	-	1	2	3.3	1.7
Community formal	5	3	12	9	-	29	47.5	24.2
Community informal	4	6	1	-	-	11	18.0	9.2
Family/friends	-	1	-	-	1	2	3.3	1.7
Accommodation	1	2	-	-	1	4	6.6	3.3
Hostel/Nursing home	-	-	1	2	2	5	8.2	4.2
Other/multiple	1	4	-	2	1	8	13.1	6.7
Total services	12	16	14	13	6	61(50)*	100.0	41.7
Services not needed	12	15	23	15	5	70		58.3
Reason for Non-Introduction								
Client unable to accept	-	1	-	-	-	1	1.6	0.8
Client refused to accept	-	4	3	5	1	13	20.6	10.8
Client deferred decision	2	6	3	-	1	12	19.0	10.0
Not accepted by service	1	-	1	1	-	3	4.8	2.5
Decision deferred by service	3	2	1	3	2	11	17.5	9.2
Service not available	3	4	6	3	1	17	27.0	14.2
Family/friends unable to accept	-	1	-	-	-	1	1.6	0.8
Other/multiple	3	-	1	-	1	5	7.9	4.2
Total reasons	12	18	15	12	6	63	100.0	41.7
Services not needed	12	15	23	15	5	70		58.3

* The number 61 refers to the total number of services assessed as needed; (50) refers to the number of persons in need of services. The percentages in ("% of services") refer to the number of services assessed as needed.

in Ashfield also led to restrictions on availability of meals, even when these were assessed by the Aged Referral and Assessment Unit as being necessary on an immediate and short-term basis, such as when a lady was recovering from a particularly painful operation on her feet, and was unable to stand to prepare meals.

Other services assessed as desirable were not available in some areas, e.g. a monitoring/maintenance service for the isolated house-bound frail/disabled aged, transport to health-related appointments, or for spouses to visit their partners in hospital, time out for carers, particularly where the person being cared for was confused or suffering from Alzheimers Disease.

Feedback systems were developing in the later stages of the period under review whereby service providers would contact the Unit when changes occurred in the lives of elderly people with whom the Unit had been in contact. An example of this occurred when a Meals on Wheels Co-ordinator reported that a single man living in a rooming-house had not been at home when his meal was delivered. Several hours later the Welfare Officer from Western Suburbs Hospital rang through from Casualty Department to ask for advice as to whether or not a patient with a fractured humerus could reasonably be expected to cope if he was returned to his rooming-house on Friday afternoon. The team member who had had previous contact with the man was able to explain not only that there would be no assistance available at the rooming house, but also that, if he was to retain his room, any accommodation which might be arranged for him would have to be at no cost, as he was entirely dependent upon his pension. In consideration of this information that man was admitted to a ward in Western Suburbs Hospital, and was later transferred to a Schedule III hospital for rehabilitation.

This example illustrates one way in which a central contact point can be utilised by workers from a number of geographically separate agencies in making sure that all relevant options are explored in devising appropriate arrangements in individual cases.

4.6 EVENTS SUBSEQUENT TO ASSESSMENT, AND CONDITIONS AT 31ST MAY, 1985

The monitoring of the progress of the referred persons after assessment and/or referral to services had been made, enabled the Aged Referral and Assessment Unit team to ascertain whether any changes had accrued in the person's condition or living arrangement. Monitoring as indicated took place throughout the life of the Unit, and a further check up of all assessed persons was made shortly before 31st May, 1985 (the closing date for the purpose of analysis of data).

Subsequent Events

Changes of some kind in the condition and/or living arrangements had occurred, or appeared to have occurred, in most persons assessed by the Aged Referral and Assessment Unit, and only in 18 cases (15 per cent) no change

was reported (Table 4.16). There was a noticeable improvement in people's physical condition and/or in their activities in 31 cases (25.8 per cent). Community services used at the time of assessment or re-activated as a result of assessment continued to be used in 20.8 per cent of cases (25 persons). A number of people (26, or 21.7 per cent) received treatment in a hospital or in a rehabilitation centre. There was also a substantial number of cases where further contact with the Aged Referral and Assessment Unit was not required or where a satisfactory outcome was evident as a result of action taken. Of the 120 persons assessed by the Aged Referral and Assessment Unit, 8 persons died before 31st May, 1985.

TABLE 4.16: SUBSEQUENT EVENTS TO 31ST MAY, 1985 *(M)

Subsequent Events	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total % of change	% of persons
All Referrals	22	29	35	25	9	120	-	100.0
Further contact not required for time being	6	6	7	3	-	22	13.3	18.3
Satisfactory outcome after action taken	9	1	6	4	-	20	12.1	16.7
Improvement in condition/ activities	7	7	12	3	2	31	18.8	25.8
Community services continued/ re-activated	4	6	9	4	2	25	15.2	20.8
Treatment in hospital/ rehab. centre etc.	3	4	8	7	4	26	15.8	21.7
Gradual deterioration	-	1	4	6	-	11	6.7	9.2
Admitted to hostel/nursing home	-	2	1	4	3	10	6.1	8.3
Deceased	1	-	4	2	1	8	4.8	6.7
Other	1	6	2	3	1	13	7.9	10.8
Total changes noted	31	33	53	36	13	166	100.0	85.0
No change	3	5	3	6	1	18	-	15.0

TABLE 4.17: CONDITION AS ASSESSED AT 31ST MAY, 1985

Condition as at 31st May, 1985	Source of Referral: Self Families Friends N	G.P. N	Hospital N	Community Services N	Other Source N	Total N	Total %
All Referrals	22	29	35	25	9	120	100.0
Condition							
Not known/not applicable	5	3	5	4	1	18	15.0
Functional Condition							
Much Worse	-	-	-	1	-	1	0.8
Worse	-	3	4	3	1	11	9.2
No Change	6	19	9	13	5	52	43.3
Better	9	4	15	2	2	32	26.7
Much Better	2	-	2	2	-	6	5.0
Personal (Health)							
Much worse	-	-	-	1	-	1	0.8
Worse	-	3	3	4	1	11	9.2
No change	7	13	10	11	4	45	37.5
Better	8	9	14	4	1	36	30.0
Much Better	2	1	3	1	2	9	7.5
Social/Supports							
Much Worse	-	-	-	-	-	-	-
Worse	-	-	1	3	-	4	3.3
No change	9	19	13	10	4	55	45.8
Better	4	7	9	5	-	25	20.8
Much Better	4	-	7	3	4	18	15.0
Environment/ Accommodation							
At home	16	22	21	14	3	76	63.3
In Hostel	1	1	3	-	2	7	5.8
In Acute Hospital	1	1	2	2	-	6	5.0
In Nursing Home	1	2	3	4	2	12	10.0
Other Arrangements	1	1	2	2	1	7	5.8
Deceased	1	-	4	2	1	8	6.7
Not known	1	2	-	1	-	4	3.3

Conditions as Assessment at 31st May, 1985

The condition of persons assessed by the Aged Referral and Assessment Unit from August, 1984 to May, 1985, as at 31st May, 1985, was made having regard to their ability to function adequately, their state of health, their social life, and the supports they were receiving. The assessment was made on a scale of five levels in comparison with the condition at the time of the first assessment by the Aged Referral and Assessment Unit: much worse, worse, no change, better, much better.

It needs to be noted that this assessment was made on both 'hard' quantitative and 'soft' qualitative criteria. Thus the assessment must be viewed with appropriate qualification as to the unavoidable degrees of arbitrariness and subjectivity used by the assessors. However, the assessment was made with great care, and may be regarded as providing a reasonable indication of the conditions observed in the people concerned at that time.

The following comments refer to Table 4.17. In the majority of cases (37.5 to 45.8 per cent) there was no great change either in people's day-to-day functioning, their state of health, or social life, and/or available supports. Of the remainder, most people showed some improvement, particularly in their state of health (20.8 to 30.0 per cent). A few people showed significant improvement, especially in social aspects of their lives and/or in the supports they were able to use. A smaller proportion showed deterioration in their condition, especially in day-to-day management ability and in their state of health (10.0 per cent). In 15.0 per cent of cases (18 persons) no assessment was possible because the person had either died or was otherwise not available for re-assessment (e.g. the person had left the area).

Most people were still living at home, although that number had decreased from 99 at the time of first contact with the Aged Referral and Assessment Unit to 76 at 31st May, 1985. The number of those living in hostels increased from 1 to 7, and those in nursing homes increased from 4 to 12. The condition of 6 people resulted in their admission to a hospital for treatment. As mentioned earlier, 8 people had died.

4.7 SUMMARY

Of the 120 people referred to the A.R.and A.U. from August, 1984 to May, 1985 a majority (63.3%) came from the aged population of Area 5 who were aged 75+ years. Many of these 'old old' people were referred by General Practitioners and had not had previous contact with community services. They lived (often alone - 47.5%) in their own homes or units, were experiencing difficulties in more than one aspect of their lives, and were likely to be suffering from some form of cardio-vascular disease (28.3%) with rheumatism or arthritis also affecting their mobility (15.8%).

The accessibility and strength of family or informal support networks were shown to be a significant factor in the ability of at-risk people to continue

to manage at home. However, over 17 per cent of the sample had never married, and 85 persons(69.8%) were without a spouse. Close to a half (43.3%) had no living children or no children playing an effective part in their lives. A surprising number of those assessed saw as their main point of reference a relative (often from the extended family) living at a distance and maintaining contact by phone.

People with non-English-speaking backgrounds were under-represented (15%) in relation to their presence in Area 5 (19.58%), and evidence suggested that assessment or assistance was sought by them, or for them, when a negative outcome was already determined.

Two areas which did not appear to be problem-related were income and accommodation. Eighty-five per cent of the people assessed were receiving some form of pension or part pension.

Patterns of referrals for assessment were not random across the five municipalities, but arose from the acceptance or otherwise of the team as a relevant and credible resource by a local network of service providers (including G.P.'s) and of elderly residents themselves.

In the process of assessment it was found that a significant proportion of the time spent related to the giving of information and to discussion and exploration of options. Post-assessment referrals were made for introduction or modification of services in fewer than half of the cases. In 14.2 per cent of cases recommendations for services identified by the assessor as being needed were not taken up, either because such services were not available (e.g. monitoring, transport, attendance at a day centre), because waiting lists existed in established services, or because the elderly person refused the service.

Re-assessment of outcomes at the end of the period under review showed no deterioration in the level of functioning in just under half of the assessed population. One quarter showed improvement, particularly in health (these included people seen on discharge from acute hospitals) while 10 per cent showed a decline. In the case of 18 persons no re-assessment was possible due to death (8) or other reasons. Most people were still living at home, although six had moved into hostel accommodation and eight had been placed in nursing homes.

During the period of its functioning the A.R and A.U was able to demonstrate that nursing home placement (which had seemed inevitable at the time of contact) had been significantly delayed or avoided in at lease twelve instances.

As indicated in research literature (e.g. Challis and Davies, 1980), work with this most vulnerable group is inevitably time-limited in its outcome. In this case, among the 120 persons referred to and assessed by the A.R. & A.U. a number (8) of deaths have occurred during the period of the Unit's operation. However, a sufficient number of those of the sample population had survived and continued to function (in some cases with noticeable gains in independence and self-esteem) in their homes or in hostels for the A.R. & A.U. to be seen to be cost-effective, even without consideration of any other positive input the Unit had made.

CHAPTER V

OBSERVATIONS AND COMMENTS ON THE UNIT'S EXPERIENCE AND ON GENERATED DATA/FINDINGS

5.1 ISSUES IN CARE FOR THE AGED

Much of the debate on the care of the aged has revolved, and continues to revolve, around the issue of institutional care versus care in the community; the latter generally being regarded as a preferable option wherever possible. The McLeay Report (1982), and much of the earlier and subsequent writings point to the imbalance between the high level of resources allocated to, and used by, institutional care and the comparatively low outlays for care of aged people in the community.

At the same time, all available evidence indicates that the vast majority of the aged population lives in the community. For example, Graycar (1984) reports that, of those aged 65 years and over, 93.6 per cent live in private households, while 6.4 per cent live in institutions; the latter group may include people living in hostels, and in long-stay hospital accommodation.

It is generally accepted that the cost of institutional care is in a ratio of above 10 to 1 when compared with the total cost of those services which are believed to maintain elderly people in their homes. The situation in which less than 7 per cent of the elderly population uses such a high proportion of funds outlayed for the care of the aged may be accounted for by many factors. Not the least of these may be found in the funding arrangements which have acted as disincentives for the States to control the proliferation of nursing home beds, while requiring matched Federal/State contributions towards the cost of providing community services. The exception has been the Meals on Wheels Service where direct subsidies are provided for meals delivered to people living at home.

In recent years there has been a drive to contain nursing home admissions and to give attention to what might be the minimum requirement to encourage elderly people to remain in their homes, or, at the very least, in unit or hostel accommodation. This change in policy has led to the adoption of the Home and Community Care Program (H.A.C.C.), and to other initiatives which are to explore various provisions, and the feasibility of developing a more co-ordinated and effective system of services for the aged.

The Aged Referral and Assessment Unit in Area 5 of the Southern Metropolitan Region of the New South Wales Department of Health was one such initiative.

The aim of this report was to provide an account of the Unit's experience over the fifteen months of its operation and to consider the feasibility of establishing such Units on a permanent basis as an integral part of services for the aged. As reported in the preceding chapters, the members of the Unit decided from the outset to adopt an action research approach to their work, to enable them to continually evaluate their on-going operation and to adapt their mode of operation where necessary in relation to encountered issues and

problems. In that process the Unit has collected a considerable amount of data on the aged population in Area 5 and their characteristics and needs. It has also obtained some insight into the operation of services in the Area, and has identified a number of issues and problems emanating from the organisation of services. Some problem areas which have emerged as being of considerable significance have been similar to those identified in research elsewhere; others have a specific local content (or source). The issues that warrant discussion here are especially those revolving around formal versus informal services; institutional versus community care; inter-professional boundaries; and Federal/State divisions of responsibility.

These issues need to be seen in relation to the aged population whose needs the various organisation and professions are expected to meet.

5.2 THE AGED POPULATION AND THEIR SUPPORT NETWORKS IN AREA 5

The Aged

As noted earlier (Chapter II) the proportion of the aged population in Area 5 is higher than the average for the Sydney Statistical Division. In most respects, however, the characteristics of the aged population are similar to what is known about the aged population generally. Most of the elderly people live in their homes, most of them rely on pensions as their main source of income. As they grow older, a high proportion suffer from health conditions and physical limitations which reduce their functional abilities and increase the need for support.

The 120 persons seen and assessed by the Aged Referral and Assessment Unit were largely in the 'old old' age group. It may also be assumed that they were referred for assessment because they were experiencing some difficulties, had become anxious, and/or needed to make some decisions about their future.

In consideration of the factors involved, it needs to be acknowledged that 'old age' is not a static state, but a process which, sooner or later, leads to a deterioration in health, in the ability to perform day-to-day tasks, and in social activities. That process, and consequently the needs of the aged, are not uniformly experienced and cannot be easily classified into neat discrete categories. At the same time, the services provided for the aged are classified and specialised. Thus the most important issue which concerns the provision of services to the aged may be seen to be the discrepancy between the needs of the aged population on the one hand, and the established diversity of services, each operating within defined boundaries of perceptions, theoretical orientations and organisation and/or professional interests. It is not necessarily the scarcity of service provision alone, but rather the manner of service organisation that is an important issue in the care of the aged.

Support Networks

The importance of informal support networks in the care of the aged has received relatively little systematic attention in Australian research literature. For example, although a number of the Social Welfare Research Centre's Reports and Proceedings address the interests and welfare of carers (Report and Proceedings Nos. 23, 35 and 38) particularly where there is a need for constant, or almost constant, supervision, not a great deal of attention has been given to the importance of those informal networks which give a support of a less intensive nature but which nevertheless contribute significantly to the capacity of elderly people to remain at home. Something of an exception is Rowland (Kendig et al, 1983) who writes of the integrative effect of 'the modified extended family' consisting of relatives who live apart yet are mutually supportive. He points out that the level of institutionalisation is strongly related, not only to the health status, but also to the availability of family and community support.

During the life of the Aged Referral and Assessment Unit, team members have found that work with family members and with neighbours can often stave off nursing home placements which have seemed to all concerned to be inevitable. Work with support networks has identified the risk factor which often accompanies the maintaining of elderly people at home - particularly where in-house 24 hour supervision is not possible. Conversations with more caring General Practitioners suggested that they do not escape from this anxiety, and this is also true of home nursing sisters. For relatives who may have the competing claims of spouses and young families, the burden may sometimes become almost intolerable.

Team members believe that it is in circumstances such as these that some of their most effective work was done. Referrals came from doctors, from family members, or from perceptive community workers (both paid and voluntary) requesting assessment as to whether or not nursing home placement was indicated - in some ways this was a request for an objective experienced professional to weigh up the competing interests of the referred person and the informal support networks.

The A.R. & A.U team found that in such situations assessment had to be made within a framework requiring as much knowledge as possible of the factors operating. The relatives also needed to be advised of the fact that nursing home placement was not possible (except by 'Scheduling', see Appendix VI) against the wishes of the referred person. If the risk was as great as perceived by the supporting network, and the referred person did not accept the need for change, the assessor had to give her support during the (often slow) process of bringing the referred person to the realisation of his/her limitations. This was particularly difficult where people were in the early stages of dementia. During the process, the assessor had to be prepared to objectify and share the risks involved with the support network until such time as crisis occurred. (Where the risk factor has already reached the critical point, and the focal person remains obdurate, it may be necessary to advise that all supports be withdrawn - this somewhat brutal form of precipitation is not lightly recommended or easily undertaken.)

Situations were encountered where a form of competition had developed between members of a family or neighbourhood, each attempting to outdo the others in manifestations of the degree of support given. This proved confusing to the elderly person and contributed to feelings of helplessness and dependency. Instances such as this needed particularly delicate handling if the well-being of the focal person was to be adequately represented and support maintained at a comfortable level.

The experience of the Aged Referral and Assessment Unit (as expressed throughout this report) was that, in attempting to maintain elderly people at home, work with informal support networks was equally as important (and, in some cases, more time consuming) as work with the target population.

5.3 THE SERVICES

Formal and Informal Services

A review of the literature shows that researchers have found that care and oversight of elderly people in the community remains, for the most part, in the hands of family, friends, neighbours (Kendig et al, 1983; Rossiter, 1984), and that community services, in fact, are utilised by only 8 per cent of the aged population (Grimes, 1985). That this is often at some cost to carers - financial, physical and social - is demonstrated by data presented by Rossiter, Kinnear and Graycar (1984), and by a number of other writers.

Fears are often expressed by policy-makers that formal intervention leads ipso facto to dependency, and therefore should be avoided wherever possible. Dependency upon **informal** networks does not appear to have the same negative connotations and is rarely questioned. Does such a view suggest that dependency exists only when it must be paid for from the public purse?

Questions surrounding dependency occupied Aged Referral and Assessment Unit team members considerably. In drawing the attention of fellow-workers and policy-makers to the social isolation and lack of stimulation experienced by some of the very old and frail people - particularly those who lived alone - team members consistently met with comments or deflections which suggested either a fairly generalised lack of understanding of the **meaning** of isolated old age, OR an unwillingness to face what may reasonably be expected to be the future experience of a significant number of today's younger-to-middle-aged people. Needs voiced by the Aged Referral and Assessment Unit for day centres for the very frail/disabled aged - none of which existed in Area 5 - and for contact workers for the home-bound, were frequently discounted as 'encouraging dependency'. What needs to be considered is that progressively more people are surviving to ages of 85+ years, many of whom are only **marginally independent,** either because of physical limitations or sensory or memory loss. Their capacity to remain at home depends upon the strength and sensitivity of the support given. If the quality of their lives is not to sink into a dreariness which must inevitably rival the negative aspects of nursing home placement there must be a recognition of their dependency upon

others, if only to bring to their lives an occasional dash of colour - whether this can be via family members, by friends, by volunteers, or by empathic paid communtiy workers.

The experience of the Aged Referral and Assessment Unit, as supported by data presented in Chapter IV, indicates that while the fact of referral itself suggested some identified need, anxiety or area of vulnerability, in almost half of these cases, the needs of individuals and their supporting networks were rarely those which could be satisfied by immediate referral to a formally organised community service. Hemer (1984) writes of the need for the development of effective, appropriate and accessible domiciliary and community services which offer a viable alternative to nursing home and hostel care. The development of such services cannot occur until the interests of elderly people are put before the self-interests of agencies, services, organisations and professions.

Inter-professional Boundaries

With the advancing tide of professionalisation, one group of workers after another joins the ranks of 'professionals'. Each new profession seeks to establish itself as a specialist in its own defined field. Inevitably there are overlaps, as social workers jockey with psychologists, occupational therapists with physiotherapists, and nurses demand their place in the professional sun.

All of these 'helping professions' exist because there are people in the community who, at various time, need help. However, in the scramble for professional recognition, once again, the needs of these people often receive low priority. Few, if any, of the professionals are prepared to step outside of their self-defined boundaries to provide a 'generalist' service, and yet very often this is what is needed.

The two Council workers in Concord (neither of whom was a 'professional') and the part-time Meals on Wheels co-ordinator in Drummoyne were the only workers in Area 5 who provided the monitoring service which was seen by the team members to be essential if at-risk elderly people were to remain at home. (See Models of Operation, Chapter II). In the case of the former, long years of experience and familiarity with local conditions led to a containment of 'problems' and responses to within the community (only 4 of 120 referrals to the Aged Referral and Assessment Unit were received from Concord municipality). (See Chapter IV). Whether or not there were situations in that municipality which needed a more specialised or 'professional' set of skills can only be speculated upon, although on at least two occasions there was some indication that there might be hidden problems remaining unresolved.

The Meals on Wheels co-ordinator in Drummoyne, on the other hand, generated the greatest number of referrals coming from a community service. (See Table 4.6) These, in turn, led to contact with General Practitioners in that area, resulting in a comparatively high and appropriate use of the assessment service.

In their search for people prepared to offer a monitoring/maintenance service (and also to provide occasional human contact) in Area 5, team members found that the only worker whose role might reasonably include such an activity was a psychiatrically trained nurse with the Five Dock Mental Health Team. (There was no generalist adult community health team in Area 5.) Experience indicated however, that the worker soon discontinued contact, stating that there was 'nothing he could do for' the referred person. A similar response was received from the Community Nurses with the Croydon Community Rehabilitation Service when requests were made for a resumption of follow-up visits to people previously known to that service.

A generally held view seemed to be that such a 'passive' form of contact should be maintained by volunteers, but, as has been shown in the Burwood model, numbers of attempts to utilise an advertised service of voluntary home visiting met with little success. Team members believe that, while some volunteers may be prepared to commit themselves to a regular long term pattern of visiting (something which is essential to old people whose contacts are limited), this cannot be a requirement of a voluntary service. There is also a need for any such visitor to develop acuity of observation and to have some understanding of the implication of what he or she is seeing, so that 'professional' help can be called in appropriately.

Weiss et al (1985) reporting on San Francisco's Project OPEN, writes of the referral to and use of services

> Once participants have settled into the services and been placed on an inactive status, a client monitoring process by a paraprofessional would detect any significant change or problem in receipt of service. Should such a change be detected, the client would be placed again on an active status. (1985:23)

That the problem of over-professionalisation is not confined to urban Sydney is demonstrated by an article in **The Lancet** (Hopkins, 1984) entitled 'Practical Help". Hopkins suggests that there is a need for 'a new type of caring and rehabilitation worker' who should be trained for 'no more than one year .... in the essential aspects of practical help'. Hopkins offers a 'Suggested Curriculum for Diploma in Health and Social Skills' covering 30 weeks x 30 hours per week.

The view held by the team is that the maintenance of human contact and the need for monitoring is of such importance in the drive to support at-risk elderly people in the community that discussion of this role could be used in the training of the 'caring professionals' to introduce to students the reality of life for the very old. Such an understanding would of itself raise the value of this form of contact to a worthwhile activity in the context of work with aged people. The need for the introduction of yet another level of sub-professional training would thus be obviated.

The composition of the Aged Referral and Assessment Unit brought together three professions, each with an area of particular expertise, but having in common an appreciation of the interests and needs of elderly people. This allowed for face-to-face contact to occur with one team member only, while input was available from an inter-disciplinary team, thus permitting a

blurring of professional boundaries in providing the most comprehensive assessment/service possible.

Institution v's Community

It needs to be recognised that the existing system of aged care exerts a 'natural' pull towards institutionalisation. Funding arrangements by which for-profit nursing homes have been directly subsidised from Federal moneys, while community services (with the exception of Meals on Wheels) have had to compete for limited State funds, have affected this situation. In New South Wales, in particular, these arrangements led (during the 1970's) to a burgeoning of the nursing home industry, while at the same time the community services battled over territorial boundaries of service provision, each jealously guarding the interests of his/her particular agency and jockeying for security of funding.

In such a climate, the servicing of client needs becomes incidental - particularly when those clients are very old, often frail and/or immobilised and sometimes confused.

The experience of the Aged Referral and Assessment Unit has been that the inevitability of nursing home placement hangs like a black cloud over the lives of the 'old old'. One of the positive aspects of the work of the assessors has been to make elderly people and their carers/supporters aware of the mix of services/aids which could allow them to remain at home until all options were negated, e.g. by acute illness, or increasing dementia.

As has been stated in Chapter II (p.20) there were 58 nursing homes in Area 5. These varied in quality and in their suitability for the range of people requiring 24-hour care. Although the Aged Referral and Assessment Unit was primarily concerned with enabling people to remain in the community, team members have been responsible for some direct placements, and have been consulted when sick or debilitated people known to the Unit have gone to nursing homes directly from acute hospitals. Progressively more enquiries have been received from relatives living outside of Area 5 seeking information about nursing homes in the area and wanting accommodation. It is perhaps significant that in almost every case where there has been a need for an elderly person to move to a nursing home, a vacancy **suited to his/her needs** has been found within a matter of 2 or 3 days (if not hours). Does this indicate that the prevailing thrust towards community rather than institutional care is having an effect on nursing home bed usage?

'Double Dipping' - Nursing Homes/Community Care

The division between institutional and community care is not clear-cut, as some of the aged who are in nursing homes also have access to community services. In gathering information and providing an assessment service in Health Area 5, team members of the Aged Referral and Assessment Unit became aware of the significant level of use of community services by nursing home

residents. This was noted particularly in the case of acute hospitals, rehabilitation facilities, various social groups, and transport.

Acute Hospitals: The system of monitoring atendance at the Casualty Department of the Western Suburbs Hospital of people aged 70+ years yielded the following data over the four month period January, 1985 to April, 1985 (inclusive).

- Attendances of all people aged 70+ years totalled 560.
- Of the above attendances, 97 (17.32%) were from nursing homes.
- Of these nursing home residents, 41 (7.32%) were admitted to Western Suburbs Hospital; and 56 (10.0%) were discharged back into care of the nursing home, after treatment at Casualty.

Diagnoses varied, but included such conditions as "constipation", "dehydration", "urinary retention", "bowel obstruction", "change of catheter", "re-insertion of catheter"'. Added to this information, consideration should be given to the fact that a number of nursing homes in Area 5, were refusing to admit people fitted with either indwelling catheters or intra-gastric tubes.

Rehabilitation: During the initial visits to nursing homes it became apparent that the services of the Croydon Community Rehabilitation Service were providing treatment to a considerable number of their residents, many of whom were picked up and delivered back by Western Suburbs Hospital buses. Enquiries made to the team-leader of the Croydon Community Rehabilitation Service at that time brought an answer that 40 per cent of people attending for rehabilitation were nursing home residents. Later enquiries yielded the reply that 'a considerable proportion of patients' were from nursing homes.As there were sometimes waiting periods of up to eight weeks before applicants could receive service from the Croydon Community Rehabilitation Service, it would seem that greater encouragement should be given to private nursing homes to employ their own therapists, and greater emphasis should be placed on serving elderly people who. although suffering disabilities or functional limitation, are choosing to remain at home.

Social Groups: Many of the social groups functioning in Area 5 included representative groups from nursing homes. Again, these were often conveyed either by Western Suburbs Hospital buses or by community buses belonging to Councils. One such group in Burwood functioned exclusively for nursing home patients, and included people with quite severe physical handicaps. Besides the advantage of group pick-up arrangements, diversional therapists employed by nursing homes frequently accompanied their charges on these outings, and were therefore of assistance during group activities.

One large community centre in Ashfield received $30,000 per annum subsidy through the New South Wales Department of Health. It provided a great range of activities and transported people in its own buses. On Tuesdays and Wednesdays when its activities were targetted to the older age group, most of those attending were residents from nursing homes. This was also the case with activities for the elderly provided at Woodstock Community Centre in Burwood.

Transport: A number of the nursing homes visited by assessors had permanent bookings for Western Suburbs Hospital buses for day-outings on a monthly or two-monthly basis.

Thus considering the relative costs of nursing home care and care in the community it needs to be acknowledged that the cost to the state of nursing home care is not the total cost, because people resident in nursing homes are receiving a considerable amount of care which is now regarded as community care as distinct from nursing home care. No doubt this enhances the quality of life for the people who are in nursing homes, but because of these arrangements many people who are remaining in their own homes are excluded from these services.

These observations raise some questions as to:

(a) the level of care offered by some nursing homes - in particular whether there is an exclusion of 'treatment' from the care offered.

(b) the suitability of some nursing home placements

(c) rehabilitation v's maintenance

(d) the recognition of the social needs of the increasing number of at risk people who are remaining at home.

5.4 THE FEDERAL/STATE DIVISION OF RESPONSIBILITIES

As has been touched upon in 5.1, care of the aged has been parcelled up under various pieces of legislation (some Federal, some State) and various funding arrangements. Such fragmentation has led to arguments and 'game-playing' between levels of government and to competition between agencies and organisation for scarce funds.

Irrespective of the source of the enabling legislation, up to the present Federal government departments have directly administered very few programs. Even where direct responsibility has remained with Federal departments (e.g. in vetting N.H. 5's for admission to nursing homes, in subsidising delivered meals, or in administering the Domiciliary Nursing Care Benefit), the attention given to this issue in the past has been of such low priority that anomalies have occurred, which, with the demographic changes, have become major barriers to be overcome if any form of integrated service is to be available to elderly people. Examples of this are the nursing home industry where subsidies paid by the Federal government have supported the burgeoning of private 'for profit' nursing homes in New South Wales. Delivered meals have received direct subsidies from the Federal government with an almost total lack of accountability for the service provided (Smith, 1984). In New South Wales this has led to a form of anarchy, with a proliferation of autonomous Meals on Wheels services across the State, with differing standards, costs and delivery arrangements. In some instances this has permitted local power-play to affect decisions about who may, and who may not, receive meals. Requirements for the payment of Domiciliary Nursing Care

Benefit have meant that in some cases (particularly in the country) carers have been forced to pay commercial market rates for supervisory visits from trained nurses. When these visits were required at fortnightly intervals, this reduced the $42 per fortnight benefit by the $8+ cost of the visiting nurse. Under pressure, the government has now agreed that in certain cases visits can occur at 3 monthly intervals.

In most cases, even where the enabling legislation is from the Federal Government, programs have been administered (and funded) through State organisations. In some instances there is a requirement for cost-sharing involving matched Federal and State grants. All of these arrangements have allowed politicking between various Departments, State and Federal, and have led to cynicism at the level of service provision.

Outcomes of Federal/State and departmental rivalries are sometimes reflected at service provision level. The 'health/welfare' tussle for the 'ownership' of the aged and disabled has, in New South Wales, resulted in a denial of the health components of the ageing process by some 'non-health' policy-makers; while the view taken by some members of the medical profession that 'diagnosis and treatment' could provide a panacea for all 'ills' besetting elderly people who struggle to avoid nursing home placement is equally unhelpfully one-dimensional. The fragmentation of services, and the confusing number of 'feet up the garden path' have arisen, in part, from the unwillingness of the helping professions to take a holistic view of each elderly person in the context of his/her life, and to co-ordinate a mix of services which will be both meaningful to that person, and will also, as far as is possible, enhance the quality of life he or she is to experience.

5.5 THE ROLE OF AGED REFERRAL AND ASSESSMENT UNITS

The findings and observations derived from the experience of the Aged Referral and Assessment Unit and recorded in this report indicate clearly a number of problem areas in the provision of community services for the aged. The difficulties inherent in developing a co-ordinated response which would effectively meet the needs of the aged population are evident at all levels of service provision; in the Federal/State division of responsibilities, in the administrative apparatus, and in service delivery at a local level.

It is appropriate to note that many of the issues recognised by the team members of the Aged Referral and Assessment Unit have been previously identified in research literature. This suggests that while some problems which the Unit encountered in fulfilling its brief had their source in Area 5, there were also other factors of more universal character which had been recognised elsewhere, such as:

- the destructive effect on the quality and cohesion of service delivery of the health/welfare conflict (Bowman, 1985, p.107; Keens et al 1983, p.30), and of professional and teritorial jealousies.

- the lack of accountability of some services, e.g. Meals and Wheels, and the lack of this requirement by funding bodies (Randall Smith, 1984).

- the need for paraprofessional monitoring of at risk elderly people who suffer mobility problems of either a physical or emotional nature. (Weiss et al, 1985, p.13 and Hopkins, 1984 p.1393).

- the politicisation of the provision of health and welfare services (Sinnett, 1982) leading to periods of service restriction (Doctors' strike 1984/85; action of Home Care Service of New South Wales in November, 1984) which adversely affect vulnerable sections of the community.

However, there are other areas, which have received little attention in research literature but have been identified by the Aged Referral and Assessment Unit Team as issues of considerable concern, e.g.:

- the negative aspects of life for isolated, incapacitated, elderly people who do not choose (and are now being actively discouraged) to enter nursing homes. Books such as **We Can Manage** (Day, 1985) address themselves to people with well developed coping mechanisms, or external support (social/financial) which reduce their level of vulnerability, but little is written about lives made barren by physical and social limitations.

- clinical information as to numbers of physical and functional limitations, number of acute episodes requiring hospitalisation in given time, etc. (Kendig et al, 1983) do not necessarily convey a comprehensive picture of a way of life.

- recognition of the effect on support networks of the very real risk involved in maintaining frail and/or confused elderly people in their homes, and the difficulties encountered in (a) convincing them that they are no longer able to care for themselves when this is patently so and the risk factor can no longer be sustained, or (b) convincing family members, neighbours etc. that there are few alternatives open other than (a), and coping with the resulting feelings of guilt.

The importance of local issues has been emphasised in various sections of this report and is also illustrated by the case studies in Appendix VI.

The role of assessment teams as a central point of contact for any person - the aged person, relative, or worker - wanting high quality care, advice or information about services for the aged has been noted by Kendig (1983, p.172). However, confusion has arisen out of some research, and particularly from Ministerial statements as to the role of assessment teams, and this was reflected in the brief of the Aged Referral and Assessment Unit.

While the majority of writers and speakers have suggested that multi-disciplinary teams should make holistic assessments of individuals living in the community, and refer them to an appropriate mix of services, others have seen such teams as accepting **all** referrals (including service-specific referrals), within a given area, visiting, assessing, and making decisions as to the nature of services to be given, e.g. that a nurse should call on Mondays and Thursdays to bath a patient, or that a home aide should clean the kitchen and bathroom only. Inevitably this has threatened the autonomy of service-providers and has contributed to tensions surrounding this, and other projects.

The actual **process of assessment** has received little attention in the literature, John Hemer's article (1983) being an exception. Hemer writes of the need for sensitivity and flexibility in tackling the varied circumstances and range of needs of individual elderly people. Because of the sensitive nature of the assessment process, requiring, as it does, the imparting by individuals being assessed of information which reveals degrees of vulnerability (where this must affect decisions for the future), and about family or neighbourhood relationships, the assessor inevitably becomes a reference person for aged individuals themselves and their support networks at a time of disequilibrium. Hemer also recognises the fact that assessment is frequently called for in times of crisis and that the 'normal ground rules prevailing in respect of this elderly person's functioning may not prevail'. He suggests that adequate decisions cannot be made in such circumstances. The Aged Referral and Assessment Unit's assessors have found that assessment visits undertaken under conditions such as these invariably resulted in short term casework with not only the focal person, but also with family and support networks. This is a view supported by Hemer in his statement that assessment can never be a 'once off' action. Appropriate referrals must be the outcome of an ongoing assessment process.

One of the main problems recognised by the team members of the Aged Referral and Assessment Unit in the early stage of the Unit's operation was that the sectional interests of 'health' and 'welfare' were a divisive force in an already confused and fragmented scene. For this reason, the Aged Referral and Assessment Unit team members have tried to be consistent in their assertion that a holistic view must be taken of each individual situation in order for the needs of elderly people to be effectively met - either from their own resources when they have been made aware of all relevant options, or from the services or mix of services available in the community.

In contact with both community workers and with planners and policy-makers, unit members have stressed the need for looking at elderly people holistically - breaking down the notion that their needs can be packaged under 'Health' or 'Welfare' or in service provision boxes. This was done in the hope that such a view should inevitably lead to co-operation between workers and the development of feed-back systems which allow for co-ordinated service-provision.

The unique position of the Aged Referral and Assessment Unit in bridging the interests of health and welfare and having no service provision attachments, has allowed the team members to adopt an educational role in relation to the process of assessment, to the needs of those being assessed, and to the community services referring and being referred to other sources.

The notion of a holistic assessment as practised by this team also needed to be explained - to general practitioners, to community and hospital workers, and to elderly people in the community (including those whose English was limited). In this latter process the varying roles of occupational therapists, community nurses (as opposed to 'hands on' home nurses), and social workers have also been outlined.

Team members have seen as of particular importance the representation of the reality and interests of the very old, frail and isolated living in the community. The limitations suffered by many such people mean that their role

is a passive one, and they are often overlooked by workers, both paid and voluntary. Demographic trends, allied with current government policy, suggest that there will be a growing number of these people, and their needs must be recognised if the quality of their lives is to be maintained - if 'community care' is not to become a cheap form of community neglect.

CHAPTER VI

FEASIBILITY OF CENTRAL REFERRAL AND ASSESSMENT UNITS

6.1 SOME CONSIDERATIONS TO BE ADDRESSED

The experience of the Aged Referral and Assessment Unit examined in this report raises a number of questions concerning the place and function of such units in the provision of community-based care of the aged population. Given the complexity of existing services for the aged in urban settings and the host of issues discussed earlier (Chapter V), questions arise as to the role of assessment units, the mode of operation, appropriate size of the area/population to be served, and, above all, the necessary prerequisites which would make an effective operation of such units feasible. In the light of the Unit's experience, these issues do not seem to have received adequate consideration in the assumptions on which the assessment units were to be formed.

The experience of one pilot project such as that described in this report cannot be regarded as adequate for the drawing of inferences which might be assumed to be universally applicable. Two major qualifications which need to be made are related to the characteristics of time and place: specific features of Area 5 of the Southern Metropolitan Region of the New South Wales Department of Health; and provision of aged services in New South Wales, which has characteristics that are not necessarily the same as in the other States. However, as indicated throughout this report, and particularly in Chapter V, many issues and problems encountered by the A.R. & A.U. have been observed elsewhere, and this is evident from the research literature in Australia as well as overseas.

The project examined in this report was required to 'demonstrate the advantage of maintaining a central referral agency for a variety of discrete domiciliary support services (Home Care - Home Nursing - Red Cross _ Paramedical Services - Delivered Meals - Social Activities - Counselling - etc.) over the traditional autonomous referral systems in terms of prescription and provision of the mix of services appropriate to client needs'. However, at the time of the appointment of the team (consisting of three assessors and one clerical worker) no prior consultation had occurred to gauge the willingness of local service providers to co-operate in such a feasibility study, and no consideration appeared to have been given to established (sometimes State-wide, as in the case of Home Care Service of New South Wales) policies of relevant centrally organised bodies. It was therefore not known what reaction would come from services which had an established mode of operation.

In order for a 'central referral agency' to operate within the terms as described, an undertaking would need to have been secured that all referrals received by individual services in a given area would be diverted to such a central unit for assessment and appropriate outgoing referral or action. The value to be achieved from such a change in referral processes should arise from the differences inherent in two models of assessment.

Assessment may be **needs-based and holistic** (as was adopted by this team under its alternative model;see Foreword; Chapter V) or **service-specific,** i.e. the needs of the referred individual are to be seen within the context of a particular service as was suggested by the brief. In the first case the elderly individual is assessed in the context of his or her living situation, with as many factors as appropriate taken into account. As has been shown in the discussion of the data collected, in more than 50 per cent of the cases seen, no community services had been involved prior to assessment, and referrals to formal community services were made as an immediate consequence of assessment in less than 20 per cent of the cases. These figures suggest that in a significant number of cases, community services as presently provided are not what is needed by very old frail and vulnerable people and their support networks. It is therefore suggested that if a referral and assessment unit is (among its many functions) to identify 'unmet' needs of the aged population, its assessments would have to begin with the perception (either self-perception or the perception of the referrer) of a **need,** which can then be considered objectively within the context of the referred person's living situation by an experienced 'outside' observer. The manner in which those needs can be met, is the second step in the process of identification and problem solving. This is the essence of a **needs-based service,** and, it may be argued, should be an essential feature of any community-based service provision. Predictably, such an orientation will lead to certain tensions in the existing services, as it will entail a re-assessment of policies, and modes of operation as well as a potential curtailment or containment of organisational autonomy.

6.2 REFERRALS AND ASSESSMENTS

The feasibility of directing all aged-related referrals to a central information and advisory centre which also offers holistic assessment, is related to, and dependent upon, such factors as the size of the area and the population which would be covered by the referral and assessment unit.

In the press statement made by Senators Grimes, Giezelt and Dr. Blewett in August, 1983, it was stated that assessment by a multi-disciplinary team 'would be a pre-condition for aged persons receiving future admission to nursing home care or for receiving community care in their home or hostel'. This does not seem to be congruent with the notion of comparatively small teams of professional people serving a population of between 20,000 and 25,000 aged 65+ years (the Department of Health planning unit equals 200,000 - 250,000 people with an average 10% aged 65 and above). The numbers of individual (self, worker, medical) referrals reaching all community services in over, say, one month, would mean that the team would be pre-occupied with assessing those people who knew about, or are known to, established community services (only 8 per cent of those aged 65 and above are currently receiving one or more community service), and there would be little time left for contact with the remaining majority, some of who may require a general assessment out of the context of specific service requirements (such referrals in the experience of the A.R & A.U. coming more frequently from General Practitioners, hospitals or informal support networks).

Early in the funded life of the A.R.& A.U. it became evident that whilst referrals received by the community services were **not** being directed to the Unit, and were therefore assessed within a **service-based** model, the Unit **was** receiving referrals for holistic assessment which was **needs-based** from a number of sources. In order to test the feasibility of a central referral agency it seemed necessary to ascertain the numbers of referrals being handled by community services in the traditional manner. Tensions existing during the first months of operation did not allow for requests to be made for referral statistics; however, the number of agencies and workers (government, non-government, and voluntary) across the five municipalities suggested that the referral numbers involved would render their assessment by a 3-member team to be an unrealistic expectation.

(In the last months of the Unit's operation the following figures were obtained (Table 6.1):

TABLE 6.1 AVERAGE NUMBER OF REFERRALS (PER MONTH) TO THREE MAIN SERVICES

Service	Referrals per Month
Sydney Home Nursing Service	
Western Suburbs Branch *	85
Home Care Service of N.S.W.	
Burwood Branch	31
Ashfield/Drummoyne	30
Meals on Wheels	
All five branches	40
Total	186

* Two nurses from the Lewisham Branch cover part of Area 5 (Drummoyne), but figures have not been obtained from that branch.

Allowing for the fact that some of these would be referrals in common, it can be seen that referrals from **these three services only** would require assessments numbering in the region of 100 to 150 per month. It needs to be noted that only 26 (21.7 per cent) of the referrals received by the project until end of May 1985 came from Community Services (which included the above three organisations). Whether **needs-based** assessment would have inflated or reduced the numbers of referrals to community services could not be established within the prevailing conditions.

6.3 CO-ORDINATION AND INTEGRATION OF SERVICES

Regional assessment teams are seen in the literature as a focal point for the co-ordination of all services for the aged in a prescribed area, leading, hopefully, to more integrated service provision.

As has been established previously (Chapter II), any attempt at co-ordination and integration in Area 5 was complicated by the make-up of the Area, with five small muncipalities, each (potentially) employing a Welfare Officer for the Aged **to work within its municipal boundaries,** but also with policy direction from the Aged Services Policy Unit of the Department of Youth and Community Services. Each council area had its own antonomous Meals on Wheels organisation. Two Home Care Branches accepted responsibility for three and two municipal areas respectively, while Home Nursing was provided from two Sydney Home Nursing Service Branches (one of which was located outside of the area), as well as by nurses employed by and working in two of the councils. The Inner Western Suburbs Area Health Board was responsible for a range of health services across the whole of Area 5. It seems unlikely that many assessment teams would be faced with such a 'busy' and complex scenario.

Another aspect of co-ordination and integration occurs at the inter-face of service delivery and has received little attention in the literature, although it is an extremely important component of effective community work. This is the informal interaction which occurs among individual workers. In cases where elderly people in the community are receiving services from a number of workers, networking and feedback mechanisms need to develop in order for each person to receive the best and most appropriate service. Any impediment to this flow of goodwill and exchange tends to reduce the quality of the mix of services as they are experienced by the recipient person. To an extent such informal interaction can be a countervailing force to the rigidity and complexity of organisational arrangements.

New South Wales Context

Service Co-ordination and integration in a given urban region in New South Wales, which includes numbers of local government areas and service provision by both centrally and locally organised government and non-government agencies, is a major undertaking. Ideally such a task should include time spent both in negotiating with organisations at State and local levels, and in delicate mediation at the interface of service delivery.

It is hoped that the implementation of the Home and Community Care Program will overcome divisions and competition which existed at the time of the operation of the A.R. & A.U. between State Government Departments, and centrally organised service bodies for 'ownership' of the welfare of the aged. As shown elsewhere in this report, these divisions arose from fragmented legislation and administrative practices, and inevitably had an effect on policy formulation and attitudes adopted at the level of local service provision.

With the binding of all relevant legislation into a single Federal Act, and with administrative responsibilities at State level clearly defined, some anomalies should be overcome and the stage set for a more co-ordinated approach.

However, during the period examined in this report, the denial of the importance of the health component in the lives of old people by representatives at State level of two of the major service providers, and the insistence by the Home Care Service that its service-specific assessment adequately covered all aspects of functioning, were factors which needed to be overcome if a useful mix of services was to be provided to individual elderly people. (It needs to be noted here that sustained contact with the Y.A.C.S. Aged Services Policy Unit led to an appreciation by that Unit of the central role played by G.P.'s in the lives of many elderly people, and, presumably of the need for any assessment unit to have an understanding of health-related and medical matters.)

Local Responses - Area 5

In Area 5 responsibility for acute hospital care, clinical services/community health, and rehabilitation was administered by an Area Health Board, with a peripheral contribution in the case of rehabilitation from a State-funded but independently administered Schedule III hospital, and a developing contribution from the Aged and Extended Care Department of the Concord Repatriation General Hospital (Department of Veterans' Affairs). At a local level, policy decisions which were beyond the scope of the Area Health Board had to be submitted to the Southern Metropolitan Regional Office of the New South Wales Department of Health for consideration, ratification or authorisation. Some policy decisions would also be made at State level, i.e. at the Head Office of the New South Wales Department of Health. The area Health Board accepted administrative responsibility for the Aged Referral and Assessment Unit, and gave support to the project as a regional (Area 5) undertaking.

As has been pointed out previously, one health-related service was administered from a central executive - the Sydney Home Nursing Service - but working relationships were quickly established with this pivotal community service. Other contacts were made with local agencies and workers during the information gathering stage of the A.R. & A.U.'s operation.

Immediate responses to the introduction of the Unit varied from wait-and-see reticence, through scepticism, to both covert and overt opposition. The

chances of the A.R. & A.U acting as a focal point for co-ordination did not appear to be good, but team members decided to work through the group of Burwood workers with the aged which was re-convened in August, 1984. With encouragement from other community health workers this was extended to cover representatives from the whole of Area 5, and was formalised under the name of the Inner West Aged Services (I.W.A.S.) Task Group, with monthly meetings, chaired by a volunteer worker from Strathfield.

Attendance at meetings varied, but usually included Council Welfare Workers for four of the five municipalities, Meals on Wheels convenors or committee members, Red Cross Worker, representatives from the Combined Pensioners Association, Burwood Home Library Service convenors, co-ordinator of Burwood Home Care Branch, a representative from the Royal Blind Society, health workers from the Western Suburbs Hospital, the Croydon Community Rehabilitation Service and the Five Dock Mental Health team as well as the Ethnic Aged Health Worker whose project paralleled that of the Aged Referral and Assessment Unit.

The two team members who attended the I.W.A.S. Task Group brought to the meetings relevant information in terms of demographic data, listings of agencies and General Practitioners, reports of conferences and seminars attended, and organisational information which had come to the notice of the Unit. Team members encouraged the identification of service gaps and have convened and/or contributed to working parties formed to address the gaps identified. With consistent emphasis by team members on the well-being of the elderly people in the community rather than on shortcomings of established services, an appreciation gradually developed of the neutral and holistic position which Unit members took in their overview of service provision and the well-being of individual aged people.

The Inner West Aged Services Task Group is now the focus of planning and submission writing for Home and Community Care Program and is considering incorporation as the means to administer projects which may be funded under the H.A.C.C. program, and which cross council boundaries and require a health/welfare orientation.

6.4 ISSUES RELATING TO AUTHORITY, ACCOUNTABILITY AND ATTACHMENT

Other issues which have not been explored elsewhere in this report concern the legal basis for a referral and assessment unit, and therefore the authority with which such a unit would operate.

Bound into this issue is the question of the point of such a unit's attachment and the organisational focus of its accountability.

A unit which offers holistic assessment must have the freedom (and the capacity) to move into the reality of the living environment of the people it is assessing - its ability to do this will come from its acceptance by the client group. But it will also need the capacity to activate such services as it sees to be appropriate. This presumes a willingness in service-providing bodies to accept the Unit's assessments and act on them. The

'neutral' position of such a unit in overviewing service provision and relating needs to gaps in services also assumes an autonomy to which neither community workers nor bureaucratic organisations are typically accustomed. Even the information and educational role inherent in the model of an autonomous and 'neutral' unit suggests an unequal power relationship with other community workers and a mutual acceptance of respective roles.

In practical terms, the attachment of a small community team to a regionally administered body e.g. Area Health Board or a State Welfare Department would have advantages in its access to physical amenities, e.g. typewriters, copy-machines etc. but these may be outweighed if the independence of such a team is seen as challenging the established structural order. (This did not occur in the case under review, but this may have been related to the short term nature of the project).

With the hoped-for devolution of conflict between welfare and health as an outcome of the implementation of the Home and Community Care Program, there remains another, and growing, group of workers with a major stake in aged care - the geriatricians. From the data recorded in Chapter IV it will be seen that G.P.'s were the source of almost a quarter (24.2%) of referrals received by the A.R. & A.U. Most of these referrals came with an acknowledgement that needs were evident and/or factors were at work in the lives of patients with which the G.P. was not equipped to deal. Many of the G.P.'s had minimal knowledge of the range of community services available, and did not understand the informal (usually local) system of worker-interaction which plays such an important part in service provision. It seems unlikely that further **medical** training and specialisation would **broaden** the knowledge base of people working in this field, while it may render them less willing to acknowledge such deficits. (See Bowman: 1985, quoted p.11 in this report).

Ideally a community-based assessment team would work in tandem with, but independent of, hospital-based Geriatric Assessment Units, with each respecting, acknowledging and utilising the particular skills and knowledge resources of the other, to the advantage of those elderly people who are seeking some form of information, support or assistance.

Community-based assessment teams might also be made accountable to local management committees consisting of residents, service-providers etc. in whom authority would be vested by the funding body. Difficulties which were experienced by the A.R. & A.U. with its Steering Committee arose partly because of the historical background to the project, but also because the model was evolving during the twelve months of the Committee's functioning. With clearer guidelines and a general understanding of the roles to be fulfilled by community-based assessment teams some of these problems need not be inevitable.

6.5 CONCLUSIONS: AN ALTERNATIVE WORKING MODEL

As mentioned in the Foreword to this report, the model of operation adopted by the Aged Referral and Assessment Unit had many features of the concept

described by Kendig in the report of the Ageing and the Family Project of the Australian National University (1983). This model suggests community-based teams with knowledge of, and access to, all community services in a given area, and also such services located outside of the area which impinge upon the lives of elderly residents. Such access would include specialist geriatric care both outpatient and inpatient, which, in line with current thinking, can be interpreted as a Geriatric Assessment Unit, or an Aged and Extended Care Department, such as is being developed at Concord Repatriation General Hospital.

The prerequisites for the establishment of such teams and their modes of operation are outlined in detail in Appendix VIII.

Community-based regional teams would need to be established in accessible centrally-located positions, offering a point of first contact for aged individuals their support networks, or agencies seeking information and advice about the needs of, and services for, aged people.

Such central referral units would need to be staffed by multi-disciplinary teams with knowledge, skills and sensitivity to respond to enquiries regarding the interests of aged people (including those from non-English speaking backgrounds), to provide home assessment when indicated, and to refer as appropriate. Teams would therefore need knowledge of, and have access to, the full range of medical and non-medical services (including organisations, services and agencies relevant to particular ethnic groups. In areas with high numbers of non-Anglo aged people, the attachment to the unit of an Ethnic Aged Health Worker would be mutually advantageous). The activities of such teams would perhaps go some way towards overcoming the frequently identified mismatch between the needs of individuals and services provided, and the unwillingness or inability of organisations providing those services to acknowledge limitations and work co-operately with a focus on the needs of elderly individuals/groups rather than on territorial imperatives.

Such units should not be established without prior consultation between relevant government bodies such as the Department of Community Services and State Government Departments which are concerned with the administration of the Home and Community Care Program. Consultation should also occur with central bodies which are concerned with service delivery at local level e.g. Sydney Home Nursing Service and the Home Care Service of New South Wales. Discussion would also need to occur with local providers of community services so that the establishment of a unit can be seen as advantageous rather than threatening.

The recommendations of community-based assessment teams should be accepted in the granting or withholding of services, such as delivered meals; and in Supporting N.H.5.'s (approval to enter nursing homes) in conjunction with local General Practitioners or Geriatricians.

The detached position ideally held by the teams would allow for a neutrality which would bridge the division between health and welfare. Their regional status would also remove them from the political boundaries of local government and would allow for an overview of services and activities which could be valuable in data-collection and planning for co-ordination and integration of service delivery. The teams would therefore have the benefit

of daily contact with elderly people both in their homes and in various forms of residential care, while at the same time being in a position to collect and feed regional information to planners and policy formulators.

With the thrust towards supporting the determination of frail aged people to remain home, recognition would need to be given to the quality of life they are to experience. Limited mobility and diminishing social networks may lead to isolation, lack of stimulation, and reduced confidence and self-esteem. There are also physical risks to be considered.

In the light of the above there is a need for empathic workers with sufficient training and experience to provide maintenance/monitoring brief for at-risk elderly people who remain in the community; such a brief to allow for flexibility of time allocation and support variation to respond to individual requirements. Points of attachment for such workers would best be multi-disciplinary teams (either assessment teams or community rehabilitation teams) who can offer consultancy as required.

In consideration of the high risk factors governing the lives of some frail and disabled old people, the major services, while allowing for long term support, would also need to provide immediate assistance in times of crisis. Such support is often short-term in nature, and can be crucial in permitting elderly people to continue in known surroundings at times of greatest vulnerability.

APPENDIX I:

THE PROJECT'S BRIEF FROM

THE DEPARTMENT OF HEALTH, N.S.W.

NAME OF PROJECT

INTERDEPARTMENTAL/INTERAGENCY ASSESSMENT AND REFERRAL SERVICES FOR AGED AND DISABLED RESIDENTS OF FIVE (5) LGA'S IN METROPOLITAN SYDNEY.

AIM

The evaluation of a pilot project which it is hoped will demonstrate the advantage of maintaining a central referral agency for a variety of discrete domiciliary support services (Home Care - Home Nursing - Red Cross - Paramedical Services - Delivered Meals - Social Activities - Counselling - etc) over the traditional autonomous referral systems in terms of prescription and provision of the mix of services appropriate to client need.

BACKGROUND

This pilot proposal was prepared by a group of service providers working in the Burwood Municipality for a variety of home support agencies. They have hypothesised that through the medium of a central referral agency, duplication of assessment mechanisms will be eliminated, comprehensive care plans more easily formulated, service provision better co-ordinated and service shortfall quickly identified.

As an advocacy group they would be able to identify problems, collate data and act as advisers and catalysts to planners of health/welfare programmes for the disadvantaged in their community.

METHODOLOGY

1. All referrals of potential clients for one or more services defined as domiciliary supportive be directed to a single agency located in a central position in the community, viz., community house or local hospital campus or other suitable environment.

2. Assessment made on the basis of comprehensive evaluation of clients' true needs rather than for the purpose of meeting the criteria of a single service or support agency.

3. Referral to the mix of services defined by assessor as most appropriate to meeting those needs.

4. Monitoring, reassessment and reshaping of treatment plan as deemed appropriate with maximum intervals between assessment of three months.

Administration of this project will be through a local representative advisory committee to the Regional Geriatric Service based at the Western Suburbs Hospital.

EVALUATION

The client record system to be introduced will -

. identify stated need of client;

. identify actual need of client as assessed;

. identify range of services provided.

Data analysis will reveal -

1. What ratio of clients were assessed as requiring a greater mix of service than was identified on the original referral (validation of Central Referral Agency hypothesis).

2. What ratio of clients could not receive full range of services assessed as necessary (quantitative identification of deficits in service provision).

3. Primary reasons for such deficits -

   . Lack of financial resources.

   . Unavailability of professional staff.

   . Unavailability of volunteers (Meals On Wheels).

   . Other.

APPENDIX II: AGENCY SCHEDULE

1. NAME OF AGENCY _____ TEL. NO. _____

2. ADDRESS _____

_____ POST CODE _____

3. CONTACT PERSON _____

POSITION/OCC. _____

4. FUNDING - PRIMARY _____ OTHER _____

5. TYPE OF SERVICE(S) PROVIDED _____

_____

_____

_____

6. DAYS/HOURS WHEN SERVICES AVAILABLE _____

_____

_____

7. TRANSPORT ARRANGEMENTS _____

8. ACCESSIBILITY _____

9. TOILET _____

10. LANGUAGES SPOKEN _____

11. NO. OF E.S.L. PEOPLE SEEN _____

(ENGLISH SECOND LANGUAGE)

12. CATEGORIES/LIMITATIONS _____

_____

_____

REFERRAL SYSTEM

13. AVERAGE NO. NEW REFERRALS PER MONTH _____

14. SOURCES OF REFERRALS _____

_____

_____

_____

15. REFERRALS OUT _____

_____

_____

_____

16. SERVICES THE AGENCY WOULD LIKE TO PROVIDE, I.E., NEEDS RECOGNISED BUT NOT MET _____

_____

_____

_____

REASON _____

_____

_____

OTHER COMMENTS _____

_____

_____

_____

APPENDIX III: RESIDENTIAL CARE SCHEDULE

Code	Quest. No.	
	1.	DATE VISITED: ----------
	2.	NAME OF NURSING HOME:----------
	3.	ADDRESS: ----------
	4.	CONTACT PERSON: ---------- Position ----------
	5.	FUNDING: Deficit Funded ☐ Private ☐
	6.	NUMBER OF BEDS — Patients Contribution
		Single Rooms ☐ $ Per Fortnight
		2 to a Room ☐ $
		3 to a Room ☐ $
		4 to a Room ☐ $
		5 to a Room ☐ $
		6 to a Room ☐ $
		Male Female
	7.	NO OF LEVELS: ----------
	8.	DAY ROOM: YES / NO
	9.	DINING ROOM: YES / NO
	10.	PATIENTS ROOMS:
		Light: Sunny & Bright / Satisfactory / Dark
		Cleanliness: Good / Satisfactory / Problematic
		Wardrobe Space: Good / Satisfactory / Problematic
		Heating/Cooling: Airconditioned: Reverse Cycle / Heated Only
		Electric Heaters / Overhead Fans
		Bathrooms: Easy access for Wheelchair
		Decor:
	11.	EXTRA SERVICES:
		(1) Diversional Therapist ☐ (2) Pysiotherapist ☐
		(3) Podiatrist ☐ (4) Hairdressing ☐
		Cost to Patient: ----------

	12.	OUTINGS: ----------
		Frequency:
		Cost:
		Who Can Go:
	13.	ARE VOLUNTEERS ENCOURAGED TO HELP RUN PROGRAMMES: ----------
	14.	DO CHILDREN FROM LOCAL SCHOOLS VISIT, GIVE CONCERTS: ----------
		----------
	15.	ARE PETS ALLOWED: ----------
		If so what arrangements could or have been made ----------

Code	Quest. No.	
_____	16.	EQUIPMENT: _____
_____	17.	GARDENS: Accessible & Used by Patients: _____
_____	18.	REFERRAL SYSTEM: _____
_____		_____
_____	19.	WAITING LIST: _____
_____	20.	PERCENTAGE OF E.S.L. PATIENTS: _____
_____	21.	IS INTERPRETER SERVICE USED: _____
_____	22.	SERVICES NURSING HOMES WOULD LIKE TO PROVIDE: _____
		_____
		_____

WHAT WE CAN OFFER:

INFORMATION regarding all aged services in the five municipalities:

e.g. Community Support Services-
(Home Nursing
Home Care
Meals on Wheels)

Shopping Service
(Where available)

Friendly visiting

Friendship groups

RSL Day Clubs

Adult learning

Physical aids-
(PADP system)

Hearing aids

Dental

Spectacles

Nursing Homes

Hostels

Respite care

Legal Advice

Aged Referral & Assessment Unit

CROYDON HEALTH CENTRE

25 CROYDON AVENUE

CROYDON 2132

phone –

745-2118

HOME ASSESSMENTS-
ADVICE, COUNSELLING,
REFERRAL (FOR BOTH
THE INDIVIDUAL PERSON
AND HIS/HER RELATIVES)
TO ANY SERVICE
OR
MIX OF SERVICES
TO MEET THE SPECIFIC
NEEDS OF THE
OLDER PERSON.

AGED REFERRAL AND ASSESSMENT UNIT

phone
745-2118

Serves:

* ASHFIELD
* BURWOOD
* CONCORD
* DRUMMOYNE
* STRATHFIELD

Consists of:

* RUTH ERREY
(Social Worker)

* CAROLE BAKER
(Community Nurse)

* SARAH FOX
(Occupational Therapist

APPENDIX IV:

APPENDIX V: LETTER TO AREA 5 GENERAL PRACTITIONERS

Inner Western Suburbs
Community Health Services
Department of Health
Southern Metropolitan Region

AGED REFERRAL
AND
ASSESSMENT UNIT
745 2118

CO - ORDINATOR RUTH ERREY
ASSESSORS CAROLE BAKER
SARAH FOX
25 CROYDON AVENUE CROYDON 2132

26th October, 1984.

Dear Doctor,

Recently a small team was recruited through Inner Western Suburbs Area Health Board, (based at Croydon Community Health Centre) to look into the feasibility of establishing an Aged Referral and Assessment Unit in an area which includes Ashfield, Burwood, Concord, Drummoyne and Strathfield.

The Unit has three members, all of whom are experienced in working with and maintaining frail aged people in the community. Professionally the team consists of a Social Worker, an Occupational Therapist and a Community Nurse.

Also based at Western Suburbs Hospital is an Ethnic Health Worker whose concern is with making sure that non-Australian born aged people have information about and access to community services.

The Unit saw as its first priority the gaining of an overview of all services for the aged which are currently available in the area. This has included services offered by voluntary groups, and by both government and non-government agencies. It has also included both nursing homes and hostels.

With this knowledge, and using an Action Research model, we are offering assessments which would endeavour to establish the individual needs of the elderly person as observed in his or her home environment.

With the agreement of the person being assessed, referrals would then be made to the appropriate service or mix of services which would meet the identified needs.

We believe that general practitioners play an important role in the care of the elderly, and have frequent and ongoing contact. When it appears necessary for some outside help to be given in order to maintain the well-being and dignity of an older person, a phone call to this unit would activate an assessment visit and relevant referral.

A copy of the assessment report outlining the action taken would be sent to you.

....2

If the concept of a central referral and assessment agency interests you and you would like to meet a team member for discussion, please ring us on 745 2118 so that an appointment can be made.

Census data indicates that the number and proportions of non-English speaking elderly is increasing, particularly in the Inner Western Sydney area. Furthermore the telephone survey of doctors practising in this area shows that a large proportion of doctors speak languages other than English and we assume that, depending on the languages spoken by doctors, they would attract patients wishing to speak to them in their first language.

The Ethnic Health Worker (Ursula Schappi) would like an opportunity to explore with you possible means of improving the information flow to patients of non-English speaking origin. If you are happy to be contacted on this matter would you be good enough to telephone 747 5311 Ext. 342.

Yours sincerely,

Ruth Errey

Ruth Errey - Co-ordinator

APPENDIX VI

THREE CASE STUDIES

In the following case studies changes have been made to names and some personal details in the interests of confidentiality, while at the same time, demonstrating the diversity of factors needing to be considered in individual situations.

CASE STUDY - MRS JONES

The Council Aged Worker from Drummoyne Senior Citizens Centre asked the Community Nurse/Assessor to call on a 90 year old lady who (although living in Ashfield) had been attending the Drummoyne Centre for some years. The worker was concerned about Mrs Jones' ability to manage at home because of her current state of depression.

Previous History

Mrs. Jones' past experience had included a number of deaths of those closest to her, beginning with her first husband, who died within five years of their marriage, her son-in-law (the husband of the only child of her first marriage), and, later, her daughter and her own second husband, whom she nursed through terminal illnesses.

The house in which she lived alone had been bequeathed to the children of her second husband, with the understanding that Mrs. Jones had the right of occupation during her lifetime.

By attending the Drummoyne Senior Citizens Centre she had met, some years previously, a gentleman with whom she had interests in common, and they began to spend much of their time together. A few months prior to the time of this referral, Mrs. Jones' friend had collapsed and died in front of her as he was about to leave the house to meet a social engagement.

Since this time Mrs. Jones had found it increasingly difficult to face living - withdrawing from social groups and losing interest in maintaining her home.

The assessor made an appointment and called on Mrs Jones finding her with her bags packed ready to go to a nursing home. Her General Practitioner had completed the necessary forms (N.H.5), and forwarded these to the Federal Department of Health for approval.

She explained that her neighbours were very supportive but on both sides they planned to go away for the four day Easter break, and, at this time, i.e. two days before Easter, Mrs Jones felt unable to contemplate the coming isolation.

She appeared to be a mentally alert, spritely lady who was slightly deaf and walked with a stick - the latter as a consequence of arthritis.

The assessor explained the system of hostel respite care, and, with Mrs Jones' agreement, a vacancy was located in a local hostel, and she moved in for a six week holiday stay.

Some three weeks after going to the hostel she became depressed, complained of severe constipation and began to lose weight. Her General Practitioner ordered a Barium Enema. By unfortunate chance the radiologist who was consulted was the one who had attended Mrs. Jones' daughter during her final illness, and Mrs. Jones became convinced that she herself was harbouring a cancerous growth. Whilst waiting for her appointment, Mrs Jones became very dependent upon the hostel staff and it became necessary to consider nursing home placement. In her depressed state she also had difficulty in relating to other residents in the hostel. Fortunately the Barium Enema showed no malignancy. During the next two weeks of her stay she made friends, joined in the activities, and began eating well.

Prior to leaving the hostel, formal community supports were discussed. She had been receiving help with her showering in the hostel and felt that she had lost some of her confidence in climbing into the bath. Meals were a problem - but it was arranged for her to attend the Drummoyne Senior Citizens Centre twice weekly and on other days the Council Aged worker from that Centre would deliver a meal on his way home. The house had been cleaned by her grand-daughter who lived in a neighbouring suburb, and who also attended to her grandmother's personal laundry during her stay in the hostel, and agreed to continue to do so on her return home. One of her step-children visited Mrs Jones in the hostel - making the trip down from Newcastle for the purpose. Her other step-children live overseas. Weekend meals were arranged with a neighbour on a 'user-pays' basis.

The assessor visited one week after Mrs Jones left the hostel. She was sitting cleaning her silver. She had written letters to some of the hostel residents. She had found difficulty with showering and now asked for the help of the Sydney Home Nursing Service, which she had previously refused.

The situation was re-assessed one month later. Mrs Jones had discontinued the Home Nursing Service as the nurse tended to call to shower her in the afternoon. She now felt able to manage independently. She had entertained some of the hostel residents for tea at her house. The Drummoyne Council Aged worker had told her of his resignation, and she was so upset by this that she felt that she would be unable to attend the Centre after he left. However, she had joined the Combined Pensioners Association and arranged for transport to meetings.

With the changes occurring at the Drummoyne Senior Citizens Centre it was necessary for delivered meals to be arranged through the Ashfield Meals on Wheels service. The co-ordinator of this service advised that Mrs Jones would have to wait for two months before she could be included on a meal delivery run. For this reason, agreement was reached with all parties that the present arrangement with the Drummoyne Meals on Wheels would continue until the Council worker's leaving date (which was still uncertain). This worker had provided other forms of practical assistance such as help with

banking and minor repairs. In the recent past he had located a replacement when her refrigerator had given up.

All of this information was conveyed to her General Practitioner as it was anticipated that she would need support from all possible sources.

Mrs Jones was last re-assessed in July. At that time she was managing well. Her preference for the future was to return to the hostel (where she had experienced respite care) on a permanent basis. This hostel had closed its waiting list - currently taking new residents who had applied two to three years ago.

CASE STUDY - MISS THOMAS

Miss Thomas, a 72 year old ex-nursing sister, was referred to the Aged Referral and Assessment Unit by the Social Worker, Western Suburbs Hospital, in March, 1985. At that time she was a patient in the hospital with a diagnosis of self-neglect and general debilitation. Her short term memory was unreliable leading to disorientation and confusion. She owned a unit in Ashfield in which she lived alone. Her nearest relative, a nephew, lived at Penrith, an outer western suburb of Sydney.

Post-discharge assessment was required to gauge Miss Thomas' ability to manage daily activities.

Referral was to be made to community services appropriate to the outcome of this assessment.

The Occupational Therapist/assessor first visited Miss Thomas in hospital and arranged to make a post-discharge visit at home. Contact was also made with Miss Thomas' General Practitioner.

The assessor found Miss Thomas to be brighter in her own home. She acknowledged her memory limitations, for which she attempted to compensate by writing reminder lists - which she invariably forgot to discard after use, thereby contributing to her confusion.

The fact that Miss Thomas was a heavy smoker added to the risks involved.

The assessor arranged for a graduated activation of community services as each area of need became apparent. These included Meals on Wheels, weekly domestic assistance from the Home Care Service (this service also organised a laundry bag-wash on a 'user-pays' basis).

The Sydney Home Nursing Service was eventually called in to supervise showering and the administration of medication, providing also a linen service through Western Suburbs Hospital.

Despite the provision of a dosette box by the Sydney Home Nurse, Miss Thomas overdosed on some of her medication, and was re-admitted to Western Suburbs Hospital within six weeks.

She was transferred to a local nursing home four days later, without consultation with the Assessor from the A.R. & A.U. It was unfortunate that this nursing home did not allow smoking, as difficulties soon arose over Miss Thomas' propensity to go looking for cigarettes - either searching for shops, or stopping passers by.

A Visiting Medical Officer at the nursing home arranged for Miss Thomas to be transferred to Rozelle Hospital for a psycho-social assessment. A Magistrate's Hearing was held at Rozelle Hospital during the first week in June, and the Aged Referral and Assessment Unit assessor was called to give evidence. At this court Miss Thomas was ably represented by a solicitor (the Public Defender). The Magistrate ruled that there was insufficient evidence that Miss Thomas' dementia was of psychotic origin, and **she was immediately discharged home to her unit.** All community services were reactivated by the Aged Referral and Assessment assessor.

A neighbour who had previously offered limited supervision, now withdrew her support, saying that Miss Thomas was not fit to remain at home.

As a consequence of the care she had received, first at Western Suburbs Hospital, then at the nursing home, and finally at Rozelle Hospital, Miss Thomas' general condition had improved.

The Sydney Home Nurse saw her regularly and reported to the Aged Referral and Assessment Unit assessor at intervals.

In mid July Miss Thomas was assaulted by a bag-snatcher in the street in Ashfield and was brought back to her unit by the police, who had to go to the neighbour for a key to gain entry. The neighbour advised the Aged Referral and Assessment Unit, and, as the O.T./assessor was on vacation, it was decided in conference with the Sydney Home Nurse, that the latter would call to assess this new situation rather than introducing a new person at this time.

Miss Thomas was found to be badly bruised (from falling in the gutter), and by the following day was suffering pain and was unable to walk. She was brought by ambulance to Western Suburbs Hospital and was admitted.

During the time that Miss Thomas was in Rozelle Hospital, tentative plans had been made to transfer her to Bodington Red Cross Hospital at Wentworth Falls where she would have room to wander in safety and would be reasonably accessible to her nephew at Penrith. These plans were now reactivated by the co-ordinator of the Aged Referral and Assessment Unit, application forms were obtained, and enquiries made about possible vacancies, smoking restrictions etc. This was then discussed with Miss Thomas and with her nephew (by phone). The recent mugging had awakened Miss Thomas to her vulnerability, and she agreed that she was in need of 24 hour supervision, and was happy with the idea of Bodington Hospital. She signed the application form and within a matter of days was taken to Bodington Hospital by her nephew.

Case Study - Mrs Forbes

Mrs. Forbes, a 75 year old widow, had been referred to a Council Worker for the Aged by a group of concerned friends who were anxious about her well-being. The Council Social Worker visited Mrs. Forbes and made a referral to the Home Care Service for domestic assistance. A relieving Home Care assessor concerned, not only with the state of the house, but also with the well-being of this lady, called in to the Aged Referral and Assessment Unit to request a member of the team to make a comprehensive assessment.

The Community Nurse/assessor made the following observations:

1. Mrs Forbes was very confused and was disoriented as to time and place. She had lived in the house for 40 years, but spoke of it as new.

2. The house smelled of gas as a consequence of Mrs Forbes turning on gas jets but forgetting to light them.

3. Mrs Forbes had an old dog of whom she was extremely fond.

4. Her top dentures were broken and she had a few lower teeth which were loose and made chewing difficult.

5. The assessor found 40 bottles of tablets - many very old, and some belonging to the dog. Mrs Forbes was not taking drugs on any regular basis and her ankles were extremely oedematous.

6. She refused to contact her General Practitioner as he had previously asked her to sign an N.H.5 (Application for aproval for nursing home benefit purposes), and she was determined not to leave her dog.

7. She had no family. Husband had died five years ago and her son had been accidentally killed 20 years previously.

8. She had a group of very caring friends - 10 in all - who visited, took her out, attended to banking etc. Mrs Forbes sometimes found these attentions overwhelming as there were inconsistencies in their assistance and advice.

9. There were indications of poor personal hygiene - dirty clothes, lack of showering etc.

10. Meals were being delivered to her by her neighbour who was Council Worker with the Aged in another municipality. (Drummoyne)

As an outcome of assessment, the following action was taken:

1. Mrs Forbes nominated a rheumatology specialist who had treated her husband and a phone call was made to establish whether he was prepared to act as General Practitioner. He agreed. An appointment was made for four days' time. A letter was written requesting a diagnosis and a drug regime.

(A major difficulty which emerged from this arrangement was that, by convention, specialists do not make house calls. If Mrs Forbes could not be taken to the consulting rooms, the only alternative possibility was for the lady to be admitted to hospital when examination was necessary.)

2. Dental Hospital (Domiciliary Unit) was contacted. Appointment made. Mrs Forbes was visited at home by that Unit within a fortnight, the troublesome lower teeth were extracted, a lower denture was to be made and the upper denture repaired.

3. Home Care Service was unable to provide an immediate service - suggested negotiation for private arrangement - name of contact given.

4. Arrangement of a meeting with all involved friends to co-ordinate action and minimise confusion.

5. Mrs Forbes refused Sydney Home Nursing Service.

6. Neighbour to continue delivery of meals.

Subsequent Events:

1. Mrs Forbes seen by Doctor at his rooms. He prescribed a new drug regime. With Mrs Forbes' permission, all old drugs were removed from the house. New drug regime was to be administered by a neighbour in consultation with the assessor.

2. Private cleaner was arranged for - number of hours, occasions of service, were carefully worked out between Mrs Forbes and her many friends who took her on outings on certain days of the week.

3. The Community Nurse/Assessor visited Mrs Forbes every second day for two weeks in an attempt to gauge her mental state. This fluctuated greatly. Sometimes Mrs Forbes went for walks with her dog in her immediate environment and was unable to find her way home, while on other occasions she appeared to have no problems. Dressing herself was a problem on some days, (e.g. trying to put slacks on as a cardigan), while on others she had no difficulty.

4. The assessor held discussions with the rheumatologist about the possibility of an organic reason for Mrs Forbes' confused state. The doctor had excluded diabetes and thyroid vitamin deficiency, but was unable to proceed with further investigations from his rooms, e.g. brain scan. After much discussion about advantages and disadvantages of admitting Mrs Forbes to hospital under his care, the assessor approached Mrs Forbes to get her thoughts about such a venture.

5. On the assessor's next visit Mrs Forbes' ankles were extremely swollen, and she was breathless on exertion. It seemed possible that she might be admitted to a local acute hospital if her symptoms increased in severity, so it was easier to discuss the possibility of hospitalisation under her own doctor in the hospital of his choice. Mrs Forbes agreed to the latter, contingent upon her dog being looked after by a neighbour, and a clear understanding that she would not be placed in a nursing home directly from the hospital.

6. Mrs Forbes was admitted to hospital and seen by a neurologist. A brain scan was ordered. On the first occasion Mrs Forbes became anxious and refused the brain scan. The neurologist felt a scan was imperative and her own doctor explained the importance of this, and so Mrs Forbes agreed to go ahead so long as a friend could accompany her at the time. The day before the scan was to occur there was a serious fire in the locality necessitating the evacuation of patients to other hospitals. In due course the scan was undertaken and no major abnormalities were revealed.

7. This result indicated that Mrs Forbes' mental state was irreversible, and Mrs Forbes returned to her home where her friends rostered themselves to give daytime supervision.

8. Within a few days of her discharge it became evident that she was a danger to herself, (e.g., by leaving gas jets turned on but unlit, and burning food on stove, mishandling radiators etc). Her doctor was contacted and she was admitted to a nursing home via the same acute hospital. Her dog and her house were being watched over by a neighbour, as she had agreed to the arrangement on the basis of 2 months' trial.

9. Final assessment showed that, whilst she had made no serious attempt to leave the nursing home, the competitive urgings of her busy circle of friends tended to impede the settling process. Her dog was still being cared for by the neighbour, and did not appear to be fretting. The matter of the empty house would have needed addressing within the foreseeable future, but as the A.R. & A.U. anticipated the cessation of funding at the end of August (later extended to 30th September) team members felt that it would have been irresponsible to become involved in what could have been a prolonged and potentially contentious undertaking.

APPENDIX VII

AGED REFERRAL & ASSESSMENT UNIT

DATA COLLECTION SHEET

SERIAL NO. ☐☐☐☐☐☐

A: PERSONAL DATA		
1. Month of first contact with A.R. & A.U.		1. Month ☐
2. Home address (L.G.A.)	Ashfield ..... 1 Burwood ..... 2 Concord ..... 3 Drummoyne ..... 4 Strathfield 5	2. LGA ☐
3. Sex	Male ..... 1 Female 2	3. Sex ☐
3.1 Marital Status	Married ..... 1 Widow ..... 2 Div/Sep ..... 3 Never Married 4	3.1 M/S ☐
3.2 Children	No ..... 0 Yes ..... 1 Not known 3	3.2 Child ☐
4. Age	60 - 64 ..... 1 65 - 69 ..... 2 70 - 74 ..... 3 75 - 79 ..... 4 80 - 84 ..... 5 85 + ... 6	4. Age ☐
5. Living	Alone ..... 1 With wife/husb ..... 2 With children ..... 3 With hus/wife & child/(ren) ..... 4 With sibling ..... 5 With other family member ..... 6 Other 9	5. Live ☐
6. Accommodation	Own house/flat ..... 1 Rented Hous. Comm ... 2 Rented private ..... 3 Hostel ..... 4 Nursing Home ..... 5 Living in home of family member ..... 6 Other 9	6. Accom ☐

7. Support Network	None ..... 0 Partner ..... 1 Children/relative ... 2 Friends/neighbours .. 3 More than one ..... 8 Other 9	7. S/N ☐
7.1 If yes, Location	At home ..... 1 In LGA ..... 2 Outside LGA < 5 km ... 3 Other metrop ..... 4 Outside metrop 5	7.1 S/L ☐
8. Means	Pension ..... 1 Private ..... 2 Pension plus ..... 3 Other 9	8. Income ☐
9. Ethnicity	Anglo ..... 1 Europe ..... 2 Asia ..... 3 Middle East ..... 4 Oceanic ..... 5 Other 9	9. Ethnic ☐
B: REFERRAL		
10. Referred by	Self ..... 1 Family ..... 2 Friends ..... 3 G.P. ..... 4 Hospital ..... 5 Gov't Service ..... 6 Community Service ... 7 Other 9	10. Ref by ☐
11. Reason for referral *	Information ..... 1 Assessment ..... 2 Specific need ..... 3 Condition ..... 4 More than one ..... 8 Other ..... 9 Detail .... (* Multiple answers where applicable)	11. Reason ☐

11.1 Assessment: (Multiple answers where applicable)

Concerns By:-
- self 1
- family/friends 2
- G.P. 3
- Other Profess. 4

Post accident 5
Post hospitalisation 6
Personal/emotional .. 7
More than one 8
Other 9

11.1 Assess. ☐

11.2 Need for

Aids 1
Accommodation 2
Support 3
Social interaction .. 4
More than one 8
Other 9

11.2 Need ☐

11.3 Condition

Confusion 1
Self neglect 2
Mobility/balance 3
Difficulty in managing 4
Current arrangements 5
More than one 8
Other 9

11.3 Cond. ☐

12 Difficulties Experienced *

Functional 1
Personal 2
Environmental 3
Social 4
More than one 8
Other 9

Details .....
.....
.....
.....

12. Diff. ☐

12.1 Functional

Personal care 1
Domestic tasks 2
Other tasks 3
More than one 8
Other 9

12.1 Funct. ☐

12.2 Personal (Health)

Memory 1
Incontinence 2
Confusion 3
Mobility/balance 4
Gradual deterioration 5
Emotional 6
Alcohol or other subs 7
More than one 8

12.2 Pers ☐

12.3 Environmental

No accommodation 1
Accomm unsuitable ... 2
Other 9

12.3 Envir. ☐

(* Multiple answers where applicable)

12.4 Social *	Family/relations .... 1 Social isolation .... 2 No support ..... 3 Support inadequate .. 4 More than one ..... 8 Other ..... 9 (* Multiple answers where applicable)	12.3 Social ☐
13. Medical Diagnosis *	CVA . ..... 1 COAD/Emphysema ..... 2 Cardio vascular ..... 3 Rheumatism/arthritis 4 Trauma ..... 5 Confusion ..... 6 Sensory Loss ..... 7 More than one ..... 8 Other ..... 9 Details .... (* Multiple answers where applicable)	13. Med/Dia ☐
14. Services already involved *	Medical ..... 1 Community ..... 2 Residential ..... 3 More than one ..... 8 Other ..... 9 Details	14. Serv Inv. ☐
14.1 Medical	G.P. ..... 1 G.P. & Specialist ... 2 Hospital ..... 3 Rehab. Centre ..... 4 More than one ..... 8 Other 9	14.1 Ser Med ☐
14.2 Community	S.H.N.S. ..... 1 Home Care ..... 2 Meals on Wheels ..... 3 More than one ..... 8 Other 9	14.2 Ser Com ☐
14.3 Residential	Hostel ..... 1 Nursing Home ..... 2 Other ..... 9 (* Multiple answers where applicable)	14.3 Ser Res ☐

C: OUTCOME

15.1 Intervention by A.R. & A.U. (Multiple answers where applicable)

- Interpretation of Ageing Process to individual & support network 1
- Counselling as necessary to individual & support network 2
- Information re Aids/Services/ Accommodation etc 3
- Education in use of aids 4
- Monitoring until situation stabilises 5
- Offering AR & AU as future info. resource 6
- Other 9

15.1 Int ARAU ☐

15.2 Services introduced or modified (Multiple answers where applicable)

- None 0
- Medical/Hospital 1
- Community formal 2
- Community Informal 3
- Family/Friends 4
- Accommodation 5
- Hostels/Nursing Homes 6
- Commercial 7
- Other 9
- Details .....
  .....
  .....

15.2 Ser. In ☐

15.3 Number of services introduced/modified

- None 0
- One 1
- Two 2
- Three 3
- Four 4
- Five 5
- Six 6
- Seven 7
- Eight 8
- Nine or + ... 9

15.3 Serv No ☐

16. Services needed but not introduced (Multiple answers where applicable)

- None 0
- Medical/Hospital 1
- Community formal 2
- Community informal 3
- Family/Friends 4
- Accommodation 5
- Hostel/Nursing Home 6
- Info. by AR & AU 7
- Commercial 8
- Others/Multiple 9

16. Serv Need ☐

16.1 Reasons for 16 (Multiple answers)

Client unable to accept	1	16.1 Reas for ☐
Client refused to accept	2	
Client deferred decision	3	
Not accepted by service	4	
Decision deferred by service	5	
Service not available	6	
Family/friends unable to give service	7	
Further investigation	8	
Other/Multiple reasons	9	

Details .....
.....
.....

17. Immediate Outcome
(Multiple answers where applicable)

No change	0	17.0 Outcome ☐
Accommodation arranged/modified	1	17.1 ☐
Family/friends support obtained	2	17.2 ☐
Aids provided/modified	3	17.3 ☐
Accepted by community service (formal)	4	17.4 ☐
Accepted by community service (informal)	5	17.5 ☐
Treatment by GP/Hospital	6	17.6 ☐
Info. given to client/service	7	17.7 ☐
Other	9	17.9 ☐
* Total No. of Actions		Total ☐

Details .....
.....
.....

18. Re-assessment/subsequent events
(Multiple answers where applicable)

No change	0	18.0 Re-assess ☐
Further contact not required for time being	1	18.1 ☐
Satisfactory as result of action taken	2	18.2 ☐
Improvement in conditions/activities	3	18.3 ☐
Community services continued/ reactivated	4	18.4 ☐
Treatment in hospital/rehab. etc....	5	18.5 ☐
Gradual deterioration	6	18.6 ☐
Admitted to hostel/nursing home	7	18.7 ☐
Deceased	8	18.8 ☐
Other	9	18.9 ☐

Details .....
.....
.....

19. Condition/situation at end May, 1985.

19.1 Functional	1 2 3 4 5	19.1 Con May
19.2 Personal	1 2 3 4 5	19.2
19.3 Social-support	1 2 3 4 5	19.3

19.4 Environmental/accommodation

Home	1
Hostel	2
Acute Hospital	3
Nursing Home	4
Death	5
Other	9

19.4

Details .....
.....
.....

APPENDIX VIII

COMMUNITY-BASED ASSESSMENT UNIT: AN OPERATIONAL MODEL

1. To function within a specified region - Population 200,000 to 250,000

2. **Administrative preference:** - to be administered at State level within Home and Community Care Program under Department of Community Services. (This suggestion in response to health/welfare division being experienced at level of local service organisation) or to be administered by an Area Health Board as a community-based team.

3. **Location:** - Alternatives (each having advantages and disadvantages) for location are as follows:

   In accommodation which is adjacent to but not in the building of an acute hospital. It should be within walking distance for reasonably easy access by patients, relatives, workers, etc. To be visible and accessible to aged people themselves as well as to members of their support networks, i.e.,

   .. central position (e.g. close to/or in a shopping centre)
   .. ground floor level
   .. on public transport routes
   .. clearly labelled
   .. reliably staffed (staff cover throughout working day including lunch-hour)

4. Staff:

4.1 Clerical assistant with competence in computer-operation for receiving, recording and maintaining information re resources, personal/medical records.

4.2 Field staff to be two-tiered:

4.2.1 Multi-disciplinary Assessment Team

Minimal - social worker
- occupational therapist
- community nurse

(a) capable of home assessment of elderly people, looking at health (including mental health), social and environmental aspects and including testing strengths of supporting networks.

(b) re-assessing where change has occurred.

(c) maintenance of records/statistics including
  (i) usage of services
  (ii) needs not met (including exploration of reasons for this)

(d) working with local groups in developing strategies to overcome gaps and shortages, reducing fragmentation and overlap, and aiming for co-ordinated delivery to individuals of appropriate services

(e) acting as a resource and consultants to Contact Workers - assuming responsibility where casework is demanding and complicated.

4.2.2 Contact Workers

Minimum Qualifications

Health/Welfare qualifications e.g. Welfare Certificate, E.N.A., with a concern for, and a facility in communicating with elderly people in a multicultural society. An understanding of and an interest in community work i.e. an ability to operate independently, and to recognise the inter-relationships between individuals / agencies / institutions.

Activities to include:

(a) providing human contact on a regular and reliable basis for otherwise isolated aged individuals

(b) being available as a source of support for carers and relatives, and being a point of contact for distant but concerned relatives.

(c) providing a case-work service - meeting those needs which do not fit within the guidelines of already established services.

(d) referring on to other workers and services in consultation with assessors.

4.2.3 Community-based Assessment Teams could also provide an attachment point for various other community workers who, while having an involvement with the aged, do not have a clear alignment with any other service e.g. Nursing Home Liaison Officers (paid under Area Health Boards, but having a strong and potentially mutually advantageous connection with a centrally based information exchange system), and Ethnic Aged Health Workers.

5. Description of Unit

Community-based Assessment Teams (as described by Kendig; 1983) are seen as something distinct from Geriatric Assessment Units, the latter being hospital based and treatment-oriented.

There would need to be channels established for referral (or inter-referral) between G.A.U.'s and community based centres, as well as with providers of a range of community services.

It is anticipated that any Aged Referral and Assessment Unit would be active in the following areas, although this should not be seen as an exhaustive list:

5.1 Information

Aged Referral and Assessment Units acquire and store in readily retrievable form, the following:-

... demographic data relating to population numbers, ethnic background, home ownership etc. for the designated region, plus comparison data for the State and Australia

... information regarding all services for the aged which are available within the designated region, eligibility criteria, contact persons etc.

... a list of medical practitioners with phone numbers, addresses and languages spoken

... a register of nursing homes in the region with current information regarding vacancies, waiting lists, respite accommodation (information to be kept current by input from Nursing Home Liaison Officers), and with up-to-date information as to fees charged, services provided, etc. Such a register would also indicate the predominance of any category of patient, in a particular nursing home e.g. cultural background, extensive care, confused, C.V.A.,Korsakoff's syndrome etc.

... a register of hostels (with details of willingness to provide personal care, respite beds) fees charged etc.

... a register of unit accommodation for aged people

... listings of educational opportunities

... information regarding functioning non-Anglo groups which have relevance for the aged.

5.2 Personal records of elderly people who are known to the Aged Referral and Assessment Unit

These would show:

Basic personal data

Services being utilised

Services indicated but not being utilised

Reasons for this

Support networks (including relatives, friends, neighbours etc.) with some indication of the degree and reliability of the support available

Hospital admissions

Medical conditions

Medications

Acute episodes

Other disabilities

By making relevant information available to service providers on request it is hoped that records such as this will reduce the need for repetitive questioning of aged people by numbers of service-providers.

It may also provide a system of remote monitoring, which while it does not replace human contact, will nevertheless give warning of changed circumstances (e.g. when a person or his/her carer is hospitalised with the possibility of future physical limitations) so that re-assessment can be activated.

It is hoped that such a record system will be accepted by, and receive input from, all providers of services, so that a complete and ongoing picture of the well-being of individuals and their support networks can be maintained.

5.3 Policy Formulation

Careful monitoring of all of the above information will provide data for informed needs-based policy formulation, and should underpin the provision of an integrated appropriate comprehensive service which is capable of meeting the needs of elderly people. Because of the centralised nature of the information system it is anticipated that community services will feel the pressure towards greater accountability (and this, in fact, has already precipitated anxiety and antagonism from some organisations).

There should be opportunities for realistic cost-benefit analysis and for reduction in the cost of services for the aged.

5.4 Assessment

Assessment can be seen as occuring at two (2) levels. One is the holistic assessment provided by an interdisciplinary team. The other is service-

specific and is concerned with the work to be carried out. The development of Regional Assessment Teams would eliminate the need for service-specific assessments.

Referrals for assessment will be accepted from any individual, worker or service in relation to persons living within regional boundaries. Assessment will only be carried out with the agreement of the person being assessed.

Most assessments wil occur at home. The assessor will consider the health (including mental health), daily living functions, environment, social relationships and support networks of the elderly person.

The Assessor will discuss with the person being assessed, the options which are available, and action will be taken and referrals made accordingly.

Unless otherwise specified the G.P. will be contacted before the assessment takes place and a report of the assessor's findings will be furnished to the G.P.

Wherever possible members of the person's support network will also be contacted, and, where this is necessary, attention will also be given to the maintenance of such networks.

It has been found that a comprehensive assessment can seldom be made on a one-contact basis. Trust needs to be established for meaningful information to be exchanged and tested.

Also experience has shown that assessment is often requested at times of crisis, or imminent crisis, when the equilibrium of all parties involved is off-balance. At such times there is a need for short term casework, and assessment must be deferred until new norms have become established.

5.5 Nursing Home Placements

The establishment of Regional Assessment Teams was seen by Government as a means for controlling the movement of people from community into nursing homes. A number of writers have suggested that 25% of people in nursing homes were inappropriately placed, (and the experience of the Aged Referral and Assessment Unit supports the view that there are substantial numbers in nursing homes who could be maintained in the community - in particular in hostels with personal care).

Although it is acknowledged that in some cases (e.g. following profound C.V.A.'s) a return from hospital to the community is unrealistic, the experience of the Aged Referral and Assessment Unit suggests that an assessment should be made of the social and environmental aspects of the lives of people who are seeking, or for whom is sought, nursing home placement. This statement is NOT made in support of a gate-keeping role for assessment teams with a view to reducing costs, but rather is ensuring that those involved are in possession of all relevant information and can therefore make an enlightened choice.

It would simplify procedures if hostel and nursing home assessment requirements were the same.

5.6 Education

In the process of accepting enquiries for information, receiving and making referrals as well as in the contacts made with both elderly people and their support networks at the time of assessment, it must be assumed that workers in community-based Assessment Teams will be in a position to develop an awareness of the reality of growing old at home, and an understanding of attitudes and provisions impinging upon this.

Workers may need to consider educating:

... elderly individuals - so that they are in a position to make informed choices as to their place and manner of living, and the range of services which are available to them at a time of their choice.

... community service providers - so that there is an understanding of the concerns of elderly people which crosses service specific boundaries and allows for imaginative, flexible and integrated service provision.

... G.P.'s - in order that they can advise their patients in the light of adequate knowledge of services, availability, criteria etc., and can recognise the implications of physical disfunction for the lives of elderly people and their carers.

... hospital staff - so that there is an integration of community and institutional interests to the advantage of elderly patients.

... administrators and policy-makers so that decisions are made in the light of 'grass roots' reality.

5.7 Co-ordination/Community Development

The regional position of Assessment Teams and their comparatively 'neutral' position, i.e. they are not confined by local government boundaries or by territorial sovereignty of a particular service organisation, suggests a role in the co-ordination of services.

If such teams can win acceptance (or have their use imposed by funding/subsidising bodies) they should be in an ideal position to observe, classify and report on the full range of needs being presented by elderly people in the area. This data can be fed to local groups of workers with the aged (including assessment team members), and can give an informed basis for the planning and implementation of a responsive and co-ordinated service.

5.8 Advocacy

Assessment Teams may see the need to engage in or support an advocacy role.

6. Day Centres

6.1 In most communities there exist numbers of social groups which offer activities and social interaction for aged people, but they do not have either the physical attributes (in terms of transport, wheelchair accessibility or accessibility for disabled but ambulant people) or the professional fall-back for people who may suffer occasional incontinence, be subject to dizzy spells and loss of balance or suffer periods of confusion.

6.2 Organisers of such social groups do not take into consideration the needs of carers i.e. a **predictable** period of some hours free from caring duties for either attention to business affairs, or simply planned recreation.

6.3 There are significantly few groups or day centres which are equipped to care for dementing people.

6.4 **There is a pressing need for day centres for the frail and isolated aged people who are living at home.**

The following factors need to be taken into account in relation to the above statement

6.5 **Funding**

Funding for Day Centre pending the availability of H.A.C.C. program financing, has been for capital costs only. No funding has been available for staffing or ongoing costs. This has been very restrictive.

There is a place for Day Centres which are administered through Area Health Boards, staffed by a combination of professional people (e.g. O.T.'s Diversional Therapists, Community Nurses) and volunteers, and located sufficiently close to acute hospitals to allow for almost immediate assistance in cases of emergency.

Among advantages would be:

... The ability to cope with a range of disabilities and medical conditions

... The provision of a substantial mid-day meal

... 'Hands on' treatment as required, e.g. dressing of ulcers, showering of incontinent people, etc. (This enables people who require daily dressings to enjoy social activities in a day centre)

... Input from professional people in the provision of stimulating programs, social interaction, etc.

No plans for day centres should overlook transport needs.

7. Transport

7.1 Transport remains a constant problem in working with elderly people in the community.

7.2 A review of available literature suggests that there have been very few attempts to tackle the problem imaginatively.

7.3 Answers at local levels seem to be the provision of mini-buses. the fact that many frail people suffering from skeletal dysfunctions, or with hemiplegia, have great difficulty in getting into a bus (or even into a back seat of a car) seems to be overlooked.

7.4 New thoughts on the provision of transport might be tackled as a problem-solving exercise by a university faculty which concerns itself with traffic directions and control. Before such an exercise could be undertaken there would need to be discussion with either/both elderly people and workers who are continually faced with problems of transport in relation to

e.g.
- shopping
- medical/hospital appointments
- visiting sick relatives
- dental care
- day centre attendance

8. Relief for Carers of Home-bound People

8.1 In-home relief for carers should be arranged by the most appropriate means available, e.g. by a **reliable** and **consistent** volunteer service.

8.2 Home Care Branches include in-home relief for carers in their list of available duties, but in many areas have been hard-pressed to provide the minimum of domestic assistance.

9. Back-up Services

Planners developing policies which encourage the maintenance of elderly people in their homes, must also accept responsibility for the provision of back-up services. These should include:

9.1 Day Centres and Day Hospitals (See 6.5)

9.2 Respite beds (with full nursing care) for elderly people who are not suffering from acute conditions, and are financially unable to make use of private hospital sector.

Examples of situations in which such care may be needed are:-

... people living in the community who have reached the point of needing nursing home care, but are unable to enter immediately because bed is not available.

... where a carer is hospitalised

... a person who is only marginally independent has a fall resulting in e.g. fracture of an upper limb, reducing his/her capacity to cope to a level below which independent living is possible for, say, 6-8 weeks.

9.3 Access to Acute beds (in e.g. G.A.U.'s) for medical assessment, where behaviour or symptoms suggest a need, and carer's level of anxiety is mounting (e.g. where there is a sudden change in behaviour, or where there are numbers of falls).

Where the diagnosed condition is responsive to treatment it is probable that the patient can return home. Where this is not so, the members of the support network can more readily accept nursing home placement, feeling that everything possible has been done.

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