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CARE AND CONTROL

THE ROLE OF INSTITUTIONS IN NEW ZEALAND

Social Monitoring Group
Report No. 2

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FOREWORD

During the last few years, there has been a move away from institutionalising people who need care or control. Community care has become the favoured option, with its social and economic advantages being proclaimed by many. Yet few analyses have been made of the effectiveness, efficiency and appropriateness of either form of care and control, separately or in comparison with each other.

This report arises from the Social Monitoring Group's concern that decisions are being made to shift people from institutions to community care, and vice versa, on the basis of incomplete information. The report is limited to a study of institutional care and control in New Zealand, but is nevertheless probably the first systematic study of the efficiency, effectiveness and appropriateness of institutional care and control. As with our first monitoring report, *From Birth to Death* (1985), it provides baseline information with which other comparisons can be made.

It is clear from the study that rather than maintaining institutional and community care as separate forms of care and control, there must be a careful integration between them, with each providing services complementary to the other. The study also shows that it is no longer appropriate to operate large institutions when not enough is known about either the residents or the organisation of the institutions. Nor is it appropriate for institutions to ignore the importance of social, economic and cultural influences.

It is hoped that the report will be read by the general public, policy makers and the residents and staff of institutions.

P. G. Koopman-Boyden

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CHAPTER 1: INTRODUCTION

Why look at institutions?

Until the early 1960s there was in New Zealand a commonly expressed sense of satisfaction with the development of health, social service and educational facilities. Many of these services were centred on or provided within institutions such as hospitals, boarding schools, children's homes and prisons. However, during the 1960s that acceptance was increasingly challenged. The post-war boom, which had sustained economic growth, began to decline and there were major changes in the population structure, with large numbers of children being born between 1945 and 1960 and large numbers of immigrants entering the country (Population Monitoring Group, 1985). An increasing amount of the nation's wealth was directed to meeting families' needs, especially in housing and education. At the same time the population, both Maori and non-Maori, was becoming more urbanised. While these broad social changes were occurring, there were also changes in approaches to people with social, psychological or health problems. In social, health and criminal justice systems there was greater emphasis on tackling problems within a community setting rather than using institutions as a means of "containing" people who experienced such problems. Reinforcing the drive toward non-institutional responses was a growing concern with individual rights and civil liberties.

However, experience in other countries, where the trend has progressed further, has led to considerable doubts among professional, community and consumer groups about certain community alternatives to institutional care or control and about deinstitutionalisation in some instances. Arguments that community care brings improved autonomy and a better quality of life have been seen as cynical rationalisations for cost cutting when adequate resources have not been made available to the providers of community care or have failed to follow deinstitutionalised patients and inmates into the community.

Significant changes continue to occur in New Zealand and cannot be ignored in developing strategies with respect to institutions and non-institutional care and control. These include the changing role of women. Their move to fuller participation in public life and paid work means that community approaches which assume the availability of women as care givers in the community need to be reassessed. Changes in the relative size of different age groups, particularly of the Maori population, and the ageing of the entire population are also of special significance.

Study objectives

The Social Monitoring Group (SMG) has undertaken this study to analyse changes in the provision of institutional care and control and in the usage of institutions, and to identify the strengths and weaknesses of institutions as forms of care and control. We expect that the key points and policy implications identified will be of assistance to policy makers, and of interest to the providers of institutional care and control and other concerned parties.

What is an institution?

For the SMG's purposes the essential features of an institution are that it

provides non-familial care, usually but not always in formalised settings, where the carers or controllers have no kin relationship with the residents. In addition, the degree of choice institutional residents have as to whether they stay in or leave an institution is often constrained. Those cared for or controlled in an institution tend to live there 24 hours a day. They sleep, eat and often work in the institution. Thus, the SMG has developed the following definition:

An institution is a place where residents choose or are compelled to reside for purposes of receiving care and/or control outside of a family setting.

Included in this definition are hospitals, boarding schools, residential schools for children with special needs, children's homes, children's health camps, prisons and other penal institutions, and old people's homes. Though administered by different bodies and catering for different groups of people in different ways, all these meet the criteria outlined in the definition above.

Approach to the task

This report contains an overview of the operations of the institutions listed above and examines how these institutions operate in terms of three key factors: resource usage, effectiveness and acceptability.

i) **Resource usage** addresses the use made of resources and where possible relates them to the quality of service given. Ideally efficiency rather than the more limited concept of resource usage would be addressed but available information does not allow that level of analysis.

ii) **Effectiveness** looks at the results achieved in terms of the organisation's own goals. This is not always possible as the goals may not be explicitly stated and have had to be assumed.

iii) **Acceptability** examines the attitudes, social values and responses of groups involved with the institutions, and their views on the use of resources and the type of service provided. Whether a service is acceptable or not may depend on the viewpoint of the observers, whether they are the individuals who are admitted to the institutions, their families, service providers, or taxpayers.

In assessing how institutions operate, often the values and perspective of only one of the parties involved are taken into account. The SMG sees several levels at which functioning should be assessed. There is a societal perspective which tends to focus on the costs to the country, both social and financial. There is the community/family perspective which focuses on the effects dependent people have on relatives and carers. Finally there is the perspective of the individual which emphasises individual well-being and rights, sometimes without regard to the effects on the other parties.

The SMG has tried to examine the resources used, effectiveness and acceptability of institutions from all three perspectives. The result is variable because the quality and quantity of the information is not uniform.

The final section of the report examines the policy issues relating to patterns of institutional usage.

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CHAPTER 2: INSTITUTIONS FOR PHYSICAL HEALTH

Introduction

Hospitalisation is the form of institutionalisation people are most likely to encounter in their lives, though the likelihood of admission is influenced by sex, ethnicity and age. The hospital system in New Zealand is a dual one. The majority of services are provided by the state, but a significant number are also provided by the private sector, consisting of voluntary agencies, charitable trusts and services provided strictly for profit. This chapter discusses the contribution made by each of the sectors.

Public general hospitals

Between 1982 and 1984 the average length of stay in a public hospital per patient decreased slightly from 10.9 days in 1982 to 10.6 days in 1984 (Department of Health, 1982a and 1984c). However, numbers of admissions increased over this same period from 414,000 in 1982 to 429,745 in 1984 (the fact that maternity figures were not included in public hospital statistics before 1981 makes it difficult to explore trends, for total admissions, over a longer period of time). A comparison of male and female admission rates showed that the overall increase in public hospital admissions between 1982 and 1984 could be attributed to an increase in the female admission rate from 1,523 admissions per 10,000 in 1982 to 1,564 admissions per 10,000 in 1984, whilst the male admission rate decreased slightly from 1,076 per 10,000 in 1982 to 1,071 in 1984.

The increase in the female admission rate is explained, mainly, by increases in special admissions without current diagnosis, which are admissions for a variety of reasons including routine and diagnostic examinations and tests. Admissions for pregnancy and for abortion also increased.

Infogram 2.1 shows that numbers and rates of admissions were influenced by both age and ethnicity. Admission rates are high for infants but decline rapidly with increasing age. They again peak for young adults and then decline before once again increasing with advancing age. Maori admission rates are consistently in the order of double the comparable non-Maori rates, for all age groups.

The first year of life is the period when hospitalisation is most likely. Hospitalisation is even more likely if an infant is male, and extremely likely if an infant is Maori. Total infant admission rates are high and have risen by almost one-third since 1978. Why there should have been such an increase is unclear. It seems unlikely that it is due to real changes in health, though this cannot be excluded. It appears more likely that the increase is due to changes in medical practice. This explanation is supported by the fact that the average length of stay per patient has decreased from 6.8 days in 1978 to 5.3 days in 1984, whilst the ratio of readmissions to first admissions appears to have increased. This indicates that although young children are staying for shorter periods of time, per admission, their chances of being readmitted in the same year have increased.

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Infogram 2.1

PUBLIC HOSPITAL ADMISSIONS
(By age and ethnicity, 1984)

Maori	0-5 yrs	5-14 yrs	15-24 yrs	25-44 yrs	45-64 yrs	Total (0-65)
No. of admissions	10,251	6,024	17,798	15,029	6,230	55,332
No. of admissions per 10,000 people of same age and ethnicity	3,094	822	2,526	2,053	1,878	1,953
Percent of all Maori admissions	18.5%	10.9%	32.2%	27.2%	11.3%	100.0%
Non-Maori	**0-5 yrs**	**5-14 yrs**	**15-24 yrs**	**25-44 yrs**	**45-64 yrs**	**Total (0-65)**
No. of admissions	33,711	27,141	62,142	104,502	60,961	288,457
No. of admissions per 10,000 people of same age and ethnicity	1,540	551	1,178	777	1,101	1,091
Percent of all non-Maori admissions	11.7%	9.4%	21.5%	36.2%	21.1%	100.0%
Admission rates Maori : non-Maori	2.0 : 1	1.5 : 1	2.1 : 1	2.6 : 1	1.7 : 1	1.8 : 1

Sources: Department of Health, Hospital and Selected Morbidity Data 1984,
Department of Statistics, Population Estimates 1984.

The rate of Maori infant admissions to public hospitals is alarming. Infogram 2.2 shows that the Maori infant admission rate has consistently been twice the non-Maori rate for a number of years, and has been increasing. In 1984, for instance, for every 10,000 Maori infants (less than one year of age), there were over 8,417 hospital admissions (as opposed to 3,726 for every 10,000 non-Maori infants). Maori infants represented 24% of admissions in 1984 but made up only 12.2% of the total population aged less than one year. Maori admission rates are even higher for certain conditions, particularly acute respiratory infections, pneumonia and chronic obstructive pulmonary diseases (including asthma).

After the first year of life the rate of hospitalisation drops dramatically for both Maori and non-Maori children. However, considerable differences between the Maori and non-Maori rates persist. Maori children remain more likely to be hospitalised, and this applies for almost all conditions.

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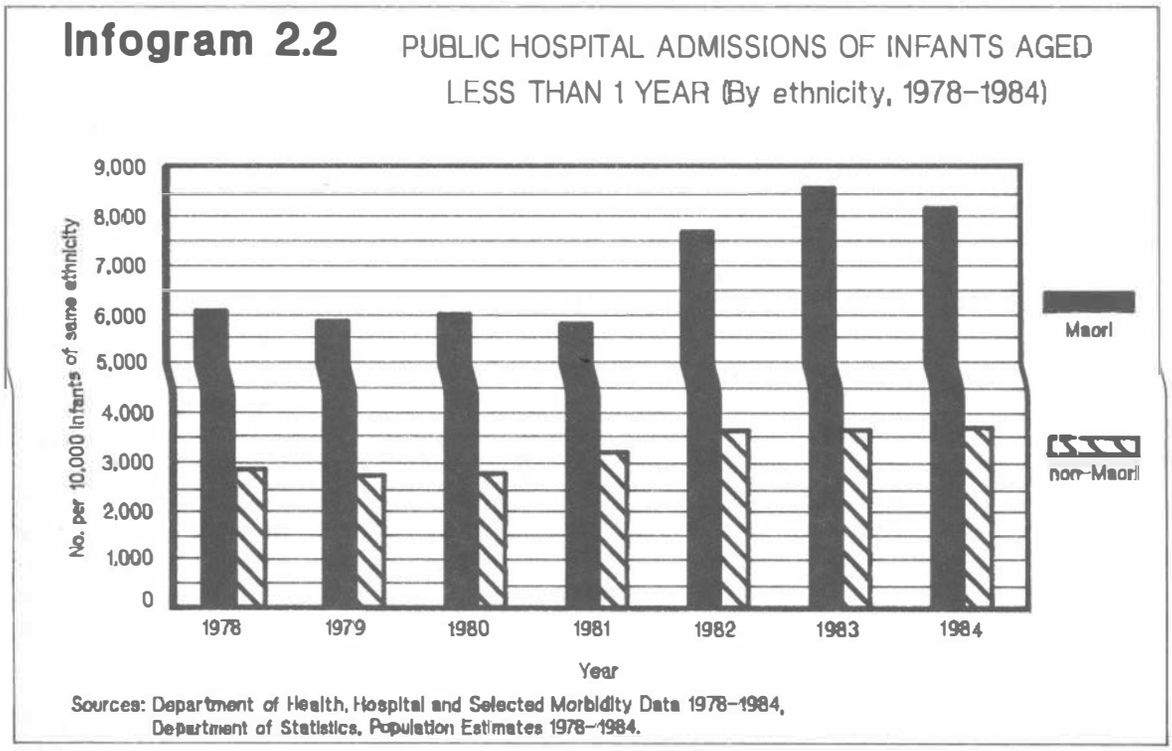

Respiratory disorders are major reasons for the admission of young children to hospitals. In 1984 acute respiratory infections, pneumonia and chronic obstructive pulmonary disorders accounted for 17% of all admissions of children aged between 0 and 14 years. With increasing age however, accidents, fractures and lacerations are more frequently the reasons for admission. Together these incidents account for almost a quarter of the children aged between 5 and 14 years admitted to public hospitals.

Research has shown that the likelihood of hospital admission is much higher for children living in families which experience high levels of stress (Beautrais et al, 1982). This is because of the strain such experiences place upon the parents. Their ability to provide adequate care for their children decreases, and the susceptibility of their children to illness increases. The amount of stress seems to be more important than common familial or social factors, such as family size or income, in explaining the likelihood of hospital admission.

For almost all conditions, since 1974, there has been a substantial shortening of stay with an average decrease of 1.5 days (21%). Maori children are kept in hospital considerably longer than non-Maori children. In 1984, Maori children (aged 1-14 years) stayed in hospital for an average of 5.8 days compared to 4.5 days for non-Maori children. Given that they are there for the same conditions, there is no obvious reason why this should be so. It may reflect doctors' perceptions of the quality of care the children are likely to receive upon their return home. Alternatively it may be a result of a tendency by Maori people to consult doctors later than other ethnic groups (Mackay, 1985). This may lead to a

more serious condition at the time of hospital admission and therefore to a longer stay.

Though the numbers involved are small, some girls aged less than 15 years are admitted to hospitals as a result of pregnancy. In 1984 there were 55 such admissions to public hospitals, usually for delivery.

New Zealand teenagers or young adults have a high fertility rate relative to their peers in other developed countries. Rates in New Zealand are approximately four times those in the Netherlands and twice those in Scandinavia. The New Zealand abortion rate for 16 to 19 year olds is high and has increased steadily over the past years with the result that during 1983 almost 25% of known pregnancies amongst women in this age group were terminated (Sceats, 1985).

In all, about 7,500 abortions were carried out in public hospitals in 1984. Half of these abortions were to people aged between 15 and 24 years, with 45 abortions to girls aged less than 15 years. Changes to the legislation governing abortions in 1977 and 1979, and the requirement for hospital boards to provide abortion facilities, has meant the number of abortions carried out in public hospitals has increased by about 30% between 1978 and 1984. However, not all hospital boards provide facilities for abortions and so some women have to travel considerable distances in order to obtain an abortion (Sceats, 1985).

Changes in the collection of health statistics, notably the inclusion of maternity figures in hospital admissions following 1981, makes it difficult to identify patterns in admissions for young adults and for women in particular. However, it is clear that, as age increases, pregnancy is a major reason for hospitalisation. In 1984, men aged between 15 and 24 were admitted to public hospitals at a rate of 747 per 10,000 and women at the much higher rate of 1,955 per 10,000, reflecting the significance of pregnancies. Large differences between the admission rates of Maori and non-Maori people continue and are in part due to major ethnic differences in fertility rates and patterns of illness. The Maori admission rate for 15 to 24 year olds during 1984 was 2,526 per 10,000, which was over twice the non-Maori rate of 1,178 per 10,000. The differing admission rates may also reflect differing cultural definitions and responses to illnesses, and the fact that primary and preventive medical services are often less readily available in the areas where most Maori people live (Davis, 1986).

For older women (those aged between 25 and 44 years), conditions related to pregnancy remain the most common reason for hospital admission. For these women, however, child bearing is more likely to be planned. The vast majority are non-Maori (88%), reflecting the tendency of non-Maori women to bear children at a later age than Maori women. Beyond 45 years few women enter hospitals for conditions related to pregnancy: only 62 did so during 1984.

Of the 51,897 babies born during 1984, 99% were delivered in hospitals. This has not always been the case, particularly for the Maori. In 1959, 9.5% of Maori births occurred other than in hospitals but by 1984 the proportion was negligible (0.02%).

For the non-Maori there has been a shift in place of birth from private to public hospitals. Private hospitals in 1945 provided almost 50% of the available maternity beds but by 1984 provided only 2% (44) of the available beds. By contrast the number of available maternity beds in public hospitals grew in line with the "baby boom" of the 1950s and 1960s. Public maternity beds peaked at

2,979 in 1972. Since then there has been a gradual reduction in number to 2,121 in 1985 (Department of Health, 1985c). This recent reduction has particular characteristics. Most notable has been the closure of small maternity units whether attached to larger general hospitals or existing as independent institutions.

Since 1972 there has been a decline in the time women spend in hospital following birth. A study of maternal and infant care in Wellington showed that whereas 31% of women stayed in hospital for more than nine days following delivery in 1972 only 18% did so in 1978 (Briggs and Allan, 1983). By 1984 the average length of stay following birth was 6.2 days (Department of Health, 1984b).

For men aged between 15 and 24 years, accidents, injuries and poisonings make up 50% of hospital admissions. For women the rate is much lower, about 17% of admissions (when admissions related to pregnancy are excluded). This reflects differences in lifestyle, attitudes and opportunities. For both sexes, however, this is the period of life during which traffic accidents (Ministry of Transport, 1985) and criminal injury to the person is most likely to occur. For men this is the period during which suicide and attempted suicide is most common (Taylor and Cummings, 1986). Accidental and intentional forms of injury lead to considerable numbers of hospital admissions and show little indication of becoming less significant.

As further ageing occurs, admissions resulting from injuries and poisonings continue to represent a significant proportion of all admissions to hospitals (10% of admissions of people aged between 25 and 64 years). During 1984, 12,697 people aged between 25 and 44 years and 6,061 people aged between 45 and 64 years were admitted as a result of these conditions. The bulk of those admitted were men (approximately 70%) and the largest single cause of injuries (approximately 30%) was motor vehicle accidents. Accidental falls (13%) and criminal injuries (7%) were also significant for men, whilst for women injuries or poisonings resulting from complications of surgical and medical care (18%), and attempted suicide and self-inflicted injury (13%), were of concern.

Admissions for injuries and poisonings are often avoidable, especially those related to the consumption of alcohol and to unnecessary risk taking. Accidents arising in the workplace can be minimised by better training of workers in addition to the installation and use of safety equipment and procedures. Although it is not possible to determine the number of admissions resulting from work-related accidents, the results of a survey of one accident and emergency unit showed that 45% of men aged between 15 and 64 years attended it as a result of work-related accidents (Hyslop et al, 1983). Surprisingly, employers still argue that too great an emphasis upon safety may endanger the profitability of a business and cause unemployment (Rowe, reported in The Dominion, 7 June 1986).

For people aged more than 45 years, and over 65 years in particular, degenerative conditions such as diseases of the circulatory system (including heart disease, blood pressure and strokes), cancers, diseases of the digestive system, injuries and poisonings, and diseases of the respiratory system are the leading reasons for hospitalisation. Such conditions typically result in longer periods of hospital stay, and require more intensive care, than the conditions associated with the admissions of most younger people. Such conditions accounted for 65% of the 85,956 admissions of over-65 year olds in 1984. Admission rates of people aged 65 years or more have been steadily increasing since 1964. Their 1984 admission rate of 2,607 per 10,000 was almost twice that of the total population for the same

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year.

Because of their greater representation in the older age groups and the cumulative effect of degenerative conditions, women have a greater likelihood of disability and consequent vulnerability. Women aged more than 75 years have a disproportionately high admission rate overall and, in particular, are over-represented amongst people admitted as a result of strokes, conditions related to high blood pressure, and falls and fractures.

Degenerative diseases are often related to hypertension (high blood pressure), inadequate exercise, cigarette smoking, and obesity, all of which tend to be related to environmental conditions and social structures. For example, the hazards of cigarette smoking have been investigated and are known, yet an estimated 28% of people aged between 15 and 19 years, 38% of those aged between 20 and 29 years, and about 33% of those in their forties continue to be cigarette smokers. This situation continues in part because of a social order which can, on one hand, allocate significant resources to campaigns aimed at alerting people to the dangers of cigarette smoking and yet, on the other hand, continue to allow far greater resources to be channelled into the promotion of cigarette smoking. An example of the significance of environmental conditions is provided in a study by Dryson (1986). He surveyed 1,342 working men and concluded that high blood pressure, inadequate exercise, cigarette smoking and obesity tend to occur together, and are often related to stress which may itself be related to working environments.

Private hospitals

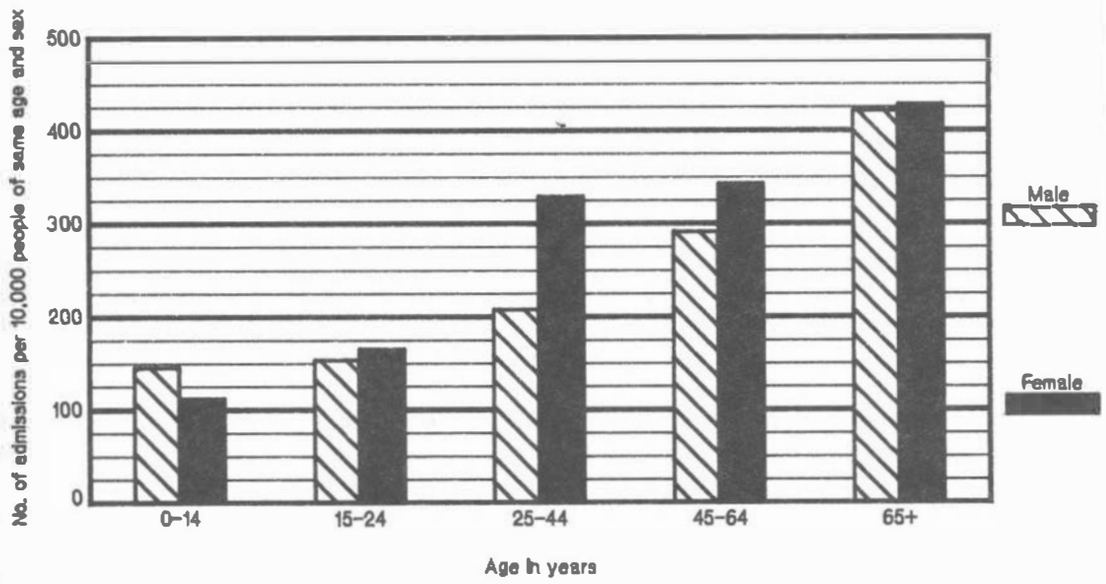
Rates of admission to private hospitals have increased in recent years. In 1979 there were 207 admissions per 10,000 people but by 1984 the rate had increased to 238 per 10,000. Both male and female rates increased, the male at a somewhat greater rate than the female, though women continued to be more likely to be admitted than men. Unlike public hospitals, however, private hospitals are one of the few institutions in which Maori people are unlikely to be found. Of the 64,489 people who had operations in private hospitals during 1984, only 1,650 (2.6%) were Maori.

As with public hospitals, age is closely related to admission rates. Infogram 2.3 shows how increasing age is associated with an increasing likelihood of admission to a private hospital bed. The reasons for admission and the types of beds to which people are admitted also change with age. For most people aged less than 65 years, admission is for a surgical procedure. Such admissions are frequently for operations which are relatively simple, elective, and involve short periods of stay.

In contrast, a large proportion of people aged more than 65 years, and more than 75 years in particular, are admitted into geriatric long-stay beds. The length of stay for such patients may have more to do with social and family circumstances than actual medical conditions. Geriatric long-stay beds are one of the subjects dealt with in detail in Chapter 8. It is, however, worth noting that there has been a change in private hospital bed usage over the last 20 years, which has seen a dramatic decrease in the provision of medical, maternity and psychiatric beds and a corresponding increase in surgical and especially geriatric beds. About 75% of the beds provided by private hospitals in 1984 were geriatric long-stay beds. This shift in bed usage may, however, only represent a more accurate recording of

usage. It is likely that many of the beds recorded as "medical" in the past were actually used as geriatric long-stay beds. The decrease in maternity and psychiatric beds is, however, real.

Infogram 2.3 ADMISSION RATES TO PRIVATE HOSPITALS (By age, 1984)



Sources: Department of Health, Hospital and Selected Morbidity Data 1984, Department of Statistics, Population Estimates 1984.

The chance of receiving treatment in a private hospital at any age depends, largely, upon access to private medical insurance and to Accident Compensation Corporation payments. Such access, for medical insurance in particular, is related to sex, socio-economic status and ethnicity (of either the individual or their guardian). This relationship sees few Maori people in private hospitals.

Almost all admissions of children to private hospitals are for surgery, especially for myringotomies, or operations on the ear, (35% of admissions in 1984) and tonsillectomies (20% of admissions in 1984). Private hospitals are performing an increasing proportion of these operations. In 1979, 40% of tonsillectomies were performed in private hospitals and this rose to 45% in 1984. Of myringotomies, 51% were performed in private hospitals in 1979 and 58% in 1984. The likelihood of children undergoing elective surgery and undergoing that surgery in a private hospital is greatly increased if their family holds medical insurance. Fergusson et al (1985) have shown that having medical insurance is a more important factor in determining whether children have ear, nose or throat surgery than the child's history of infection or their social or economic circumstances (social and economic circumstances may well determine access to medical insurance, however).

As well as the already-noted shift of birth services from the private to the public sector, there has also been a similar shift in abortion services and in services relating to reproduction and development. Contraceptive management and examinations, in private hospitals decreased 25% from 8,801 admissions during 1977 to 6,612 during 1984. Similar admissions to public hospitals increased by 41%

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over the same period of time.

The decline in admissions for contraceptive management and examination, abortion and childbirth has been compensated for by increasing numbers of admissions for disorders of the musculoskeletal system and for injuries and other conditions resulting from accidents and poisonings. Such admissions more than doubled for both men and women between 1979 and 1984. Many of the admissions of young people, especially young men, were attributable to accidents incurred on the sports fields and on the roads. Most commonly, these injuries included fractures of the skull, sprains and strains of joints and adjacent muscles, and the late effects or complications of injuries. For older adults, disorders of the joints and especially problems with the knee were significant. Of the 14,782 people admitted for these conditions during 1984, 57% were men. On average, admission was short, typically about three days. For admissions of this type the cost of care is often paid, at least in part, by the Accident Compensation Corporation.

Also termed diseases of the musculoskeletal system are a variety of arthritic conditions which result in a large proportion of admissions of people aged more than 45 years to private hospitals. With increased age the frequency of such admissions rises, replacing admissions for sport and road accident injuries.

Diseases of the genito-urinary system (including disorders of menstruation, of the uterus and of the breast) and hernias are the most frequent reasons for admissions of people aged between 25 and 64 years to private hospitals. The majority of those admitted for these conditions (74% in 1984) were women, with periods of hospitalisation being brief (on average 4.8 days).

Hernias are the most frequent reason for admissions of men aged between 45 and 64 years to private hospitals. During 1984, 87% of the 3,990 people admitted to private hospitals for the treatment of hernias were men. When a hernia results in surgery, the cost of the procedure is often paid for by either the Accident Compensation Corporation or private medical insurance. Of all people treated for hernias during 1984, 45% were treated in private hospitals.

Over the last ten years, private hospitals have come to play an increasing role in the hospital care of the elderly. Since 1978 the percentage of geriatric beds provided by private hospitals has dramatically increased, from 34% of the total in 1978 to 54% in 1984.

As people grow old they are admitted in increasing numbers to private hospitals, especially for diseases of the nervous system and supplementary classifications (which are discussed in Chapter 8). Admissions to private hospitals for diseases of the nervous system have increased from 10.7% of admissions in 1974 to 16.4% in 1984. Frequently such admissions are for surgical procedures relating to disorders of the eye and length of admission is brief. However, a significant proportion of admissions result in long or permanent periods of hospitalisation and are dealt with in Chapter 8.

Hospices

As of March 1986 there were six hospices operating in New Zealand (Department of Health, 1986a). Statistics are not readily available for all and when available vary in quality from hospice to hospice.

The hospice movement in New Zealand is still in its formative stages but, unlike the majority of other institutions, hospices have a clearly defined philosophy and objectives. They are planned to provide care and support to the terminally ill. In caring for these people, hospices have the objectives of relieving physical symptoms (pain in particular) and emotional problems which are of distress to the patient. Such care can be active or passive. The most appropriate form of care is that which provides the maximum relief coupled with the greatest possible quality of life for the patient. Prolonging life is not regarded as a priority if it infringes upon quality of life.

Though in the formative stages, there appears to be emerging a system of dual hospice provision, with hospices being provided both by, and independently of, hospital boards. At present most hospices offering inpatient care are operated by religious organisations and community trusts. None charge formal fees to the people they care for. Independent hospices arc heavily reliant upon community support for funds and ancillary staffing. In at least one case some of the costs of providing beds are met by the local hospital board on a contractual basis (New Zealand Private Hospitals Association, 1985). In addition to discrete hospice units, the hospice philosophy is being applied to terminal care in some public hospitals where special facilities are being provided.

The type of care provided in hospices is not necessarily the usual institutional type. Indeed inpatient care may be incompatible with the objectives of the hospice movement if it detracts from the patient's quality of life. It has been emphasised by workers involved in the hospice movement that "given their choice, most patients facing death would prefer to die in their own bedrooms at home, but we must ensure that they die in dignity and free from pain" (Wright-St Clair, 1983 p.50). However, inpatient care becomes necessary when difficulties are being encountered in relieving symptoms, and to provide necessary relief for the carers of the dying person. When patients are admitted as inpatients the period of stay tends to be brief (8.6 days during 1983/84 at Te Omanga hospice).

The majority of people cared for by hospices are over 65 years of age and arc cancer patients. At the Mary Potter hospice in Wellington, 62% of the patients treated in 1981/82 were more than 65 years of age. The hospice estimated that included amongst these people were half of those to die of cancer in Wellington during the year.

Resource usage

The proportion of health funding spent on institutions is reported to have increased from 64.5% in 1960/61 to 69.5% in 1979/80 (Hyslop et al, 1983). Total public health expenditure declined, in real per capita terms, by 13% between 1982 and 1986 (Cooper, 1986), but it is not possible to determine how much that decline affected spending on institutions, as opposed to spending on primary and community care. Monies are distributed to hospital boards by the Health Department but the accounting procedures used by boards do not allow determination of whether the money has gone to institutional or non-institutional services.

Funds are apportioned to boards according to their population, with adjustments for structural elements of the population such as the number of people within certain age groups, and with some allowances for special services that may be provided. The population-based funding formula, in being applied at a regional level, takes account of all hospital services in the region. In assessing each

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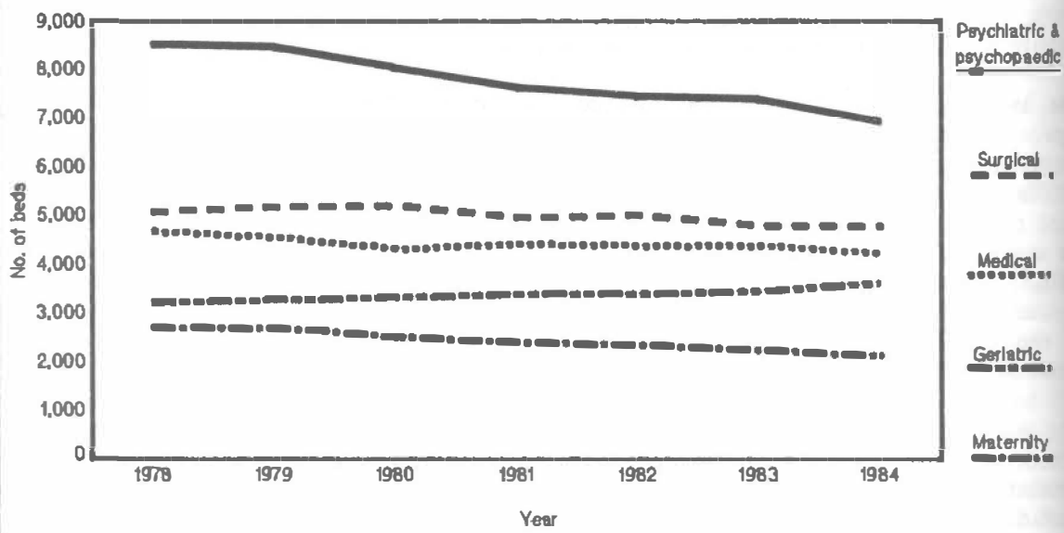
area's needs, public and private hospital provision is considered. This process has resulted in a reduction in the total number of hospital beds available from 32,552 in 1978 to 30,999 in 1985. The decrease has not, however, been uniform in all service areas or between public and private service providers.

The most marked decrease in bed numbers in public hospitals has been in the numbers of psychiatric and psychopaedic beds, which are discussed elsewhere in this report. Reductions in the birth rate and in the length of time mothers spend in hospital following birth have also led to a decrease in the number of maternity beds provided (Infogram 2.4). The demand for maternity beds is, however, likely to continue, and possibly increase, in the immediate future as the children of the "baby boom" years continue having children themselves.

Infogram 2.4 NUMBER OF BEDS AVAILABLE IN PUBLIC HOSPITALS BY TYPE (1978–1984)



Source: Department of Health, Hospital Management Data 1978–1984.

The way maternity services are delivered has also changed with a move away from small maternity hospitals. A study in Christchurch found that in the five years following the closure of the only small public maternity unit in that city, deliveries by general practitioners fell from 1,400 per year to 760. Deliveries carried out by specialists rose from 250 to 670. Attributing this change to decreased numbers of beds available to general practitioners in maternity hospitals and to the low rate of the maternity benefit, Kerr (1986) questions the use of specialist resources where general practitioners previously operated at less cost.

Changes in therapeutic procedures, coupled with the desire to reduce costs, have led to a shortening of average stays in New Zealand hospitals. For almost all conditions the length of stay has dropped, by as much as 70% in some cases. For a few conditions there has been an increase in length of stay, notably for people with disorders related to the circulatory system.

The average length of stay in New Zealand hospitals is relatively long by international standards. In the United States of America, for example, the average length of stay in 1982 was 7.1 days. The OECD, in reporting such differences in stay, points out that a short stay is not necessarily more cost-effective than a longer stay as recovery may be slower without full hospital care and there may be an increased possibility of relapse and consequent readmission.

The cost per patient-episode is mostly determined by length of stay. Pugh (1985) showed that, at $275 per day, the daily cost of surgical care in hospitals administered by the Otago Hospital Board was almost twice that of geriatric care and three times that of psychiatric care. However, the length of stay for surgery is much shorter than for the other conditions and means the cost per patient is much less.

Pugh's work is a rare example of the costing of particular services. Even where charges are made for public hospital services, mostly to non-New Zealand citizens, the amounts charged are derived from historical charges, periodically adjusted on an ad hoe basis, rather than from calculated costs.

It is difficult to draw firm conclusions about the efficiency of public hospital services because of the lack of information, especially information about finance. However, there are clear signs that hospital administrators have become more concerned about the efficiency of their systems and that changes arc occurring. Better information systems should soon be in place, allowing more extensive assessments of procedures to be undertaken. It seems particularly important in a system where non-administrative professionals have most control of resources (for example, doctors prescribing pharmaceuticals and determining length of stay) that they are aware of the costs they incur in their use of those resources.

The number of beds available in private hospitals has risen and the number available in public hospitals has declined. In 1976 the private sector contributed just over 17% (5,119) of all hospital beds but by 1985 it provided almost 19% (5,918) of beds. The type of health care offered by private hospitals changed during that time. The numbers of beds available for the treatment of medical disorders declined dramatically but were replaced by increases in surgical beds. This shift reflects changes in sources of funding. Surgical bed increases are a response to private medical insurance and to funds from the Accident Compensation Corporation (ACC), both of which spread the individuals' costs over all contributors, making access to private treatment easier. In other words, the services provided by private hospitals have developed where financial support is most readily available.

The ACC's methods of data collection do not allow the inferences above to be fully tested. However, during the period 1974/75 to 1984/85 (financial years) there was a tenfold increase in payments by the ACC to private hospitals (Infogram 2.5).

It has been estimated that in total 46% of private surgical costs are paid from medical insurance, 22% from ACC payments, and 18% from state subsidies and benefits, with only 14% of costs coming directly from patients (Smith, personal communication 1986). Further, it has been found that, of the people who do have private medical insurance, 15% have their premiums paid by their employers as an employment-related benefit (Cooper, 1986). People who are unemployed, who have a low level of educational achievement, who are full-time parents, who hold low status jobs or come from a background of low socio-economic status are the people least likely to be covered by medical insurance, and consequently least likely to

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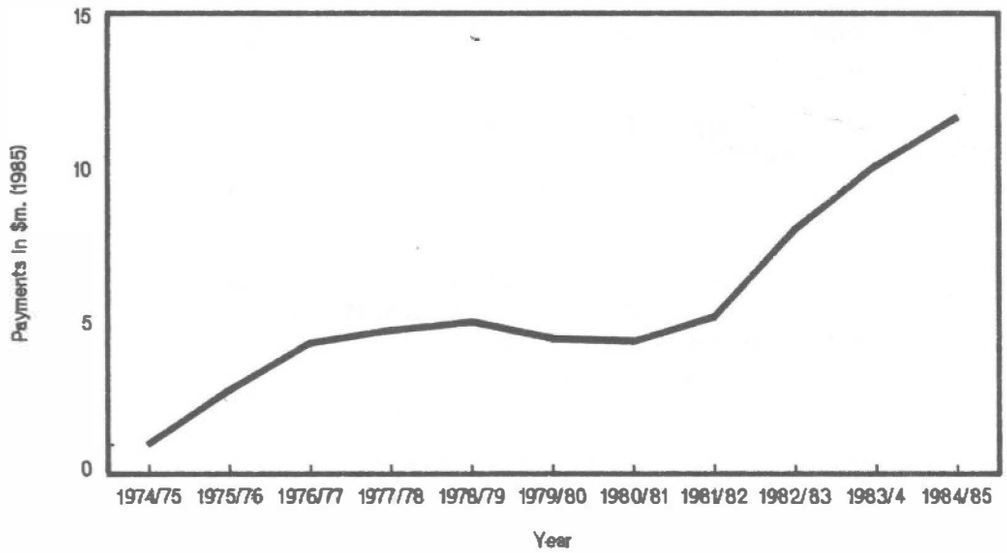
have access to private health services (Chetwynd et al, 1983).

Infogram 2.5 ACC PAYMENTS FOR TREATMENT IN PRIVATE HOSPITALS (1974/75–1984/85)



Source: Accident Compensation Corporation, unpublished data.

The Public Service Association argues that if all government grants/subsidies to private hospitals are included, then more than 48% of the private system's costs are met from public funds. This money, they suggest, could be better spent in the public sector on the provision of essential services (Public Service Association 1985).

Effectiveness

Outcomes of hospital treatments are not easy to assess. The goals of hospital services are more often assumed than expressed, especially in the long-established services. Furthermore, critical attention paid to the results that hospitals achieve, relative to other styles of care, is often clouded by considerations of cost and of professional dignities.

The appropriateness and effectiveness of hospital care for physical conditions has been questioned in a number of areas. Maternity care has been the arena of most continuing debate on the appropriateness of hospital, as against home-based, services (Donley, 1986). There has also been a great deal of debate about the type of hospital service which can most effectively provide maternity services.

The closure of small hospitals has been argued on the grounds of efficiency (Advisory Committee on Small Hospitals, 1983). However those arguments have been challenged by recent research which shows that small hospitals are as safe as larger units (Rosenblatt et al, 1985). There has been strong argument for the retention of small maternity hospitals with suggestions that the real reasons for centralisation of maternity services lie not in concerns about greater safety, but in the wish of specialists to maintain and even increase their control over the birth process (Coney, 1984).

It has been suggested that large maternity hospitals over-employ high technology (Davis, 1981). The Mental Health Foundation of New Zealand has argued that this may be a causal factor in postnatal depression, and that home births attended by midwives may be more effective in this area (Mental Health Foundation of New Zealand, 1986).

A concern about the appropriateness of hospital care has also been extended to other areas of health care. One of the most dramatic examples is in the care of heart attacks, where it has been shown that home care is as effective as hospital care and less disruptive to the individual (Mather et al, 1976).

Concern has been expressed at the incidence of iatrogenic disorders (conditions caused by the treatment for other disorders) associated with hospitalisation. Complications resulting from surgical and medical treatment are responsible for 14% of admissions of women aged between 25 and 64 years (Department of Health, 1984b). Further, there is evidence which suggests that the hospitalisation of elderly people increases their likelihood of being admitted to some form of long-term care (see Chapter 8).

The provision of new or extra services, especially those with high technological and professional components which absorb large amounts of health monies relative to the number of people they serve, has led to wide debate and controversy. Recent examples of this include facilities for heart surgery and for the treatment of people with fertility problems. In effect, a decision has to be made about the importance and priority of providing an ever-expanding range of services. The political influence of those suffering from particular disorders is likely to be significant in such discussions, as is the "glamour" associated with the competing claims of different services. Thus the image of surgery as a life-saving measure may engender more sympathetic attention than the less spectacular role of community-based nursing services which have an important preventive role.

In defence of private hospitals, Moore and Frater (1986), in a study of private and public hospital surgical care commissioned by the Southern Cross Medical Care Society, showed that patients stayed for a shorter time in private than in public hospitals. They suggested that this is indicative of greater efficiency in the private sector. However, as was noted earlier in this chapter, length of stay does not necessarily indicate efficiency in terms of either cost effectiveness or patient outcomes. Furthermore, although the study sought to compare equivalent operations in both sectors, there is some doubt about whether the situations were fully comparable. For instance, whether a family holds medical insurance is a more important determinant of whether children receive surgery in private hospitals than the seriousness of the conditions suffered (Fergusson and Harwood, 1985). This may extend to other age groups and indicates that the two sectors may treat conditions which are different in degree of both severity and urgency. To be definitive, a study of the two systems would need to assign patients randomly to treatment in either the public or private systems so that differences between

people and conditions can be controlled.

There are substantial amounts of public money going into the private health sector, as well as into the public sector, yet there is a lack of information about what it is spent on and who receives the benefits. Because the public has a right to know how its resources are being spent, the accounting systems of both public funders and public and private recipients need greater clarity.

Acceptability

It is a measure of the control professionals have of general health services that there is no statutory requirement for independent review of processes in public hospitals. The Patients' Rights Movement has campaigned for those in hospital care to be told more of what is proposed to be done to them, so that they can make more informed choices. One result of this has been the practice, in many hospitals, of giving patients a statement of their rights upon admission.

Much recent comment on the acceptability of various treatments has come from women who themselves, and in their roles as mothers, are major users of health services. The debate over acceptable practice in maternity care has already been referred to. This is a field of practice where women's questioning of such routines as episiotomies has led to changes. Significant questions remain, however, especially those relating to the use of technology in the birth process and the woman's right to have control over what happens during that process.

The differences in rates of hospitalisation between Maori and non-Maori groups are alarming, particularly for the very young and for young adults. In relation to infant health, public attention has focused on infant mortality rates (the incidence of deaths) rather than on infant morbidity rates (the incidence of sickness). The former tends to show a convergence of Maori and non-Maori rates which is not the case with morbidity, as indicated by hospital admissions.

The discrepancy between Maori and non-Maori rates of infant hospitalisation is not a new phenomenon. Given the persistence of the trend, there is a surprising lack of available information that explores contributory factors. The material that is available tends to explore differences in rates and effects of particular clinical conditions rather than the social, economic and environmental circumstances surrounding them.

Clearly New Zealand has a major problem in the field of infant health, especially Maori infant health. It is difficult to explain the differences in admission rates without more information on the incidence of particular disorders in the total population. Genetic factors may account for some of the differing health outcomes. It has, for instance, been suggested that Maori people have a genetically-based susceptibility to respiratory disorders (Mackay, 1985). This is, however, unlikely to be a sufficient explanation. Lifestyle factors, arising from the social and economic conditions and the physical environments in which children live, are important (SMG, 1985; Pomare, 1980; MacKay, 1985). There are also problems arising from inequitable access to medical services, and the appropriateness of medical services vis-a-vis Maori cultural attitudes.

The Health Department has responded to issues of infant mortality and morbidity by targeting resources through its "priority area" health teams. These groups work in areas of social and economic disadvantage to encourage preventive health

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measures such as immunisation. There has also been support given to community-based health programmes aimed at providing more culturally acceptable health services to the Maori people. In rural areas, efforts have been made to establish clinics on or near marae.

Infant ill health is clearly associated with social and economic disadvantage and it is only when such obstacles are neutralised, or at least reduced, that major progress can be expected. If there is no political or social support for change, greater resources directed into the field of infant health generally, and Maori infant health in particular, may be of some immediate benefit.

Concerns about practices which are culturally insensitive have been highlighted recently and have, in some instances, led to changes in hospital practices. Examples of this are the treatment and release of bodies after death and of the placenta after birth, both of which are particularly important to the Maori. The issue of greater cultural sensitivity in dealing with Maori patients highlights the more general need for those who run health services to be sensitive to the individuality and particular needs of all their patients.

A continuing problem in achieving change in these areas is the capacity of health professionals to recognise the rights of people to make decisions and the role and importance of non-physical matters in the maintenance of good health. An example of this is in the provision of facilities for parents to stay with their children when they are admitted to hospital. Though this is widely recognised as a desirable practice, there is evidence that it is not accepted by all professionals and that some may make the parent feel an intruder (Fergusson et al, 1980).

Key Points

*** The average length of stay in public hospitals is decreasing. However, numbers of total admissions and readmissions are increasing.**

*** Maori people are twice as likely as non-Maori people to be admitted to public hospitals. Of particular concern is the extremely high rate of admission for Maori infants. Maori people are, however, less likely to be admitted to private hospitals. Unequal access to medical insurance is a contributing factor.**

*** There have been major shifts in the type of services provided by both public and private hospitals but the changes have been most dramatic in the private sector where there has been an increase in geriatric and surgical beds in recent years.**

*** The services offered by the private sector are those for which reimbursement and state subsidisation are most readily available.**

*** It is difficult to assess the efficiency of hospital services in both the public and private sectors because of the lack of information.**

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CHAPTER 3: INSTITUTIONS FOR THE MENTALLY ILL

Introduction

This chapter examines the three main types of institutions providing care for the mentally ill in New Zealand. Psychiatric hospitals provide care for both the mentally ill and the intellectually handicapped (the latter are included in the next chapter). Psychiatric units in general hospitals provide acute care for the mentally ill, and a variety of voluntary bodies such as the Salvation Army provide specialist alcohol treatment facilities, additional to those provided within psychiatric hospitals.

These are not the only institutions to which people suffering from mental illness are admitted. Many of the elderly, for example, who are suffering some degree of degenerative neurological disorder such as Alzheimer's disease, are admitted to public hospital assessment and rehabilitation units, to old people's homes or to private hospitals but information on these people cannot be separated out for inclusion in this chapter.

Admissions to institutions for the mentally ill

Between 1977 and 1983, total admissions to institutions for the mentally ill increased by a little over 4%: from 13,614 in 1977 to 14,182 in 1983 (excluding admissions attributable to intellectual handicap). Recently, however, there has been a significant decrease in total admissions, with only 13,521 in 1984. This decrease in actual numbers of admissions has been paralleled by a decrease in population-based rates of admission from 44 per 10,000 in 1977 to 41 per 10,000 in 1984 and suggests a real reduction in the use of psychiatric institutions. The reduction has occurred because of lower numbers of admissions to psychiatric hospitals (8,681 in 1984 compared with 9,543 in 1983), in spite of increasing total admissions to psychiatric units (4,211 in 1984 compared with 3,998 in 1983). In 1984, 62.5% of total admissions were to psychiatric hospitals, 30.3% to psychiatric units and 7.2% to alcohol treatment centres.

To identify whether the number of individuals entering psychiatric institutions is increasing or decreasing, it is necesary to break the number of total admissions into first admissions and readmissions (Infogram 3.1). First admissions represent individuals entering a psychiatric institution for the first time. The incidence of first admissions increased slightly between 1977 (4,156 admissions) and 1984 (4,171 admissions). They did, however, peak in 1979 and have declined since, especially between 1982 and 1984. As with total admissions, the recent decline in first admissions is because of a decrease in first admissions to psychiatric hospitals (2,370 in 1984 compared with 2,673 in 1983), in spite of an increase in first admissions to psychiatric units (1,525 in 1984 compared with 1,506 in 1983) and alcohol treatment units (310 in 1984 compared with 298 in 1983).

Readmissions are admissions of people who have previously been admitted to a psychiatric institution but are in need of further institutional care. The number of such admissions has declined slightly between 1977 (9,458 admissions) and 1984 (9,350 admissions). This decline is related to a decline in first admissions rather than a reduced incidence of readmission. Readmissions have consistently accounted for slightly more than two out of every three admissions to psychiatric

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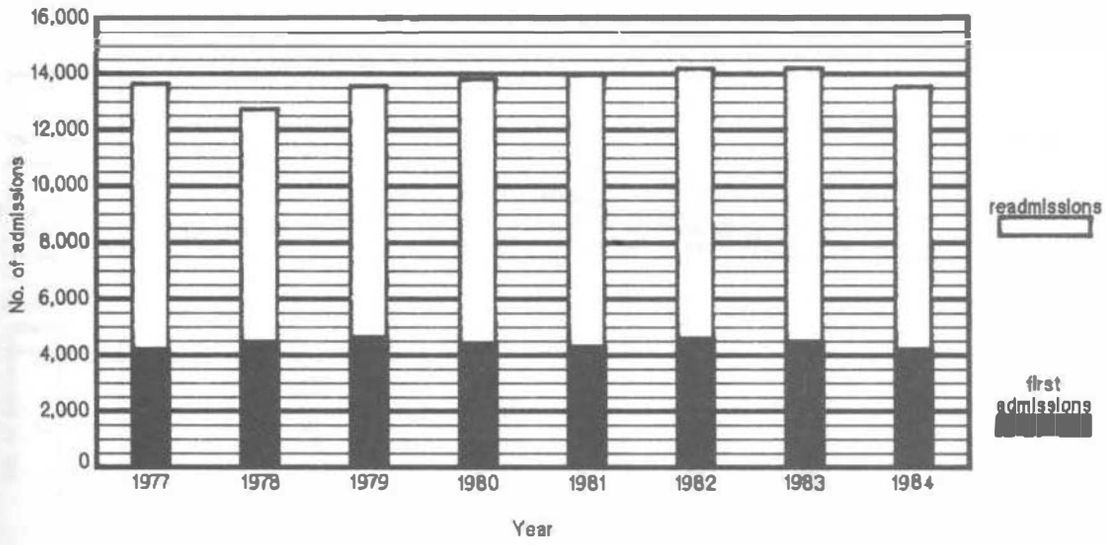
Infogram 3.1 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Numbers by type of admission 1977–1984)



Note: Admissions attributable to intellectual handicap are not included.

Source: Department of Health, Mental Health Data 1977–1984.

institutions. Patients admitted to psychiatric hospitals are more likely to have had a past history of institutional psychiatric care (73% of total patients admitted in 1984) than those admitted to either alcohol treatment units (69%) or psychiatric units (64%).

The recent decrease in total admissions may be a one-off occurrence rather than a sign of continuing change. It is, however, related to a change in the proportion of Maori and non-Maori admissions which has been developing for some years. The decrease in total admissions during 1984 was solely due to a reduction in non-Maori admissions, with Maori admissions for that year continuing an upward trend evident since 1979. During this period the number and rate of total Maori admissions has markedly increased from 1,317 (50 per 10,000) in 1977 to 1,814 (62 per 10,000) in 1984. Over the same period the non-Maori admission rate has stayed reasonably stable with a slight decrease over recent years (Infogram 3.2).

Despite the importance of ethnicity, age is the factor which has the most significant relationship to numbers and rates of admission. Few children are admitted to psychiatric hospitals or units, but rates of total admission increase rapidly with increasing age. First admissions typically occur at a relatively young age when psychiatric disorders are first diagnosed. Total admissions peak in number and rate at ages 25 to 34, after which they gradually decline (Infogram 3.3). With increasing age, a greater proportion of admissions are readmissions, reflecting the difficulty of curing psychiatric disorders. In fact most disorders

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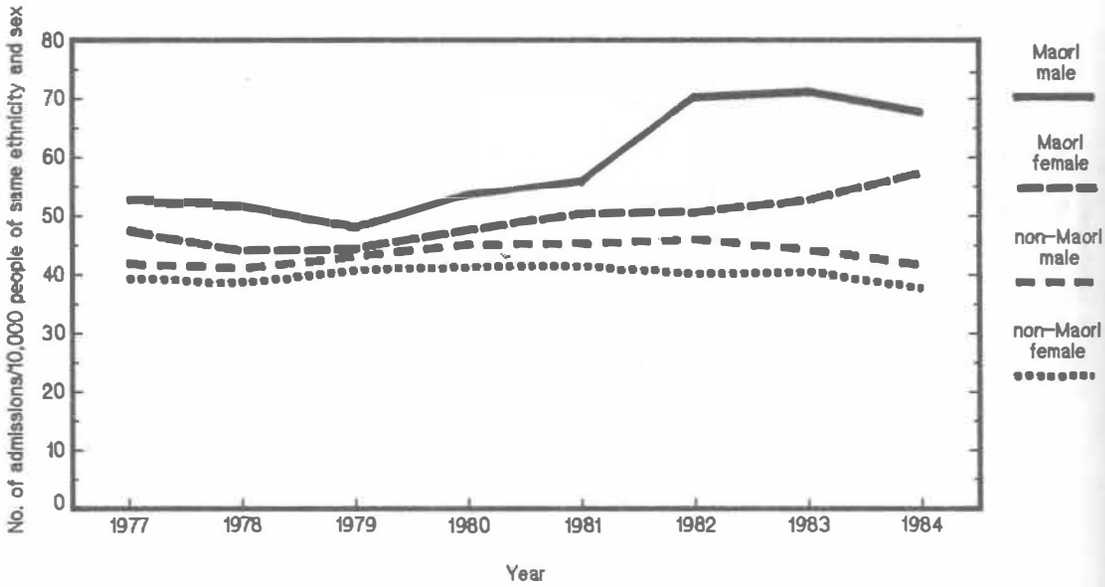
Infogram 3.2 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates by ethnicity and sex, 1977–1984)



Note: Rates do not include admissions attributable to intellectual handicap.

Sources: Department of Health, Mental Health Data 1977–1984,
Department of Statistics, Population Estimates 1977–1984.

have recurring symptoms, meaning more than one admission is often likely. With advanced age (over 65 years), first admissions again increase because senile psychotic conditions result in new institutional admissions of people aged more than 65 years. Such admissions are often long term or permanent, this being the explanation for why the rate of readmissions proportionately declines for the elderly.

Infogram 3.4 shows the major psychiatric disorders leading to institutional admissions for treatment. Collectively the psychoses represent the main causes of admission, with schizophrenia being the major single cause of admissions for almost all age groups.

Admission rates tend to decrease with age for schizophrenia and other personality disorders (these include such conditions as anorexia nervosa). The decrease in admissions for the personality disorders may reflect the fact that many of them are closely related to age, such as adolescent disorders. For instance, the reduction with age in rates of admission for schizophrenia reflects longer stays in hospital for some patients as ageing occurs, making readmissions less frequent. For other patients there may be a lessening in the severity of symptoms as ageing occurs, as a result of the disorder running its natural course. More effective treatment regimes have also resulted in a less frequent need for readmission.

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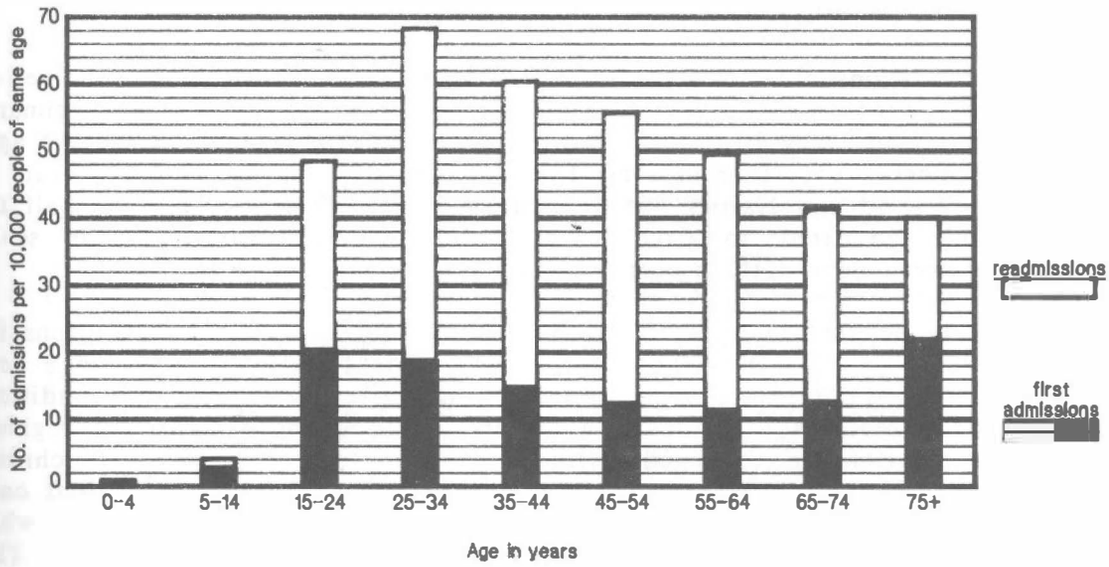
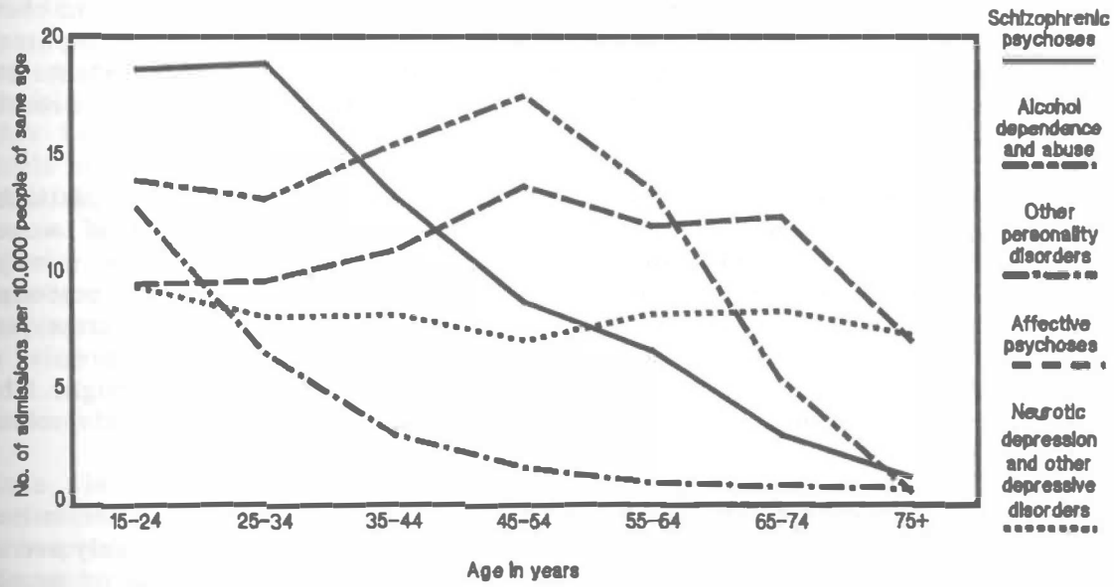
Infogram 3.3 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates by age and type of admission, 1984)



Note: Rates do not include admissions attributable to intellectual handicap.

Sources: Department of Health, Mental Health Data 1984,
Department of Statistics, Population Estimates 1984.

Infogram 3.4 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates for major conditions by ages, 1984)



Source: Department of Health, Mental Health Data 1984.

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The rates of admission for alcohol-related disorders and the affective psychoses increase with age until people become elderly (over 65 years). The rates of admission for alcohol disorders increase because they are "chronic relapsing disorders", which often necessitate readmission after an initial discharge. And the rates for the affective psychoses increase because they are late in onset by comparison with the other main causes of admission.

The above conditions are less significant among the elderly (people aged over 65 years) as causes of first admission. For this age group, it has been estimated that at least one in every 20 people aged 65 years or more and one in every 5 aged 80 years or more suffers from some form of senile dementia of a moderate or severe nature (Todd and Haines, 1983). Not surprisingly, then, more than half the elderly people admitted to psychiatric institutions are admitted for senile disorders, and over 90% of these people are aged 75 years or more.

Though elderly people are most commonly admitted to psychiatric institutions for senile disorders, many of the elderly who are resident in institutions have been there for many years and were admitted when younger because of chronic conditions such as schizophrenia, not for senile disorders. With changed treatment regimes, especially medication, and changed attitudes towards keeping people with chronic disorders in institutions, fewer people are now admitted for such conditions on a long-term basis. Thus the numbers of elderly long-stay patients admitted when young, for chronic conditions, can be expected to decline in future years. This will result in an increase in the proportion of those first admitted at an older age for senile and pre-senile disorders.

Since 1977, the average length of stay before discharge, for all conditions and in all psychiatric institutions, has decreased significantly: from 161 days in 1977 to 116 days in 1984. Length of stay in psychiatric hospitals is, however, about five times longer than the 25-day average stay in psychiatric units.

Reasons for admission are closely related to sex, as well as age. Males and females tend to be admitted to psychiatric institutions for generally different reasons and at quite different rates. Overall, women are admitted at a lower rate than men (39 per 10,000 women compared with 44 per 10,000 men). Infogram 3.5 shows that women are a little less likely than men to be admitted for schizophrenic conditions and much less likely than men to be admitted for alcohol dependence and abuse. Women are, however, admitted at a greater rate than men for neurotic depression and other depressive conditions, and for affective psychoses.

To some extent this general pattern of differences in rates by sex for particular disorders reflects differences in lifestyle. For example, the isolation of women in suburban environments with their young children has been cited as a major causative factor leading to depressive disorders and in particular, post-natal depression (Mental Health Foundation of New Zealand 1983). Sex-role stereotyping may also be an important factor leading to women being diagnosed as depressive or neurotic. Research indicates, for instance, that health professionals might label a woman depressive rather than diagnose her as having an alcohol-related problem (Howden-Chapman, 1984).

While the general principle of men being admitted more often than women is true within both Maori and non-Maori ethnic groups, Maori women are more likely overall to be admitted to psychiatric institutions than either non-Maori men or women (Infogram 3.2). This fact suggests that although sex roles do influence psychiatric admissions, as does age, other factors also affect the risk or chance

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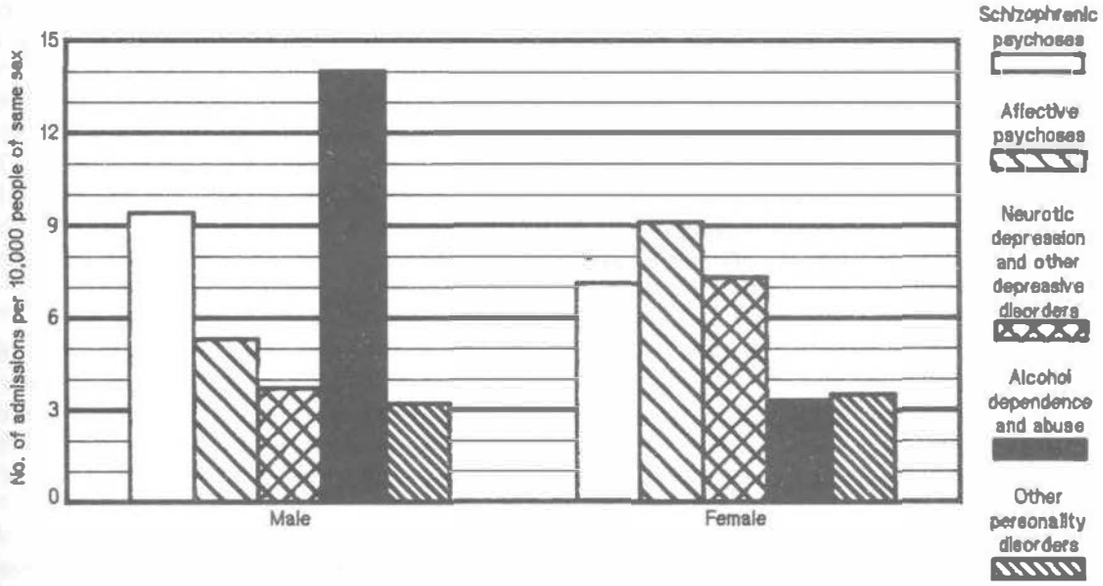
Infogram 3.5 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates for major conditions by sex, 1984)



Source: Department of Health, Mental Health Data 1984.

of admission. Maori people are admitted for much the same types of conditions in similar proportions to non-Maori people, but they are admitted at a far greater rate. Racial stereotyping and cultural insensitivity may be a factor in explaining this difference as may the relatively deprived economic and social conditions in which many Maori people live.

How a person is referred for in-patient psychiatric treatment varies with the ethnicity of the individual. Non-Maori people are most frequently referred from other health services, such as general practitioners and public hospitals. Maori people are more likely to be admitted following referral from non-medical agencies (especially law enforcement agencies), or following self referral. Maori people are, in fact, more than twice as likely to be referred from law enforcement agencies as non-Maori people (Dawson et al, 1986). Thus the high rate of apprehension for criminal offending amongst Maori people could, to some extent, be associated with their over-representation in psychiatric institutions.

Resource usage

Little information is available on the costs of providing psychiatric institutions. The funding for their operation is included in the general grants to hospital boards who decide individually how much of those funds should be allocated to psychiatric services. The amount spent will, therefore, vary between one board and another. Within any board's expenditure it is difficult to identify the total amount spent on psychiatric services.

There are considerable differences in the types of service provided by the various facilities. General hospital psychiatric units are designed for acute admissions, not for those in need of committal or long-term care nor for those with chronic relapsing disorders. These people are more likely to be admitted and readmitted to psychiatric hospitals. Psychiatric hospitals are likely to have older, larger and less suitable buildings than the more newly established psychiatric units. The staff-to-patient ratio is lower in psychiatric hospitals and, in some cases, the hospitals are isolated from major population centres. This poses problems in terms of transport, staff recruitment and service development, especially pre-hospital assessment and after-care or daycare services (Dowland and McKinlay, 1985). The strain of having to work in such conditions can be marked and may affect the capacity of staff to work effectively. These factors are likely to have a negative outcome for the patients of some psychiatric hospitals (Dowland and McKinlay, 1985).

Pugh (1985) calculated that psychiatric inpatient care costs approximately $90 per day. By comparison with other health services, this is a low daily cost. Surgery, for instance, costs over three times as much at $275 per day. However, mental illness normally involves much longer stays in hospital than do other conditions, so the total cost per illness-episode is likely to be much greater.

The number of available psychiatric hospital beds has been reduced from 6,821 in 1978 to 5,418 in 1985 (Department of Health 1978c, 1985c) although, as has been shown earlier, the number of admissions has increased slightly. The reduction in beds is due to changes in approaches to the care of the mentally ill, with long-term institutional care no longer being seen as the usually desirable course. Instead people are admitted to institutions for assessment, and for the development of treatment programmes to stabilise their conditions so that they can return to the community. As a consequence, there are shorter periods of stay in institutions. However, some people are still admitted for long-term care, and the likelihood of this increases with age.

The availability of psychiatric hospital beds has been shown to affect rates of admission. Malcolm (1984) showed that hospital boards which have high numbers of psychiatric beds relative to their population tend also to have higher rates of admission, though there is nothing to suggest a greater incidence or severity of disorder in those areas. Hence the availability of institutional services may act in some circumstances as a disincentive to the development of community-based services and as an encouragement to make greater use of institutional services.

Effectiveness

The outcomes of inpatient care for people with mental illness are not easy to assess. The goals of the services are more often assumed than expressed, especially with the long-established services. However it seems there has been a shift in purpose, with a growing recognition that many psychiatric disorders cannot be cured and must be managed or controlled. The implicit objectives of institutions for the mentally ill have changed from asylum, or separation from the community, to treatment and community integration. Thus, in relation to disorders such as alcoholism and schizophrenia, there is acknowledgement that relapse is likely and overall progress relatively slowly made.

The various facilities for the treatment of people with alcohol-related problems tend to operate programmes aimed at helping the individual to accept the reality

of their problem and to explore ways of overcoming it, usually with the goal of abstinence. They have shown a capacity to adapt the orientation of their programmes from a mainly middle-aged clientele to a younger age group and now have a more individualised approach to treatment. Attempts are made to involve the families of people in the treatment process but resources for this are limited. It is an area that deserves further attention.

Many people suffering from major psychiatric disorders, such as functional psychotic disorders, can be treated both more effectively and more economically in the community than they can in an institution (Hoult et al, 1983). Hoult's study also indicated that the relatives of psychiatric patients tend to prefer community care. Such care does, however, require at least the same level of resources, in terms of professional support and consequent funding, as does hospital care. The components of community care in the Hoult study were 24-hour availability of professional staff, crisis intervention, continuity of care over a long term, the providing of care and support to the patient in the community, the teaching of living skills to patients, and the educating and training of carers. To be successful, community care must have a high patient/professional staff ratio and ready access to professional services at all times. To date, that level of resource commitment has only rarely been available for any length of time. Hoult warns that, "if community care is opted for purely because it is the 'cheaper' mode of treatment and attention is not paid to the quality of community treatment, then the consequences will be negative rather than positive." (Hoult et al, 1983 p. 166).

There are examples where with careful planning and preparation there has been success. Sunnyside Hospital in Christchurch has developed the means to relocate patients from the hospital to the community with positive results for them and for their families (Sheerin and Gale, 1984). Key factors in making the transition effective seem to be adequate preparation of the patients for the change, good community support and the possibility of ready readmission if needed. Also important is the education of staff about the changes and reassurance that their position is not threatened. The reality of community care is that it is unlikely to need fewer staff resources but that staff will need to learn new skills for a changing care environment.

The reduction in length of stay, and in the number of psychiatric beds available, has been made possible by using hospital admission to stabilise the person's condition and then discharging them into the community. Unless there are adequate services in the community to support people, this practice is likely to be ineffective for both the patient and the health administrators because rapid deterioration in the person's condition and consequent strain on caregivers will lead to early readmission. It is also important that the members of communities are ready to accept people with mental illness. A number of studies have indicated widespread fear and rejection of the mentally ill amongst "normal" community members (Walkey et al, 1981).

Acceptability

Psychiatric treatment in whatever form has long been the subject of debate, with particular emphasis being placed on people's rights to lead their lives as they wish, without being forced to conform to particular styles of behaviour or being deprived of the freedom to participate in the wider society.

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Because of the particular vulnerability of people suffering from mental illness, official visitors are appointed in psychiatric hospitals and patients may express concerns to them about the acceptability of the care they receive. However, a wider public concern about the rights and well-being of psychiatric patients has been stimulated by the work of such groups as the Mental Health Foundation and the Schizophrenia Fellowship. This has led to reassessment of processes in mental health services and to the involvement of consumers in some areas of planning and control.

A departmental review of mental health services has condemned some facilities and practices within hospitals (Department of Health, 1986b). It suggests that improvements will be made by the provision of more resources, including staff, and by hospital boards taking a more planned approach to psychiatric hospital care. In particular, it comments on the lack of statements of objectives drawn up by boards and hospitals and on the lack of services responsive to regional needs. Improved planning by managers is likely to be helped by the preparation of a national mental health policy, which itself has been proposed for some time, and by regional service guidelines.

The rising rate of Maori admissions has made the development of culturally sensitive programmes especially important for psychiatric hospitals. There is a need, especially, to realise that there are alternative, non-Western ways of viewing and experiencing health and illness (Dowland and McKinlay, 1985). The institutions' response to this has not been uniform but those hospitals which serve large Maori populations have begun to address their needs in a more culturally appropriate manner. Tokanui Hospital near Hamilton has perhaps gone furthest by establishing a unit run according to Maori procedures, and taking a holistic view of well-being with mental illness as one part of the total concept.

Key Points

* Over recent years, numbers and rates of total admissions to institutions for the mentally ill have stabilised. This trend is in spite of steadily increasing Maori admission rates over the same period. The admission rate of Maori women is, for instance, far greater than either the non-Maori male or the non-Maori female rate and is still increasing. The Maori male rate is even greater.

* Men are more likely to be admitted to psychiatric institutions than women, but for generally different types of conditions. Whilst men are admitted at high rates for alcohol dependence and abuse, women are more often admitted for depressive conditions.

* Average lengths of stay in institutions for the mentally ill have decreased so that reductions in the numbers of beds provided have been possible.

* Psychiatric units in public hospitals are generally new and have good staff/patient ratios. Psychiatric hospitals, however, are often old with large, inappropriately designed and isolated buildings. Further, there are indications that psychiatric hospitals are understaffed and have difficulty recruiting and retaining staff.

* Although community care of the mentally ill can be more effective and acceptable to patients and relatives, it is unlikely to be cheaper than institutional care in terms of resource commitments, especially given the need for continuing access to professional staff and support services within the community setting.

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CHAPTER 4: INSTITUTIONS FOR THE INTELLECTUALLY HANDICAPPED

Introduction

Intellectual handicap arises from a variety of causes and its identification is, to some extent, dependent on its severity. The most severe forms are often congenital and may be identified at, or relatively soon after, birth. Moderate and mild intellectual handicap may have a physical cause but environmental and social factors may also be involved. The less severe forms of intellectual handicap may not become evident until the person is subjected to increasing intellectual demands, usually when they start school.

The consequences and significance of intellectual handicap for a person's ability to participate in society, and their capacity for self care, is the result of both social and environmental factors, as well as the person's intellectual ability. Whether or not an intellectually handicapped person is ever likely to be admitted to an institution is, then, the result of both personal and social factors. This chapter looks at the institutions to which intellectually handicapped people are most likely to be admitted and examines the circumstances which increase the chances of admission.

Who is in institutions for the intellectually handicapped?

A survey of intellectually handicapped people living in New Zealand in 1971 showed that almost 40% of them were in either psychiatric or psychopaedic hospitals (Morrison et al, 1976). The situation had changed little by 1981 when a study in North Canterbury showed that although proportionately more intellectually handicapped people were living in community residential facilities (such as group homes and hostels) than was the case in the earlier national study, this was associated with a decrease in the percentage living in their family home rather than a decrease in the proportion living in hospitals. Hospitals still provided for nearly 40% of intellectually handicapped people (Prentice and Barnett, 1983).

There are four psychopaedic hospitals (that is, hospitals catering solely for people with intellectual handicap) in New Zealand. Between them they care for just over 50% of all intellectually handicapped people in hospitals. The remainder live in psychiatric hospitals throughout the country.

Although the proportion of intellectually handicapped people resident in institutions has shown little change, their numbers decreased by 16% between 1971 and 1983: from 4,329 in 1971 to 3,621 in 1984 (Department of Health, 1984a, 1983e). There has also been a corresponding decrease in the number and rate of admissions, which is related to the overall decline in births since the mid 1960s.

The numbers of both first admissions and readmissions to psychopaedic and psychiatric hospitals have been gradually decreasing since 1974, though there is considerable variation from one year to another (Infogram 4.1).

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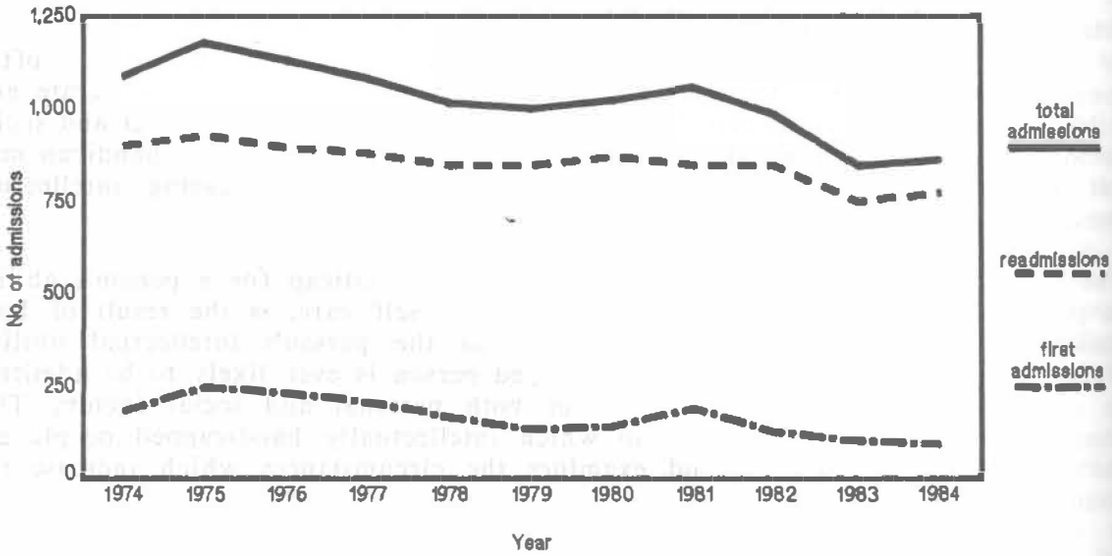
Infogram 4.1 HOSPITAL ADMISSIONS DUE TO INTELLECTUAL HANDICAP (1974–1984)



Source: Department of Health, Mental Health Data 1974–1984.

The proportions of intellectually handicapped males and females in hospitals seem to be changing. Morrison et al (1976) reported that almost 54% of intellectually handicapped hospital residents were male, but by 1983 this had risen to 60% (Department of Health 1983a). The incidence of intellectual handicap in the total population is higher among males than among females (17.8 per 10,000 for males, compared with 15.1 per 10,000 for females (Morrison et al)), and this to some extent explains the higher percentage of intellectually handicapped people in hospitals who are male. Prentice and Barnett (1983) suggested that the generally higher incidence of identified intellectual handicap among males may reflect social attitudes toward achievement, with more expectations of success placed on males. Social attitudes may also play a part in the differences in placement of male and female intellectually handicapped people, with males perhaps more likely to have, or to be seen to have, behaviours which make them unsuitable for placement in community residential settings.

The likelihood of institutional admission increases with age. In the Morrison study, only 7% of intellectually handicapped children aged less than 14 years were in hospitals, whereas the figure rose to almost 56% for those aged 30 years or more. Prentice and Barnett showed that few of the very young are in hospitals in the North Canterbury region, but the proportion rises quite rapidly with age, especially once the school-age years are passed. In this study more than 60% of all intellectually handicapped people aged more than 30 years were in hospitals, with the figure rising to 80% of those over 60 years. This age pattern shows the influence of past policies when admission to hospital was regarded as the most appropriate course of action for all intellectually handicapped people. It also reflects the increased demands of adult intellectually handicapped people on their

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carers, who are themselves ageing and may therefore be more susceptible to stress, sickness, and disability or death.

The other major determinant of hospitalisation of the intellectually handicapped is the severity of their disability. Morrison et al (1976) reported that, of the intellectually handicapped people in hospitals, 15% were mildly intellectually handicapped and 33% were moderately handicapped. These groups have received particular attention from the New Zealand Society for the Intellectually Handicapped (IHC) and hospital-based workers, and there has been a large drop in the numbers of them admitted. Many who had been long-term hospital residents have been integrated into community residential settings. At Mangere Psychopaedic Hospital this has meant that all the mildly handicapped residents have been discharged and the moderately handicapped group is constantly changing as they are admitted for only intermittent care. Beds are now used for short stays which may be aimed at assessment, at the development of individualised programmes, or to provide a break for carers (Board of Health, 1982). The same is likely to be true of other hospitals.

Most intellectually handicapped residents of hospitals have been in the hospitals for a long time. Watson et al (1985) report that 10% have been resident for less than one year, 75% for five years or more and 28% for 20 years or more.

Resource usage

The trend for psychiatric and psychopaedic hospitals to care for fewer intellectually handicapped patients as inpatients and to admit more people for short- rather than long-term care is likely to continue. Changes in policies of care, with their increased emphasis on community rather than institutional provision of long-term care, are influential in this but other factors are also operating. Laugeson (1978) concludes that although more intellectually handicapped children could survive because of lower infant mortality, the combined effects of various social and medical changes (such as the capacity to identify intellectual handicap in time to terminate the pregnancy) and the overall decrease in the number of live births means that there may be fewer intellectually handicapped children to care for in the future.

In terms of service development, however, those factors are somewhat counter-balanced by the influence of the ageing of the intellectually handicapped people born as part of the "baby boom". Increased age is associated with an increased rate of institutional admission. Of equal significance is the ageing of their parents, whose reducing capacity to care for them may lead to an upsurge in the numbers of intellectually handicapped people needing non-family care in the medium term.

In the short and medium term, hospitals can anticipate a greater proportion of their residents having profound levels of handicap. This, coupled with an increased demand for short stays for assessment and carer relief, will require changes in the ways the hospitals function. A particular goal should be to determine how their relief-care service can be made more acceptable to the families of the intellectually handicapped so that the high levels of stress borne by these families can be reduced (Chetwynd, 1985a).

The inclusion of the costs of hospital care for the intellectually handicapped in the general accounts of mental health services makes it difficult to work out the

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financial aspects of this service. The cost for the 2,429 psychopaedic beds in 1979 was established as $28,000,000 (Board of Health, 1982) but that is likely to be an underestimate because of the misclassification of beds. (The effect of such misclassification can be appreciated in the apparent increase from 2,664 psychopaedic beds in 1983 to 2,837 in 1984. In reality this change was due to the reclassification of beds in psychiatric hospitals which, though described as "psychiatric", had in fact been used for psychopaedic care.)

The annual cost of care per resident of the psychopaedic hospitals in the year ended 31 March 1985 was calculated at between $22,670 and $23,710 on average, and at $25,850 for one psychiatric hospital (Controller and Auditor-General, 1985). This was considerably more per resident than the cost of care in community-based residential services provided by the IHC, which was calculated at $12,900 for a child and $14,700 per year for an adult. This is largely explained by the higher staff ratios in the hospitals, and reflects differences in their residents' needs for care. The difference is also partly attributable to the lower rates of pay which workers for IHC receive.

Effectiveness

Consistent with a change in attitudes to intellectually handicapped people's ability, and their right to participate fully in society, has been a change in the general goals of providing institutional care for the intellectually handicapped. The emphasis is now on providing assessment facilities, coupled with the development of training schedules which may be applied outside the hospital setting, and on providing short-term stays to provide relief to the intellectually handicapped person's carers. Long-term care is considered suitable only for the severely or multiply handicapped person.

There have been few evaluations of the hospitals' performance in developing effective assessment and training schedules but Webb (1985) reported research which showed that the greatest difference between the community units and hospitals studied was that the latter were more likely to have consistent, daily training programmes aimed at both remedial training and ongoing behavioural development. She points out that the intellectually handicapped are permanently disabled and therefore in need of lifelong training and support. Her research also showed that in all care situations studied, the greater the degree of handicap the lower the standard of service in terms of staff/resident contact and resident-oriented management. In terms of improving the environments of intellectually handicapped people, those in which the older and more severely handicapped live warrant most attention.

Government-funded care can be provided for up to four weeks in a year to enable the carers of intellectually handicapped people (and other dependants) to have a break from their responsibilities. This can be by placement of the dependent person in a public hospital or private institution or by payment for someone to assume care in the person's normal community setting. However, Chetwynd (1985a), in a study of factors contributing to stress on mothers caring for an intellectually handicapped child, found that some families did not use this option and went without holidays altogether. She does not discuss the reasons for this but a study by the Society for Research on Women (1979) found that many people caring for disabled people felt that hospital care was no substitute for the type of care they provided.

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Acceptability

There has been a significant change in approach to the care of the intellectually handicapped in recent years. The earlier view of long-term institutional placement as the most desirable method of care has been replaced with a view of it as appropriate only in cases where the severity of handicap makes community-based care impossible. A 1974 study concluded that nearly 54% of the intellectually handicapped residents of psychopaedic and psychiatric hospitals were capable of living in a more independent environment (Booth and Jeffery, 1974).

The IHC, which was formed by parents of intellectually handicapped people in 1949, has been very influential in bringing about a change in orientation to the care of the intellectually handicapped and in providing community-based facilities for them. Their community-based residential services catered for 15.5% of all the intellectually handicapped in 1983 (Caseley, 1985).

The other major alternative to institutional care for intellectually handicapped people is care provided by their families. Despite a variety of support structures having been set up to assist families in this role, caregivers have been shown to suffer disadvantages relative to other families in terms of their financial well-being, their general capacity to participate in the normal life of their community, and in the levels of stress they experience (Society for Research on Women, 1979; Chetwynd, 1985a, 1985b).

Though fewer people are being admitted to long-term care, and although many who were formerly in hospitals have been moved into community settings, Jack (1985) describes this as "very limited progress" and says that with current policies and practices it will be 50 years before most of those presently in hospitals will have been moved into the community. The unavailability of suitable community settings is the main impediment to change. There are always likely to be a sizeable group of intellectually handicapped people who, because of the extent of their disabilities, both physical and intellectual, will need the intensity of care provided only in hospital settings.

The question of which government department should be responsible for the care of intellectually handicapped people has also been questioned. Intellectually handicapped people are not sick but disabled. Studies show that an emphasis upon training is more effective in caring for them than an emphasis upon nursing (Jack, 1985). It therefore seems appropriate that responsibility for such services should be transferred to the Department of Education, although Jack suggested the Department of Social Welfare. There is, in fact, already some overlap with the Department of Social Welfare, in that the Department provides the funding for short-stay care (which provides relief for the earers of intellectually handicapped people).

Shared responsibility between departments should be avoided if possible as it presents problems for the families of intellectually handicapped people. It forces them to deal with a variety of bureaucratic systems relating to their child's health, education, and residential care.

Key Points

*** The number of severely intellectually handicapped infants being admitted to hospitals on a long-term basis is gradually declining. It is, however, unlikely**

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that the number and proportion of intellectually handicapped people cared for on a long-term basis in hospitals will decrease in the medium term. The number and proportion may even increase. This is because of the ageing of the population and the ageing of the parents caring for large numbers of intellectually handicapped people born during the "baby boom".

* Increasingly, new admissions of young intellectually handicapped people to hospitals are for short- rather than long-term stay, and are intended for assessment or for the relief of carers.

* While community-based care is likely to be cheaper for the state, hospital boards, and area health boards than institutional care, this is because of the sacrifices (either of pay or of life opportunities), of those who do the caring in the community.

* Intellectually handicapped people are not sick but disabled. A planned and continuous programme of training is the most effective way of caring for them.

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CHAPTER 5: INSTITUTIONS PROVIDING SUBSTITUTE CARE FOR CHILDREN

Introduction

In New Zealand, the role of primary carer of a child is almost always exclusively accorded to the child's parents and in particular to the mother. The welfare of the child is in large part dependent upon parental ability to provide for the child's needs. Thus the well-being of the child depends upon the well-being of the parent(s) (Beautrais et al, 1984).

When parents cannot or will not take this responsibility, a variety of state and voluntary organisations may become involved to ensure the child is cared for. Whether the agency is governmental or voluntary, it will usually attempt to place the child or children concerned in a community-based setting, such as a foster home. For some children, however, placement in an institution becomes necessary. The reasons for institutional placements and the characteristics of children affected are discussed in this chapter.

Children in the care of the Department of Social Welfare (DSW)

Where parents cannot or will not provide adequate care or control for their children, the Department of Social Welfare has the responsibility to ensure the children are cared for. Infogram 5.1 shows that the number of state wards (that is, children for whom the state has parental responsibility whether by court order or by agreement with the children's natural parents) has been steadily declining over recent years. If the state takes responsibility for care, the child will not necessarily be admitted to an institution. Infogram 5.1 also shows that only a minority of children in state care are in institutional care (31% during 1985). Most state wards continue living with their parents or relatives, or are placed in foster care.

Those children most likely to come into the care of the Department of Social Welfare are aged more than 10 years; few state wards are aged less than 5 years. This pattern has become accentuated over recent years, with an increasing proportion of older state wards and a decreasing proportion of younger state wards (Infogram 5.2).

Of the majority of children in the Department's care who are aged more than 10 years, a large proportion are more than 15 years old (40% in 1984). Even though young people of this age have certain freedoms, such as freedom from compulsory education, in some circumstances they are still felt to be in need of adult supervision. The guardianship and supervisory powers available to the Director-General of Social Welfare may continue until the person concerned is 20 years of age. If people aged more than 17 become liable to other forms of supervision, such as supervision by the Probation Service, they are likely to be discharged from Department of Social Welfare care.

The declining numbers of state wards over recent years probably reflect a combination of factors including a falling birth rate, the greater social acceptance of ex-nuptial birth, and more readily available financial support for single parents. They also reflect the introduction, in 1981, of the Department of Social Welfare's policy "Planning for Children in Care". This policy requires that when the Department is involved in providing or overseeing care for a child, a

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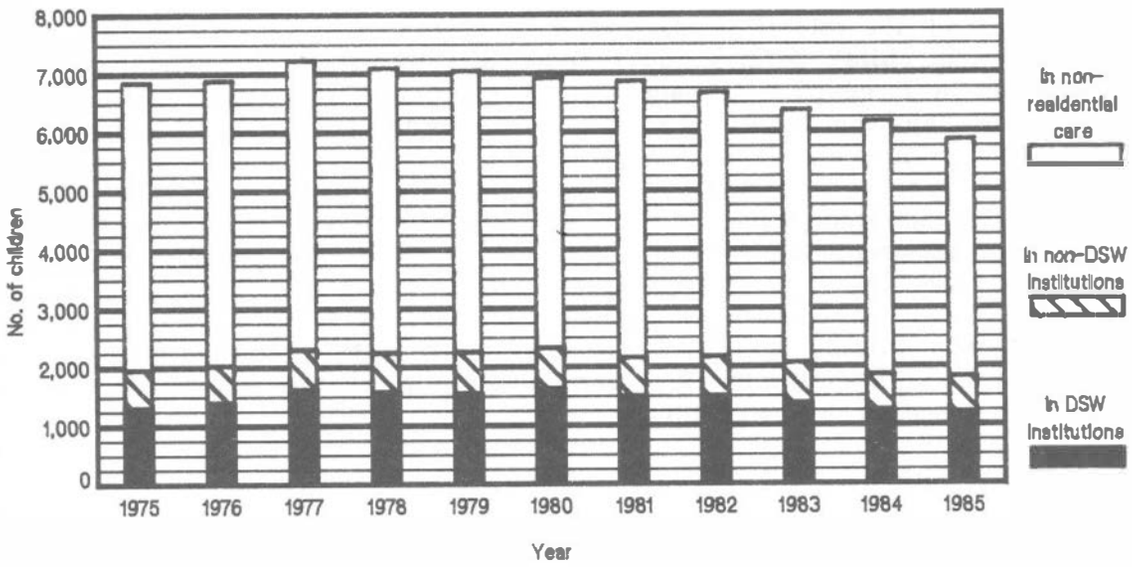
Infogram 5.1 CHILDREN IN THE CARE OF THE DEPARTMENT OF SOCIAL WELFARE (1975-1985)



Source: Department of Social Welfare, Annual Reports 1975-1985.

social worker develops a clear plan of action for the child's future and this plan is periodically reviewed. Such plans and purposefulness have been a significant factor in reducing the numbers of children admitted to care.

As well as the falling rates of admission to care, there has been a decline in the number of care orders imposed by the courts: from 87% of all state wards in 1975 to 75% in 1985. This is likely to be due to a greater emphasis on prevention, and to the emphasis on working with families, rather than taking over the responsibilities of families. The rise in the number of children admitted to care with the agreement of their parents (1,008 in 1985 compared to 519 in 1975) is indicative of a sharing rather than a controlling attitude.

The reasons for the admission of children into care are not well reported. A survey carried out in 1971 is probably the most comprehensive study of young children admitted to care by guardianship order (MacKay, 1981). The study found that the admission of young children was usually because of neglect or indigence (that is, being without an adult willing or able to accept responsibility for the child's maintenance). For older children, misbehaviour and the perception that the child is beyond the control of its parents become more significant as reasons for admission.

It is not possible to determine from currently available information how long a child is likely to remain in care. MacKay's study showed that five years after being admitted to care, 72% of children of all ages were still in care, as were 88% of those aged between two and four years at the time of being admitted to care. This does not mean, however, that these children are likely to be in institutional care: most are in foster care.

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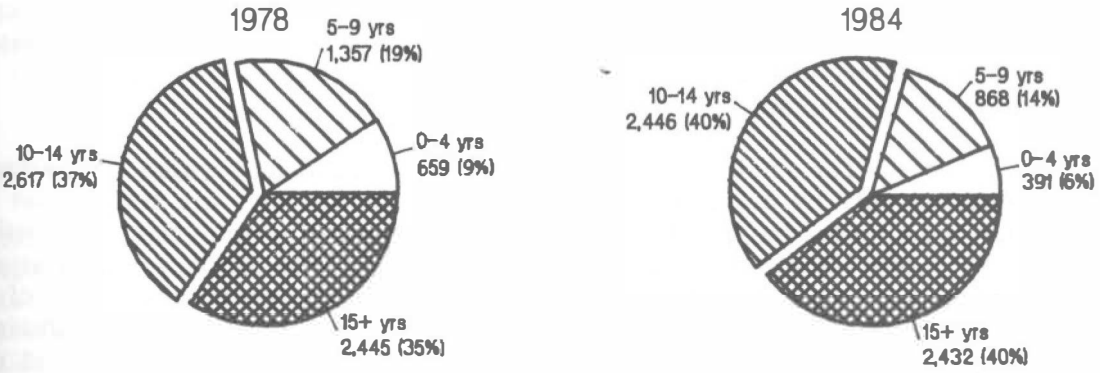
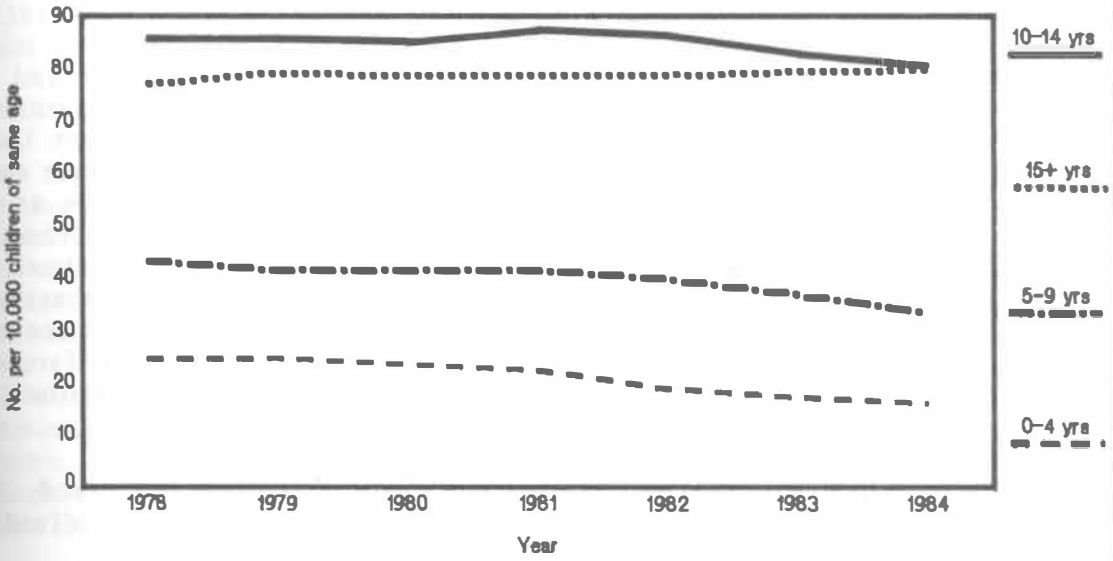
Infogram 5.2 CHILDREN IN THE CARE OF THE DEPARTMENT OF SOCIAL WELFARE (1978–1984)

a) No. Of Children, By Age, In The Care Of The Department of Social Welfare



b) Rate Of Children, By Age, In The Care Of The Department of Social Welfare



Sources: Department of Social Welfare, unpublished data,
Department of Statistics, Population Estimates 1978–1984.

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Children in Department of Social Welfare institutions

In 1962, 23% (810) of the children in the care of the Department of Social Welfare were in some form of institution (whether residential institutions, special schools, private institutions, psychiatric institutions, hospitals or boarding schools). This figure rose proportionately and absolutely to 33% (2,306) during 1980 but by 1985 it had dropped to 31% (1,807). The growth between 1962 and 1985 must be seen against the near-doubling of the total number of children in the care of the Department of Social Welfare. More significantly, a change occurred in the type of institution to which children were admitted. The number of children placed in short-term institutions, in special schools, in extended care institutions and, most markedly, in psychiatric and psychopaedic hospitals declined. The greatest change was in the growth in the number of Department of Social Welfare family homes.

Family homes cater for small numbers of children in residences which differ from ordinary housing only by being somewhat larger than most. They arc staffed not by professional social workers but by people whose principal employment is outside the home. They provide a more "normal" environment than do the larger institutions and are especially appropriate for older children for whom prospects of a fostering placement are limited. The adaptability of family homes is a distinct advantage as they can cater for small groups with special needs and can avoid the separation of children from their siblings.

The type of residential institution a child is admitted into is related to the age of the child. Few children in departmental care who are aged less than five are actually cared for in an institution of any kind (only 16%, or 36 children, during 1984). Most of these children were to be found in Department of Social Welfare family homes.

As children grow older, aspects of control as well as care become explicit and the rate of institutional placement increases. Further, fewer fostering opportunities are available for older children, though some are placed in independent living arrangements such as flats. During 1984, 22% of 9-year-old state wards were cared for within residential institutions with the proportion increasing to 47% at the age of 14 and declining to 27% for those aged more than 15 years. Generally, there is a cumulative effect operating in which increasing age is more likely to be associated with previous experience of residential care and with behavioural difficulties. There has also been an increase in the numbers of children and young people remanded to the custody of the Department of Social Welfare and placed in institutions: from 5% (of all children in departmental institutions) during 1975 to 8% in 1985.

Boys are more likely to be in institutions than are girls (33% and 26% respectively in 1984). This reflects differences in male and female offending patterns.

The Department of Social Welfare docs not routinely collect information on the ethnicity of children taken into its care but in the year ended 31 December 1984, 51% of the 1,368 children coming into the care of the Department of Social Welfare were Maori (Department of Social Welfare unpublished statistics). Once in care, Maori children seem much more likely to be admitted to some form of institutional care, especially in the Auckland area. The Ministerial Advisory Committee report on institutional racism (1985) showed that 62% of children in residential homes in the Auckland area were Maori. Further, the population of children in institutions

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who are Maori appears to have been rising. In 1959, Maori children made up "only" 25% of boys admitted to the Owairaka Boys Home. By 1969 the proportion had risen to 70%, and by 1978 to 80% (Department of Social Welfare, 1982).

As has already been noted older children and especially older boys are more likely to be admitted to institutional care because of behavioural problems or delinquency. Of the children admitted into the care of the Department of Social Welfare, Maori children are older (on average) than non-Maori children and are more likely to have come to the Department's notice because of misbehaviour. Although data is not available to support a conclusion that this is the reason for higher rates of admission to institutions, there is subjective support for this conclusion (Department of Social Welfare, 1982b).

Children in voluntary agency institutions

From the material provided in the Directory of Residential Facilities for Children (Department of Social Welfare, 1983b) it seems that, at least in principle, voluntary agencies provide care for children of all ages. However, only two specialise in the care of disturbed children, 29 (45%) have minimal facilities for caring for disturbed children, and 33 (51%) describe themselves as being able to care for a "moderate proportion" of disturbed children.

As at 31 March 1985, a total of 603 children (of whom 36% were state wards) were being cared for by 36 voluntary agencies in a total of 62 residential institutions. These 62 institutions could potentially accommodate a maximum of about 900 children if used to their full capacity (Department of Social Welfare, 1983b). Only 9 homes, however, accommodated more than 15 children (Department of Social Welfare, unpublished statistics).

Over the last 20 years the number of children cared for by voluntary agencies has more than halved (Infogram 5.3). This reflects changes in social attitudes to child care, lower fertility rates and the impact of social policy, especially the introduction of the Domestic Purposes Benefit (DPB). It also reflects the financial costs of providing residential care for children. A report of an inquiry into childcare related the reduced role of voluntary agencies to the financial difficulties they face because of what was seen as inadequate government support for either preventive or residential care (Cahill et al, 1977).

The voluntary sector, like the state, has moved away from institutional childcare (especially large children's homes) because of a feeling that they do not provide suitable environments for children. Thus, although the number of children's homes administered by voluntary agencies has remained relatively constant, many large homes have closed and several much smaller institutions have opened.

The characteristics of the children in these institutions are not known in any detail. McDonald (1976) suggested that voluntary agencies were likely to provide long-term care for younger European children who were admitted because of family problems. The state system by contrast was more likely to care for non-European children who were often older and admitted because of misbehaviour.

Information supplied by the Salvation Army about the residents of its children's homes gives some support to McDonald's suggestions. Of the 104 children admitted to their homes during 1984 and 1985, the average age when first placed in care was

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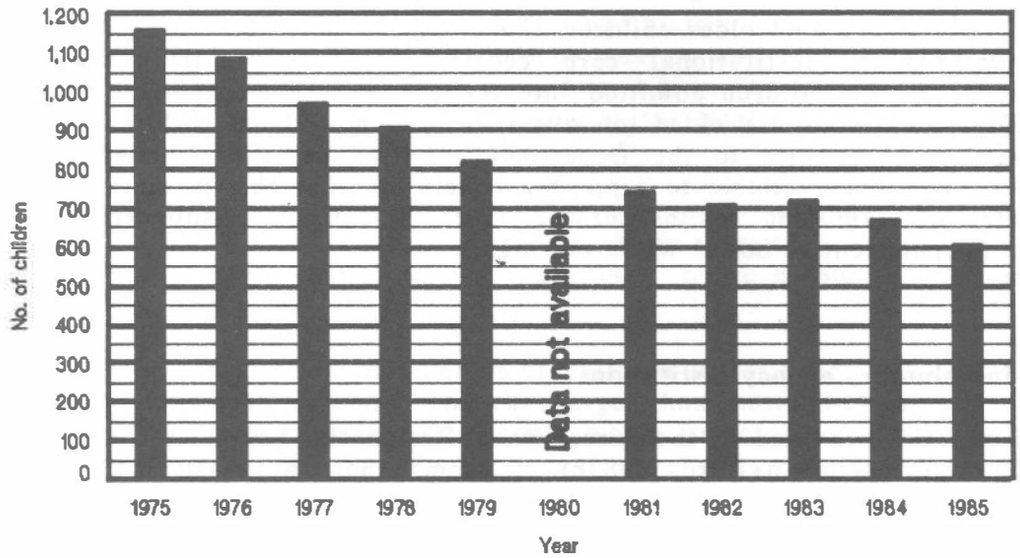
Infogram 5.3 CHILDREN IN VOLUNTARY AGENCY RESIDENTIAL INSTITUTIONS (1975–1985)



Source: Department of Social Welfare, Annual Reports 1975–1985.

9.2 years and the average age of all children resident was 11.5 years. 76% of the children were boys and 43% were of Maori or Pacific Island origin. The primary reason for admission was parent- rather than child-related in 72% of cases. Most referrals came either from the family itself or from a general practitioner involved with the family (Salvation Army, personal communication).

The children admitted to care in voluntary institutions do, however, now tend to be older and to have more behavioral problems than was previously the case. Care and supervision of such children requires higher staffing ratios which are more expensive to maintain.

Resource usage

During the period 1973 to 1986, the proportion of the Department of Social Welfare's social-work spending which went on residential services dropped from almost 60% to under 30%. This reflects a very large increase in the funding of non-residential social work services, which rose from $18,719,549 (expressed in 1986 dollar values) in 1972/73 to $84,403,000 in 1985/86. Spending on residential services increased from $25,786,782 in 1975 (1986 dollars) to $48,115,933 in 1982; and since that time there has been a decline in the actual amount spent, to $30,885,000 in 1985.

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This drop in spending has been achieved despite an overall increase in the number of children being admitted into residential care. It has been possible because of the increased use of family homes which are much less expensive than other residential options, mainly because of lower expenses associated with staffing (Infogram 5.4).

The Department's capacity to make greater use of family homes is, however, limited to some extent by the need for more secure facilities for some young people, especially the growing number being admitted on remand. The impact of the Criminal Justice Act 1985, which came into effect on 1 October 1985 and which prohibits the remand of offenders aged 16 or under to prison, is difficult to foresee. A much greater number of young people are being referred from the courts and require secure short-term accommodation. The Department of Social Welfare expected to provide 400 places for young people remanded in custody in the first 12 months of the Act's implementation.

It is not possible to make completely valid comparisons of the costs between institutions. In many respects the different types of institutions serve quite different populations. National institutions, for example, cater for older children whose behaviour is of concern to society and who may have previously experienced other forms of care, including family homes. These children often need greater levels of security, associated with higher staffing ratios. Ordinary schools often have difficulty in adapting to such children who, as a consequence, are educated within the institution.

Childcare is a costly business and, though the level of support to voluntary institutions has increased, it compares unfavourably, for example, with the level of subsidy provided to voluntary organisations caring for the dependent elderly. As the voluntary sector's ability to provide residential care has declined, the state sector has had to assume a proportionately greater role.

Overall, the Department of Social Welfare appears, through a process of developing cheaper residential options which also more closely resemble "normal" family life, to have improved the efficiency of its residential services in terms of both cost and quality of service. The more careful planning for the future of children who come into the Department's care has also meant that fewer children are likely to be placed inappropriately in children's homes.

Effectiveness

Residential institutions provide shelter and care for children and young people whose families are unable to provide that care, and for whom no community-based care can be found. They also provide custodial care for children and young people who are either awaiting court hearings or who have been judged to be in need of greater control than their parents can exercise. The capacity of an institution to meet these goals without distortion in one direction or the other is doubtful, for there is an obvious tension between the function of care and that of custody.

There is widespread agreement that large institutions are least likely to have positive qualities but there are no conclusions as to optimum size. As far as possible the Department of Social Welfare and voluntary agencies seek to replicate the key elements of family life in their residential programmes. For this reason Department of Social Welfare family homes are restricted to a maximum of six children. As homes get larger there is a greater need for routines. In its larger homes the Department seeks to operate smaller internal units to avoid the more

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Infogram 5.4

FINANCIAL COSTS TO THE DEPARTMENT OF SOCIAL WELFARE OF PROVIDING INSTITUTIONAL CARE FOR CHILDREN AND YOUNG PEOPLE

(Cost per bed for year ended 31st March 1985)

Group homes

Provide care for pre-adolescent children with behavioural problems. The future of group homes is currently under review.

National institutions

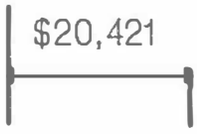
National institutions provide extended care and training for the group of most difficult boys and girls who have proved to be beyond community placement or any other placement previously attempted by DSW.

Boys' homes

Boys' homes meet the immediate or emergency needs of boys who are in difficulty with their families, communities or the law. In the main they provide for the 10–17 year age group and the majority of cases are on police warrant or remand.

Girls' homes

Girls' homes meet the immediate or emergency needs of girls who are in difficulty with their families, communities or the law. In the main they provide for the 10–17 year age group and the majority of cases are on police warrant or remand.



Reception centres

Reception centres provide temporary accommodation for younger children coming into DSW care while their circumstances are sorted out and plans made for their future, whether this means return home or placement elsewhere.

Family homes

Family homes serve a variety of needs. They provide short-term care in areas where there are no institutions; and provide long-term care for children and young people not suited to institutional placement, for young people in the care of the DSW who have or are about to begin working but require a supportive environment, and for young people discharged from DSW's long-term training institutions and special schools.

Sources: Department of Social Welfare, New Horizons, 1982,
Department of Social Welfare, unpublished data, 1985.

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institutional procedures. Of particular concern has been the capacity of residential institutions to meet the needs of the large numbers of Maori and Pacific Island children admitted to them. A working party of the Department expressed reservations about the small number of staff from similar cultural backgrounds to these children and about the ability of the institutional environments to develop culturally appropriate programmes (Department of Social Welfare, 1985b).

Acccptability

In DSW's terms, institutional care is not the preferred type of care. Since 1925 placement in the community has been the goal, and institutional placement the least favoured option. In fact fostering, which is the traditional community placement, has declined in availability. In 1966, 48% of state wards were in foster care; by 1971 this proportion had dropped to 41% and has remained at that level. In 1966, 16% were living with relatives. This dropped to 10% in 1977 and has continued at that level. There are several reasons for this decline: until recent adjustments, financial support for foster parents was very limited; work patterns especially for women have changed; and there have been increasing numbers of state wards in the older age groups, which are not so popular with potential foster parents.

The public's ambivalence over the role of children's homes makes their acceptability a matter of shifting opinion. Among professionals, residential institutions are seen as the least preferred option in childcare, but as one that in some cases is unavoidable. It is thought by some workers that, for young people who are undergoing psychological difficulties, the emotional pressures of family life may be too intense and they are better off in the relative anonymity of group living. The importance of peer rather than family influence in adolescent development is also cited as an argument for group care.

The Department of Social Welfare has placed a greater emphasis on institutions as vehicles for social work rather than custodial care. Staff have more than just a custodial role. They are expected to help the children learn ways of adapting to the wider community. To this end, training of residential social workers has received greater emphasis in recent years. In 1986, 3% of residential social workers had a professional social work qualification, compared with 0.3% in 1979. However, this still compares unfavourably with the 31% of DSW field social workers who had professional social work qualifications in 1986. The Department of Social Welfare has sought to involve the community in the life of institutions. The reverse, involving the children in the community, is often not possible because of negative community attitudes towards children in residential institutions.

Given the clear indications of over-representation of Maori people in Department of Social Welfare homes, it is regrettable that the department docs not routinely collect data on ethnicity.

Department of Social Welfare children's homes have their standards of service assessed by lay people in the form of visiting committees. These committees have had problems in developing an effective style of operation but in recent times some, at least, have taken on a clear advocacy role in respect of the children in the institutions.

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Key Points

* Although both the Department of Social Welfare and voluntary welfare agencies provide institutional care for children, neither have a preference for providing this type of care. Both prefer to provide community care whenever practical.

* Numbers of children coming into Department of Social Welfare care have decreased in recent years.

* Of the children coming into Department of Social Welfare care, only a minority are admitted into institutions. Most continue living with their parents or relatives or go into foster care.

* Institutional admission is more likely for boys than girls, for Maori than for non-Maori, and for older children than for younger children.

* In the past, voluntary agencies (and particularly churches) have had a strong tradition of providing institutional care for children in need. However, over recent years this activity has been declining. As a result the number of children admitted to institutions administered by voluntary agencies has dropped markedly.

* Institutions are often thought of as places for "bad" children. However, admission to DSW or voluntary care is more often due to family circumstances than to the behaviour or personal characteristics of the child. With increasing age, though, behavioural problems (and particularly criminal behaviour) do become more significant as reasons for admission.

* Family homes are the cheapest Department of Social Welfare institutions to operate, in terms of Department expenditure. They also seem to be the most effective and acceptable DSW institution. Generally the Department of Social Welfare has become more purposeful in its approach to children in care, and seems to be making more effective use of its resources. However, a shortage of adequate information is a major problem in making such assessments.

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CHAPTER 6: OTHER INSTITUTIONS FOR CHILDREN

Introduction

As well as hospitals and children's homes, there arc a variety of institutions designed to meet the particular needs of certain groups of children. Special schools, health camps and boarding schools are discussed in this chapter. These institutions have as their only necessary common point the fact that they accommodate children: they are grouped more for convenience of presentation than because of a common idcntity.

Residential special schools

Some children have needs which, in order to be met, require the provision of special educational programmes. These needs may arise from physical disabilities, such as impaired sight or hearing, or from learning difficulties related to social, psychological or behavioural problems.

The education system provides a wide range of alternatives aimed at meeting the special needs of these children. Most special needs programmes are provided within the normal day-school structure, reflecting the current educational policy of "mainstreaming" wherever possible.

In some cases, however, children with special educational needs are referred to residential schools. Of the 9,773 pupils who were in special educational settings during 1983, only 867 (9%) were in special residential schools (Department of Statistics, 1984c). Further, the indications are that the number of pupils in such schools will decrease as more resources are devoted to "mainstreaming" (Department of Education, personal communication 1987).

Residential special schools are provided by either the Department of Education or by voluntary agencies who receive most of their funding for providing and operating these schools from the government. Infogram 6.1 provides details of the schools, and the nature of their pupils' special needs. As can be seen from this infogram, special residential schools fall into two main categories: those serving children with special needs resulting from physical impairment or handicap; and those serving children with special needs resulting from psychological, social or behavioural problems. Children in the latter category are referred to special schools when their problem is considered so severe that the child's continued presence in the "normal" community will severely disadvantage his or her educational attainment and future opportunities, or the opportunities of others with whom the child will mix.

Children are referred to special residential schools after assessment by professionals, most often educational psychologists, or by Department of Social Welfare social workers. Children whose behavioural problems are such that thcy are considered delinquent are cared for or controlled by the Department of Social Welfare rather than the Department of Education, and are unlikely to be referred to special residential schools.

The number of children with special needs, such as children with visual or hearing impairment, is relatively low. As a result, some special residential schools have developed as national or regional facilities, and children referred to them often

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Infogram 6.1 SPECIAL RESIDENTIAL SCHOOLS IN NEW ZEALAND (1984/85)

PROVIDER	SCHOOL	NEED PROVIDED FOR	ROLL
State	Keiston School (Auckland)	Hearing impairment	55 (may include day pupils)
"	Van Asch College (Christchurch)	Hearing impairment	132 (may include day pupils)
"	Hogben School (Christchurch)	Learning difficulties	84
"	Salisbury Girls School Nelson	Learning difficulties	80
"	Campbell Park School Oamaru	Learning difficulties	104
"	Waimokoia School (Auckland)	Maladjustment	32
"	McKenzie Residential School (Christchurch)	Maladjustment	25
"	Wilson Home (Auckland)	Physical handicap	64
Voluntary agencies	Homai College (Auckland)	Visual impairment	96 (may include day pupils)
"	Glenburn School (Auckland)	Maladjustment	31
"	Hohepa School (Clive)	Intellectual handicap	134
"	Birchfield Home School (Christchurch)	Intellectual handicap	
"	St Dympna's Special School (Carterton)	Physical and intellectual handicap	30
Total	All special schools	All special needs	867

Source: Department of Education, Directory of Special Education and Guidance Services in NZ 1984/85.

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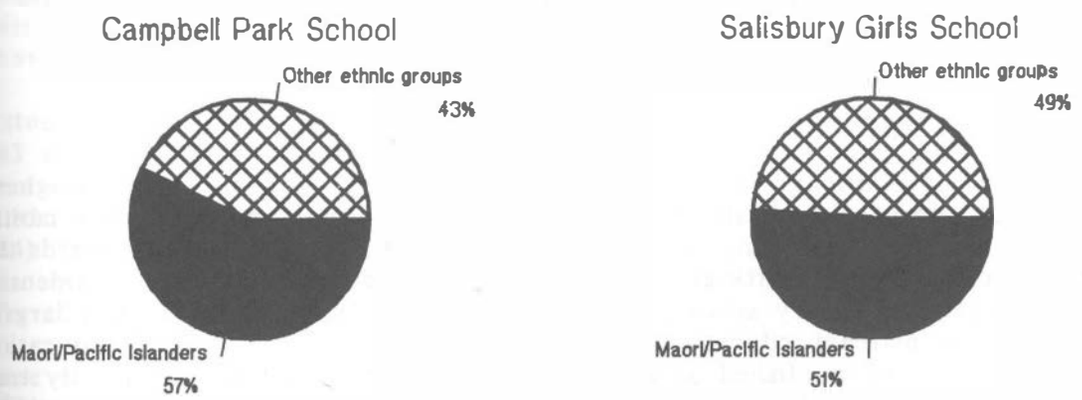
become residents of national institutions whether or not they are in need of total institutional care. Some schools, notably those catering for children with hearing or visual impairment, provide both residential and day facilities.

There is little information available about length of stay in residential special schools but it can be lengthy; for example the average stay in schools for slow learners has been reported as three years (Wilden and Rivers, 1980). Some schools, such as those for maladjusted children, provide schooling only up to second form level.

Information on the personal and family characteristics of children who attend special residential schools is not readily available. A count of pupils at Homai College, a special residential school for children with visual impairment, showed that the majority of pupils were European with some representation of other ethnic groups including Maori, Asians and Pacific Islanders (Royal New Zealand Foundation for the Blind, personal communication, 1985). The proportion of Maori and Pacific Island children in residential special schools for children with learning difficulties is, however, alarmingly high (Infogram 6.2) and has risen in recent years.

Why there should be so many Maori and Polynesian children in special residential schools for children with learning difficulties is not clear. The same trend is apparent for Maori children in special educational programmes within normal schools. In a review of special education, Wilton (1979) noted that the incidence of Maori children in special classes (in normal schools) was four times greater than expected. It is likely that this reflects the fact that learning difficulties can be the result of inadequate access to primary health care and good quality pre-school education. The fact, for instance, that Maori infants have an extremely high rate of hospitalisation for ear infections may have a detrimental effect on their later educational attainment. Further, their presence in special schools, and in educational programmes for slow learners, may reflect selective definitions of educational attainment and ability based upon cultural misunderstanding and racial stereotyping.

Infogram 6.2 ETHNIC COMPOSITIONS OF TWO DEPARTMENT OF EDUCATION SPECIAL SCHOOLS FOR CHILDREN WITH LEARNING DIFFICULTIES (1984)



Note: Data is not available for Hogben School, the third such special school.

Source: Department of Education (Special Education Section), unpublished data.

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Resource usage

Residential special schools are expensive facilities to run, compared with other types of schools. As well as teaching staff they employ domestic, social work and specialist personnel, leading to a staff/pupil ratio of almost one to one.

The schools' estimated running costs for the financial year 1986/87 were $10,150,000, with an overall cost per pupil of $25,600. There is, however, considerable variation in costs between the schools, with Hogben at $19,000 per pupil per year the lowest and Kelston at $36,600 per pupil per year the highest (Havill, 1986). Why there is this difference is unclear. Hogben is a school in Christchurch for children with learning difficulties and Kelston is a school in Auckland for children with hearing impairments.

Effectiveness

The degree to which pupils are able to adjust to community and family life after discharge from a special school was described by a recent major review of residential special schools as the most important measure of the schools' effectiveness (Havill, 1986). By that standard, most of the schools have not been very effective. Pupils leaving schools for children with learning difficulties adjusted poorly in terms of obtaining employment. Only 11% were found to be in open employment in the most recent investigation. A study of leavers from schools for maladjusted children also showed little long-term benefit. By comparison, 45 of 47 school leavers from Van Asch college in 1984/85 were in open employment.

Impediments to effectiveness were identified as including: failure to recognize the multicultural nature of the clientele; insufficient work done with families; lack of specialist training for workers; under-utilisation of residential social workers; and the failure in many cases to develop a plan for the child before he or she was admitted to the school.

For all these schools, the ultimate test of their effectiveness should be whether the children's needs could have been met as effectively in normal schools or other community-based educational settings. Havill feels that this is possible for most children, but acknowledges that while the residential placement may not advantage the child it may have an important role in relieving pressures on others (particularly the child's usual carers and teachers) connected with the child in the "normal" community.

Acceptability

Of all the institutions examined, residential special schools seem to have received the least critical attention. Research on special education has mostly focused on particular learning strategies and has been directed mainly towards the children in day-school settings. Within the total education system, residential special schools are a very small part, and one which seems to have been largely ignored by mainstream educationalists until a recent Department of Education review (about to be published at the time of writing). This seems especially true of the schools for children with learning difficulties, perhaps because, unlike those children with physical impairments such as sight or hearing, they have no related formal associations of adults with similar handicaps or impairments, such as the New Zealand Foundation for the Blind.

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Though definite evidence is not available, it seems that Maori and Pacific Island children are over-represented in special schools catering for children with psychological, social and behavioural problems, but not over-represented in those catering for children with special physical needs.

This could suggest that where the definition of special need is imprecise, as is the case with learning difficulties or maladjustment, there is a greater likelihood on the part of professionals to apply these classifications to Maori and Pacific Island children than to children of European origin. These difficulties may in fact be due to general social and economic disadvantage and to monocultural elements present in the education system. The more frequent incidence of health problems amongst Maori infants may also be a contributing factor, especially the high incidence of ear infections. These factors are unlikely to be either overcome, or compensated for, by placement of children in special residential schools.

Havill's review (1986) suggested that there were many elements of residential schools that were unacceptable. Their size and isolation could restrict family contacts and on that basis he proposed that Campbell Park School in Oamaru be closed down. He also pointed out that there are areas of the country in which relatively few children are referred to special residential schools. Presumably the methods developed in these areas to meet the special needs of children might be applied to all areas.

Children's health camps

Since 1919, children's health camps have sought to promote children's health, increase their self-confidence and foster positive behaviour modification by means of short-term residential placement.

The camps have had varied fortunes but retain a particular place in the eyes of New Zealanders because of their association with the sale of health stamps. These sales have contributed to funding the service since 1929.

Though initially set up to care for children with physical problems such as malnutrition, the camps now care for children with social, emotional or psychological difficulties. They provide a stay of about six weeks during which children attend school at the camps. The camps offer a change of environment to assist the child to cope with the stresses of the wider environment or to overcome behavioural problems.

A study of children resident in six of the seven health camps operating in early 1983 showed that 2,624 children attended health camps in that year, staying on average for six weeks. The children were referred for family reasons (39%), health reasons (31%) and behavioural reasons (30%), (Routledge and Johnston, 1984). The children's ages ranged from five to twelve years. Nearly half were less than seven years old. More boys than girls were referred. Most children had been referred by public health nurses or by general practitioners.

There was a tendency for children to come from geographical areas identified by Reinken et al (1985) as being of relatively high health risk, such as South Auckland and Porirua. More particularly, one third of Maori children at health

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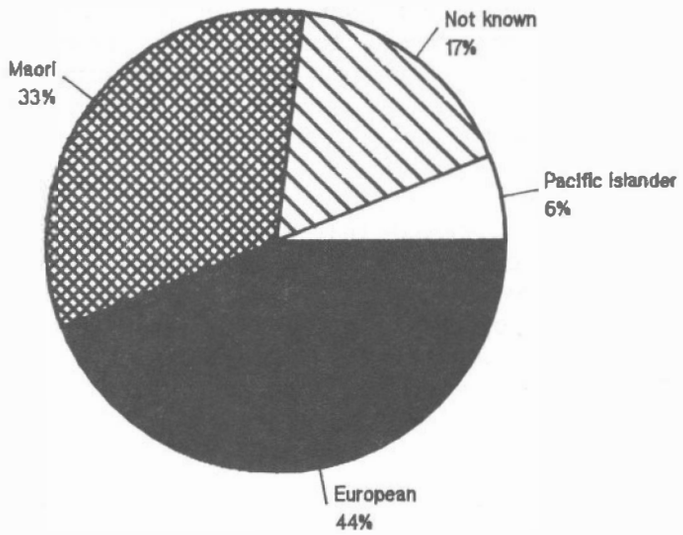
camps came from areas of highest risk compared to one-fifth of Pakeha children. Maori and Pacific Island children were clearly over-represented in the camps (Infogram 6.3).

Infogram 6.3 ETHNICITY OF CHILDREN IN HEALTH CAMPS (1983)



Source: Routledge and Johnston, Going to Health Camp, 1984.

Resource usage

The seven health camps are administered by regional committees. They receive most of their funding by way of a government grant, with lesser contributions from the sale of health stamps, parental contributions and donations. Revenue from the sale of health stamps has fallen, in real terms, by almost 90% between 1944 and 1982. The sale of health stamps is probably now more important as a way of making the name "health camps" known to the public. A 1984 review committee suggested a new approach to funding based upon a capitation system of payment from government (rather than the existing deficit-funding system) and an increased percentage from health stamp sales. It also suggested a greater financial contribution be made by parents (Hancock et al, 1984).

Effectiveness

The impact on children of their stay in health camps is uncertain, but it does not appear to be long-lived. Public health nurses' follow-up reports indicate initial improvement but a tendency for it not to be maintained (Routledge and Johnston, 1984).

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While the most important reason for referral was family problems, it seems unlikely that problems arising from family functioning would be overcome by removing a child from the family for a short period. Perhaps if ongoing family work was provided by social workers or others there would be a greater chance of success, but this does not seem to be a requirement of placement. Nevertheless there may be value to both child and family in some instances simply by virtue of having a break from each other.

Acceptability

The committee set up to review children's health camps expressed concern about the capacity of the camps to meet the cultural needs of the large client group of Maori and Polynesian children. It urged greater sensitivity in referral of children and in camp procedures (Hancock et al, 1984).

The review committee supported the continuance of the children's health camp movement, but it proposed new goals that argued for an extended involvement of children's families at all levels, with associated non-residential preventive work. These goals are not clearly stated so their operation is difficult to envisage.

However, the goals outlined appear to overlap with those of other agencies, notably the Department of Social Welfare. Given the problems associated with families receiving attention from a diversity of groups, the creation of yet another service seems unwarranted. The review committee suggests the health camp movement should remain under the Health Department rather than the Department of Social Welfare because of its more positive connotations. By itself this does not seem sufficient justification.

The health camps could have a role in providing the base for imaginative family-oriented residential programmes, but these will work best if integrated into the full range of services currently addressing needs in this area. A change of administrative base will not, in itself, lead to improvement in services but may lead to better co-ordination of efforts.

Boarding schools

Most children are educated in state-funded schools as day pupils but a relatively small group attend boarding schools. Some children do so because their families live in areas remote from any school or school transport. There are two options for them: they can be enrolled with the correspondence school; or they can live away from home, either with other families or in boarding hostels. Government subsidies arc available to parents who choose the latter option for their children. Some other children attend boarding schools not because of isolation, but because their parents prefer them to do so even though day-school placements may be available. Parents in this category do not receive boarding subsidies for their children.

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Primary boarding schools

Very few children of primary school age who attend private boarding schools do so because of rural isolation. Obviously their parents see advantages in residential rather than day schools but there is no documentation available on what those advantages are seen to be. In 1984, boarding subsidies were provided for 137 primary children (Department of Education, 1984). Most of these children attended state primary schools and lived with other families, for there are no state primary school hostels. Only 52 attended private primary schools and either lived in boarding hostels or with other families.

There are 24 private primary schools with boarding facilities. Nine of the 24 boarding schools cater for girls only, 12 for boys only and 3 for children of both sexes. Most have a religious orientation. Two of these schools are integrated with the state system: they are funded by the state but retain their special character and can exercise control over the type of students and staff involved in a way that state schools cannot. The remaining 22 schools are privately run.

Secondary boarding schools

At secondary school level, a far greater number of children live in boarding hostels. Thirty-nine state secondary schools have boarding hostels. Twenty-six integrated schools and 16 private schools also provide hostels. There are 33 hostels for girls only, 31 for boys only and 17 cater for both sexes.

Since 1978, the number and the percentage of pupils boarding away from home to attend secondary schools have remained stable (Infogram 6.4), with far more boys than girls attending boarding schools.

In 1984, the state provided a total of 3,632 boarding bursaries to secondary pupils attending either state or private secondary schools. These children came from areas remote from the nearest day schools. They made up only 28% of the children boarding away from home to attend secondary school. This represents a decrease from 1978 when 35% (4,266) of children boarded away from home because of geographic isolation, and was probably partly due to a changing population structure which has seen a decrease in the numbers of school-age children in the population. More recently, the downturn in the rural economy may have limited parents' ability to meet the extra costs (additional to those met by the state bursary) of placing their children in boarding schools. Although numbers of boarders in boarding schools have declined, there has also been a move toward children living in school hostels rather than with other families: in 1978, 13% of children boarded with families; in 1984 only 6% did so.

Parents have a choice about where to "spend" their boarding subsidy, either in the public or private sector. In reality, however, there are severe restraints on this choice. In 1986 the subsidy for the full school year's board was $1,180. This did not cover the boarding fees charged by any school, whether state or private (state $2,270 per year average, private $2,394 per year average, in 1986). The private schools also charge tuition fees. To be able to exercise full choice, parents need considerable resources of their own.

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Infogram 6.4 CHILDREN BOARDING AWAY FROM HOME TO ATTEND SECONDARY SCHOOL (1978-1984)

	1978	1979	1980	1981	1982	1983	1984
Boys	7,538	7,253	7,328	7,860	7,262	7,198	7,725
Girls	4,633	4,828	4,628	4,616	4,625	4,695	5,192
Total	12,171	12,081	11,956	12,476	11,887	11,893	12,917
Total secondary pupils	234,505	229,523	225,780	224,926	223,501	230,748	231,657
% secondary pupils boarding	5.2%	5.3%	5.3%	5.5%	5.3%	5.2%	5.6%

Note: These figures include children attending state secondary schools, integrated schools, area schools, departmental special schools, and private schools. They do not include children boarding privately.

Source: Department of Education, Education Statistics of New Zealand 1978-1984.

A group of boarding schools cater particularly for Maori pupils. The numbers of Maori secondary school pupils who have received financial assistance from the Maori Education Foundation for boarding expenses has been declining in recent years, as is shown in Infogram 6.5.

Resource usage

All boarding schools, both state and private, require some financial contribution from parents to help cover the costs of their children's care. The amount paid varies between schools and according to whether they receive a boarding subsidy.

All boarding schools receive some form of financial support from the state. State and integrated schools with boarding facilities receive almost all their funding from the government.

As well as the boarding subsidy which parents may choose to "spend" at private boarding schools, private boarding schools receive grants of various types for equipment and buildings. The biggest contribution they receive from the state is a subsidy on teachers' salaries. Formerly, 50% of the cost of teachers' salaries was met by the state; but from 1 April 1987 this has been reduced to 25%, with a loss of revenue to private schools of $7,150,000. The schools have increased their fees to meet the shortfall and, according to a survey carried out by the Association of Heads of Independent Schools, as many as 10% of children from rural areas attending private boarding schools in 1986, and expected to re-enrol in 1987, were to be withdrawn (The Dominion, 18 December 1986).

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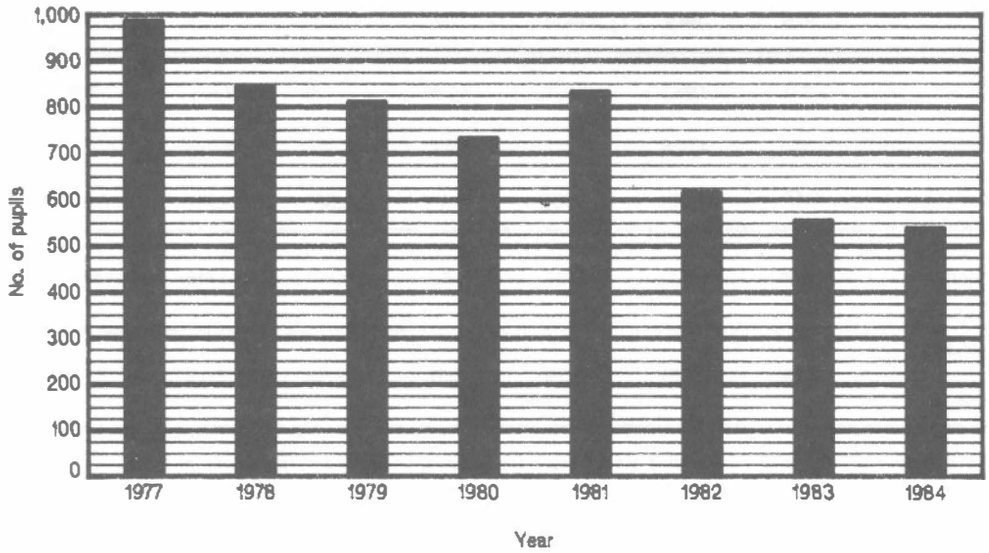
Infogram 6.5 SECONDARY SCHOOL PUPILS BOARDING AWAY FROM HOME WITH MAORI EDUCATION FUND ASSISTANCE (1977–1984)



Source: Maori Education Fund Annual Reports 1977–1984.

The number of grants made by the Maori Education Foundation for boarding assistance has steadily diminished. There are several reasons for this. Firstly, there is a concern about the cost and demand for this form of education. The Foundation noted in its 1980 annual report that almost 20% of awards were not taken up or were discontinued as the pupils left during the year. They suggested this could be because of increases in fees and the parents' inability to meet those increased costs. Secondly, the Foundation seems to be increasingly concerned to spread its resources more broadly.

Finally, the Foundation's income is mostly derived from the unclaimed revenues from Maori land administered by the Maori Trustee. In recent years, improvements in administration and greater awareness of entitlement has meant less money remains unclaimed. There is, therefore, less to distribute. In 1985, the Foundation made no new awards for boarding bursaries although it continued those to which it was committed and gave supplements to government boarding bursaries. Thus the number of Maori pupils able to attend boarding schools is likely to decline further.

Effectiveness

In the absence of reliable information, one can only speculate about why parents send their children to boarding schools (excepting those who do so because of their isolation). Codd and Burridge (1972) found that in one state school for boys which had both boarders and day pupils, at least 46% of the parents of boarders perceived "educational" advantages for their sons in attending boarding school. This seems to be a matter of faith rather than fact, at least in purely

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academic terms because, as the study showed, the boarders at that school were relatively disadvantaged academically compared to the day pupils.

However, there may be other advantages in the long term. There is a common belief that boarding schools maintain a high social position for their pupils and thereby improve their later opportunities in life. Baldock (1977) supports this, noting that the majority of pupils in private and single-sex state boarding schools are from professional and other high-income families. The social contacts made, and the access these give to employment and other opportunities after leaving school, may be more important than purely educational outcomes.

Parents must see the advantages to their children in attending boarding schools as being more relevant to males than females because of the large differences between the sexes in attendance figures.

Acceptability

Boarding schools have a unique position among New Zealand's institutions in that they tend to be regarded very positively. In attending boarding schools, children and their parents are making a "trade-off" between the advantages of family life and perceived social and educational advantages. Yet little is known of who attends them or what the outcomes of attendance are.

On occasion, children may be sent to boarding schools because of difficulties in their family situations, or in their own behaviour. This is most clearly seen in the increased numbers of state wards placed in boarding schools. In 1985, 5% of all state wards (291 children) attended boarding schools whereas in 1972 only 1% of state wards did so. Boarding school placement may also sometimes be an informal response by families to their own difficulties.

Parents may want their children to have an education with a religious background, as most private boarding schools are denominational. The Anglican, Catholic and Presbyterian Churches have provided this type of education for many years. More recently the Mormon Church has established its own boarding school system.

Not all Maori children who receive assistance from the Maori Education Foundation attend boarding schools; and not all of those who do, go to Maori schools. For some Maori families, religious affiliation is possibly more important than cultural identification, especially for Catholic or Mormon families. However, the boarding schools which serve a primarily Maori group, six in all, are seen as attractive because they provide an enriching Maori environment. Like other boarding schools, most are provided by religious organisations, and are associated with academic success and with having produced many students who have subsequently become leaders of the Maori community (Douglas, 1985).

The positive perception and lack of knowledge about boarding schools seem to give them a degree of freedom in administration unknown to other institutions which care for children. The Board of Health's Committee on Child Health (1982) suggested that some form of monitoring programme would "be of value in assisting the principals of schools, which have boarders, in the overall care given to their pupils" (p. 95). To date no such system of monitoring has been instituted. As a result, there is little official information available on schools with boarding facilities.

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Key Points

Special residential schools

* The majority of children with special needs are educated within the normal school system. Those who attend special residential schools are likely to either live in areas where there are no alternative facilities, or to have such extensive needs that they require more attention than those alternatives can provide. Consequently the children residing in special residential schools are often isolated from their families and the "normal" community.

* Although there is a shortage of useful information, it seems that residential placement may be of doubtful value in terms of positive outcomes for the children involved.

* In special schools for children with learning difficulties or who are maladjusted, Maori and Pacific Island children are grossly over-represented.

Children's health camps

* Children's health camps are long-established institutions whose clientele has changed from children who have primarily physical needs to children with primarily social and emotional needs.

* The change in service has not been accompanied by clearly defined goals or methods of service and as a result there are doubts about the effectiveness of the service they provide.

* Given that health camps now serve children with primarily social and emotional needs, it seems clear that their programmes should be oriented more to working with the child's family and in the child's community.

Boarding schools

* Most children attend boarding schools because of the advantages their parents perceive for them in attending, not because they are the only alternative available. It is therefore surprising that little information is available on the advantages or disadvantages of boarding schools. In fact, little monitoring of any type occurs in relation to boarding school hostels.

* Parents of children who live in remote areas may receive boarding bursaries for the education of their children in boarding or day schools. Although such bursaries are seen to give parents "choice", the degree of choice depends upon other resources available to parents, such as disposable income.

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CHAPTER 7: INSTITUTIONS FOR OFFENDERS

Introduction

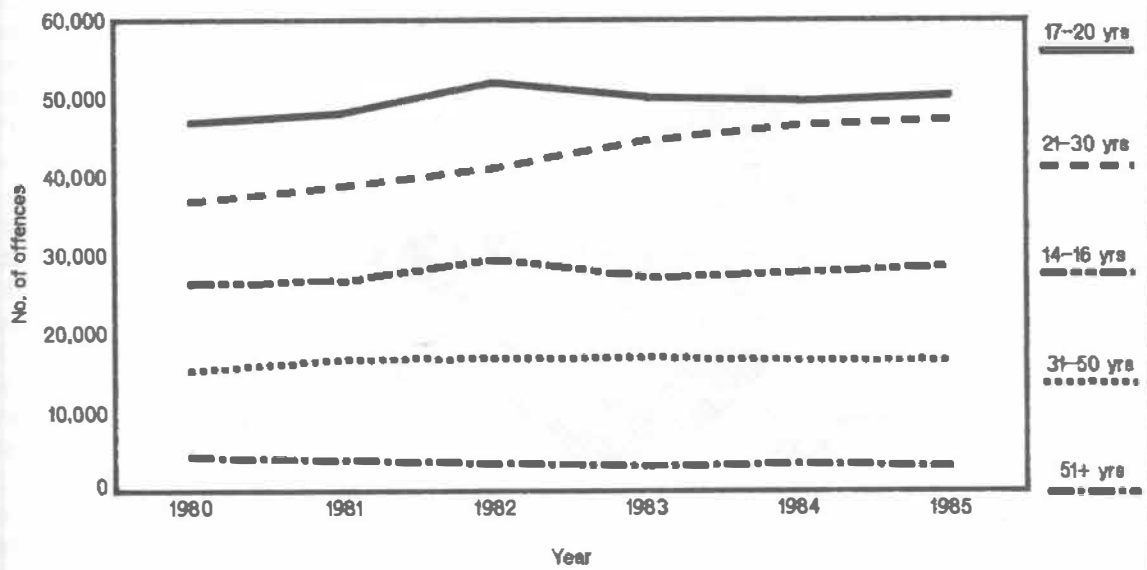
New Zealand has a variety of institutions used for detaining people who are awaiting criminal trial or who have been sentenced to a term of imprisonment following conviction of a criminal charge or charges. People may also be placed in prison for civil (non-criminal) matters, including default of debt.

There are separate facilities for male and female prisoners, offering varying degrees of security. There are youth prisons for young people (less than 20 years of age) which provide a regime very similar to that in prisons for adults. Corrective training institutions, also for young people, provide a particularly rigorous way of life modelled to some extent on systems of military discipline.

Who criminally offends?

Most people detained in the nation's prisons, whether awaiting trial or sentence, or serving sentences imposed by the courts, are young adults. Their presence in prisons reflects the fact that they are the people most likely to be apprehended for offending. In 1985, for example, people aged between 17 and 30 years made up 67% of all offenders apprehended by the police (Infogram 7.1). Infogram 7.1 also shows that the apprehension of young adults for offending has been increasing over recent years, particularly for those aged between 21 and 30 years. To a certain extent this trend can be attributed to the increasing numbers of people in these age groups. However, even when changing population structures are controlled for, offending rates continue to show an increasing trend. For instance, the offending rate of 17 to 20 year olds increased by 27% between 1978 and 1984: from a rate of 1,614 per 10,000 in 1978 to a rate of 2,046 per 10,000 in 1984. Similarly the offending rates for other age groups also increased: the 14 to 16 year old rate by 27%, the 21 to 30 year old rate by a spectacular 45%, and the 31 to 50 year old rate by 18%.

Infogram 7.1 REPORTED CRIMINAL OFFENCES BY AGE (all offences 1980–1985)



Source: New Zealand Police, unpublished data.

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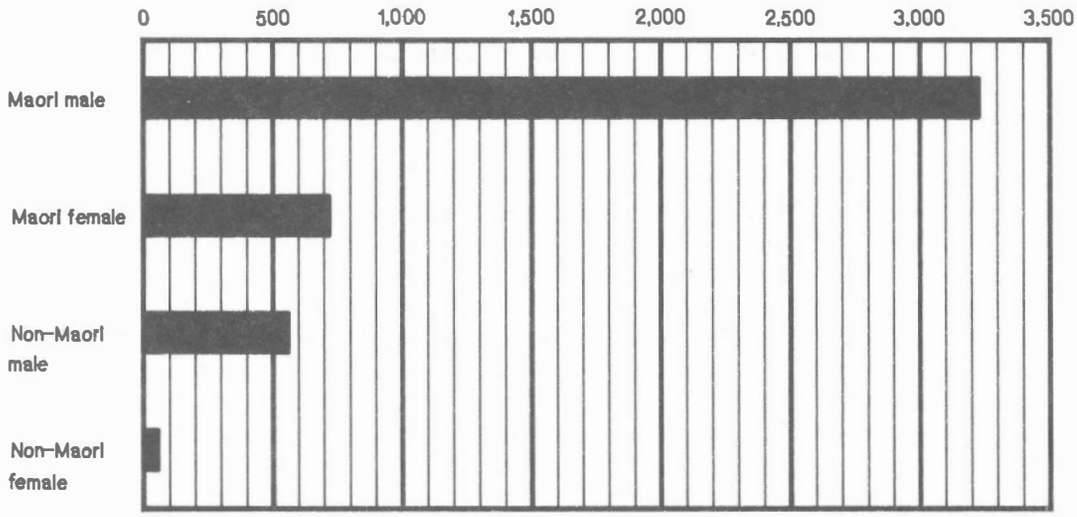
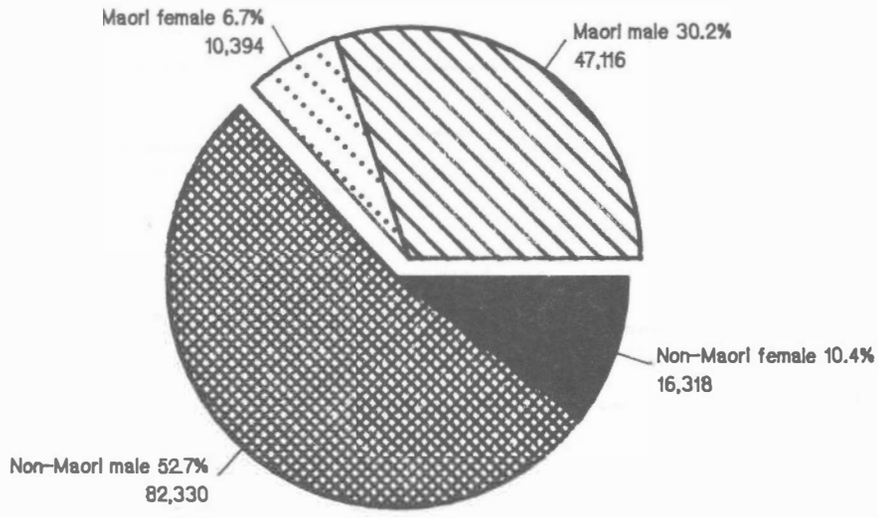
The only age group not to show an increase in the rate of offending between 1978 and 1984, were the over 50 year olds. Their offending rate actually decreased by 6% from 53 per 10,000 in 1978 to 50 per 10,000 in 1984.

Infogram 7.2 REPORTED CRIMINAL OFFENDING BY ETHNICITY AND SEX (all offences) 1984

a) No. of reported offences per 10,000 people of same ethnicity and sex



b) Numbers of reported offences



Source: New Zealand Police, unpublished data 1984.
Department of Statistics, Population Estimates 1984.

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Although offending patterns are predominantly age-related they are also related to ethnicity, sex, and socio-economic status. For all age groups the people most likely to be apprehended for offending are male and Maori (Infogram 7.2). The full significance of ethnicity is illustrated by the fact that Maori women have a higher apprehension rate for offending than non-Maori men.

One of the few New Zealand studies investigating the relationship between socio-economic status, ethnicity, and offending was conducted by Fergusson et al during 1975. A sample of 5,472 boys born in 1957 was randomly chosen. Analysis showed that 10.9% of the boys had appeared at least once before the Children's Court. It also showed that being non-European increased the risk of offending, as did declining socio-economic status. The risk of offending for non-European boys from the lowest socio-economic group was 1 in 3.5, and for those of the highest socio-economic group it was 1 in 10. The comparative ratios for European boys were 1 in 9 from the lowest socio-economic group and 1 in 26 from the highest socio-economic group. The researchers coneluded that although socio-economic status is related to offending "it is not possible to dismiss differences in European and non-European offending rates as being solely due to socio-economic factors" (Fergusson et al, 1975 p.18).

Remands in custody

People who have been apprehended for offending (whether alleged or proven), and who are awaiting trial or sentence following conviction, may be held in prison either because of the serious nature of the offence or because there is reason to fear they might reoffend or abscond if left in the community. Remand prisoners awaiting trial are regarded as innocent and are not subject to all the strictures of imprisonment. They may, for example, wear their own clothing, receive visitors more freely than sentenced prisoners and have freedom of written correspondence. However, problems of understaffing in prisons and a lack of work or activities for remand prisoners mean that in practice they are likely to be locked up for longer periods in any one day than sentenced prisoners. In many ways the lot of the remand prisoner, though usually of shorter duration, is harsher in its immediate effects than that of the sentenced prisoner.

For all age groups, remand prisoners account for approximately half of all people received into New Zealand prisons. This proportion has shown no change since 1977 (when statistics first became available). In 1984 a total of 5,979 people were remanded to prison. Young adults aged between 17 and 29 years made up 75% of remand prisoners, reflecting their high proportion amongst people apprehended for offending. The rates at which people are remanded to prison decrease with age as Infogram 7.3 shows.

Concern has been expressed about the remand of young people (aged less than 17 years) to adult prisons. In 1984, 5.9% of the people remanded to prison were aged less than 17 years. A review of such remands to Mt Eden prison in Auckland carried out by Judge Wallace (1984) was highly critical of this practice, and also of the general lack of facilities for remand prisoners. Recent changes to the Criminal Justice Act mean that people aged less than 17 years cannot now be remanded to prisons. If remand in custody is necessary, it must be to a Department of Social Welfare institution.

In 1984, 93.7% of remand prisoners were men. Given the male to female offending ratio of 5.8 to 1, the remand ratio of 14.9 to 1 is greater than one would expect.

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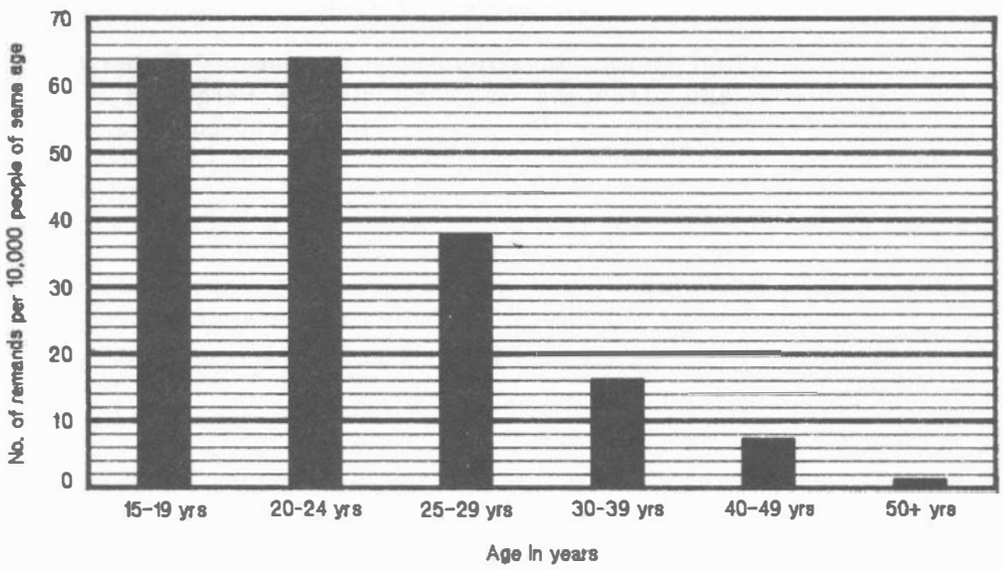
Infogram 7.3 RATES OF PRISON REMAND BY AGE (1984)



Sources: Department of Statistics, unpublished data 1984,
Department of Statistics, Population Estimates 1984.

Without looking at the types of offences committed, the conclusion can be drawn that men are more likely to be remanded in prison than women.

Of all the people remanded in prison during 1984, 48.3% were Maori (Infogram 7.4). This proportion is about 10% greater than one would expect given that "only" 36.9% of reported criminal offences are attributed to Maori people. It has not been possible to investigate whether Maori people commit more serious offences than non-Maori people. If this is so, it might explain the greater remand in custody of Maori people. If not, other factors, including the attitudes of those involved within the judicial processes, need to be changed.

Normally remand in prison is for a relatively brief period of time. In 1984, 64% of remand prisoners were in prison for a period of less than two weeks, with 3% being in prison for more than two months. Variations in length of remand do, however, occur between men and women, and Maori and non-Maori. Maori people tend to be remanded for longer periods of time than non-Maori people, and men for longer periods than women. In 1984, 39% of Maori remand prisoners spent more than two weeks in prison compared to 33% of non-Maori remand prisoners, and 36% of men spent more than two weeks in prison compared to 28% of women. To explain these discrepancies, it would be necessary to relate types of offences to period of remand.

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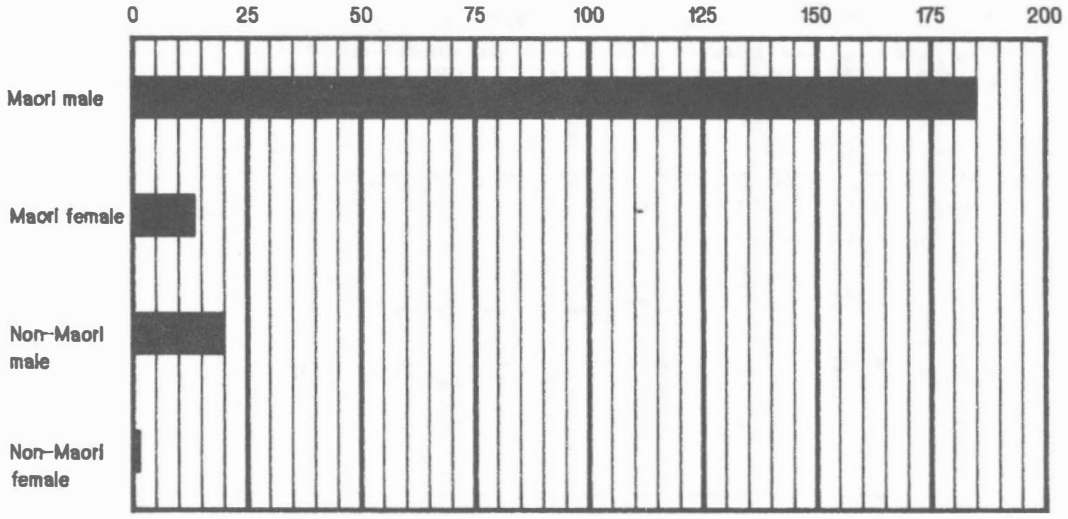
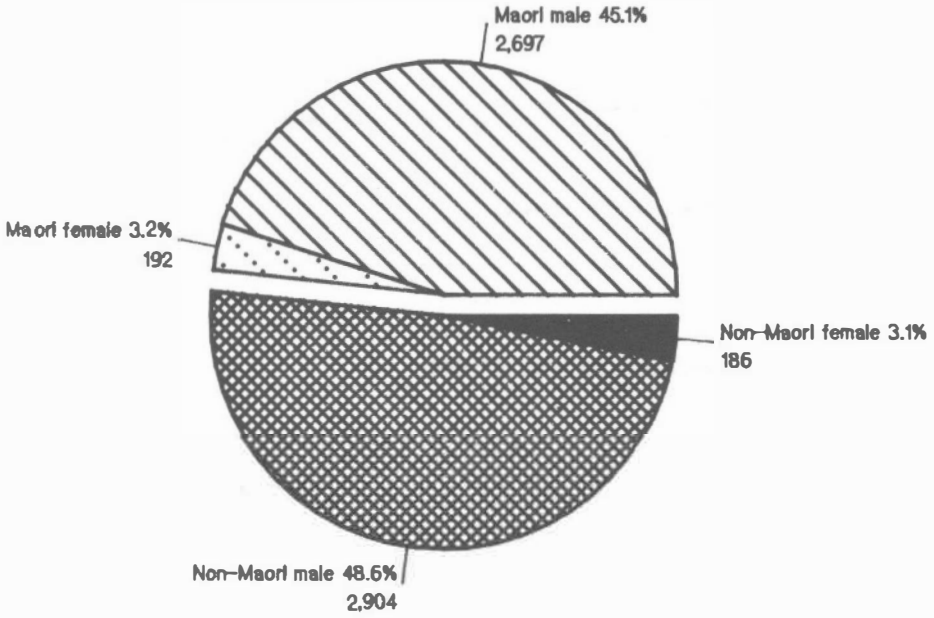
Infogram 7.4 REMAND PRISONERS BY ETHNICITY AND SEX (1984)

a) No. of remands per 10,000 people of same ethnicity and sex



b) Numbers of remands



Sources: Department of Statistics, unpublished data 1984,
Department of Statistics, Population Esitimates 1984.

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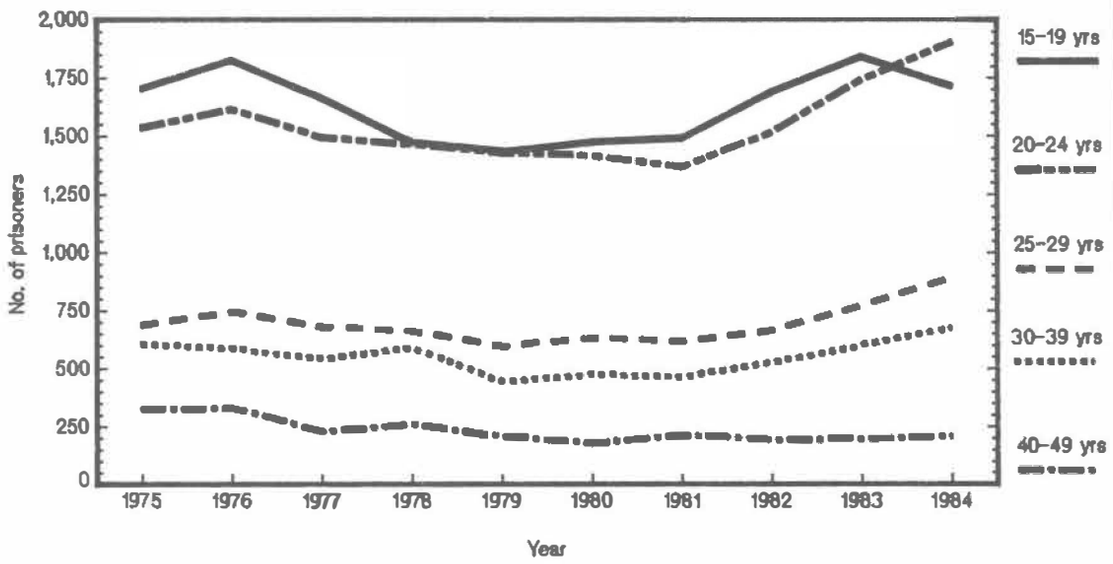
Sentenced prisoners

During 1984, a total of 5,902 people entered New Zealand prisons to serve sentences of imprisonment. Such experiences are confined almost entirely to people in the younger age groups, particularly those aged less than 25 years. As age increases, the number of prisoners received decreases (Infogram 7.5). For the past 20 years, more than half of all prisoners have been aged less than 25 years (64.6% during 1984). Further, of the 2,085 prisoners aged more than 25 years in 1984, 70% were aged less than 35 years and only 1% were more than 55 years old.

Since 1980, the numbers of people imprisoned in all age groups, except those aged more than 40 years, have steadily increased (Infogram 7.5). As with offending patterns, these trends reflect increasing rates of imprisonment, even after controlling for changing population structures.

Infogram 7.5 NUMBER OF SENTENCED PRISONERS BY AGE (1975–1984)



Sources: Department of Statistics, Justice Statistics 1975–1984.

Maori people have made up more than 50% of all sentenced prisoners since 1979 (Infogram 7.6) whilst committing 37% of all offences (Infogram 7.2) and accounting for 9% of the total New Zealand population. The Maori male imprisonment rate of 186 per 10,000 is 13.8 times greater than the non-Maori male imprisonment rate and has been steadily increasing over the last ten years (Infogram 7.7).

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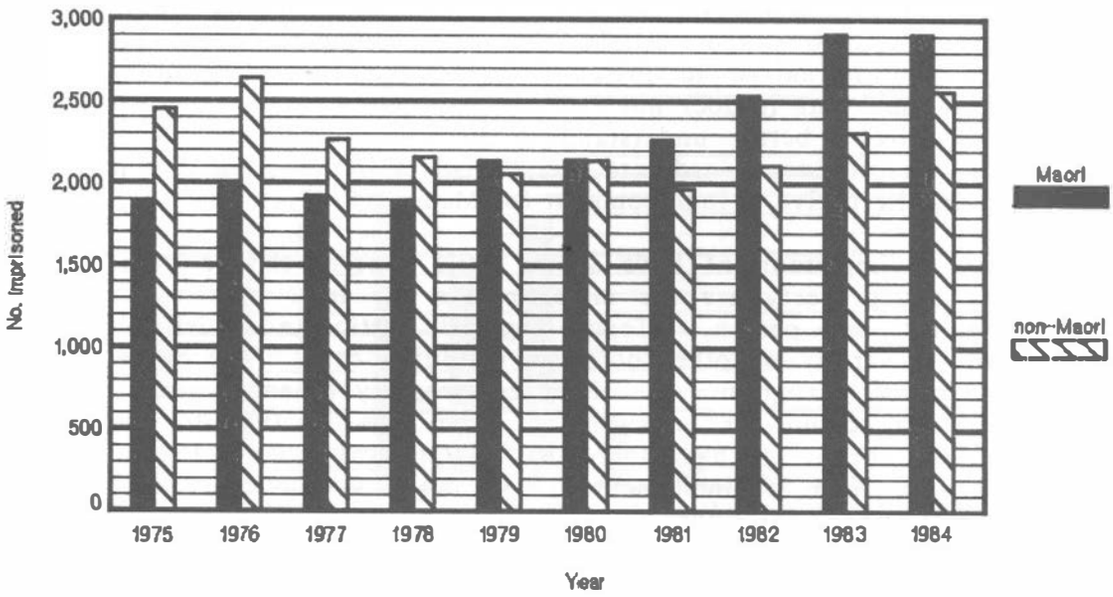
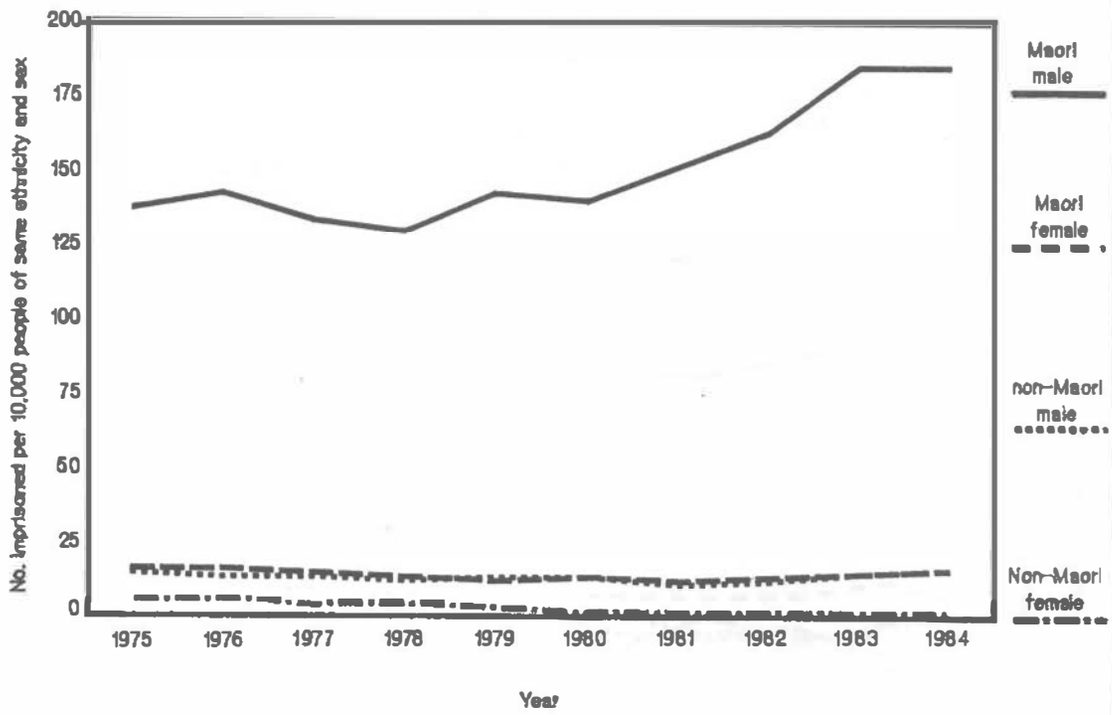
Infogram 7.6 SENTENCED PRISONERS BY ETHNICITY (1975–1984)



Sources: Department of Statistics, Justice Statistics 1975–1984.

Infogram 7.7 SENTENCED PRISONERS BY ETHNICITY AND SEX (1975–1984)



Sources: Department of Statistics, Justice Statistics 1975–1984,
Department of Statistics, Population Estimates 1975–1984.

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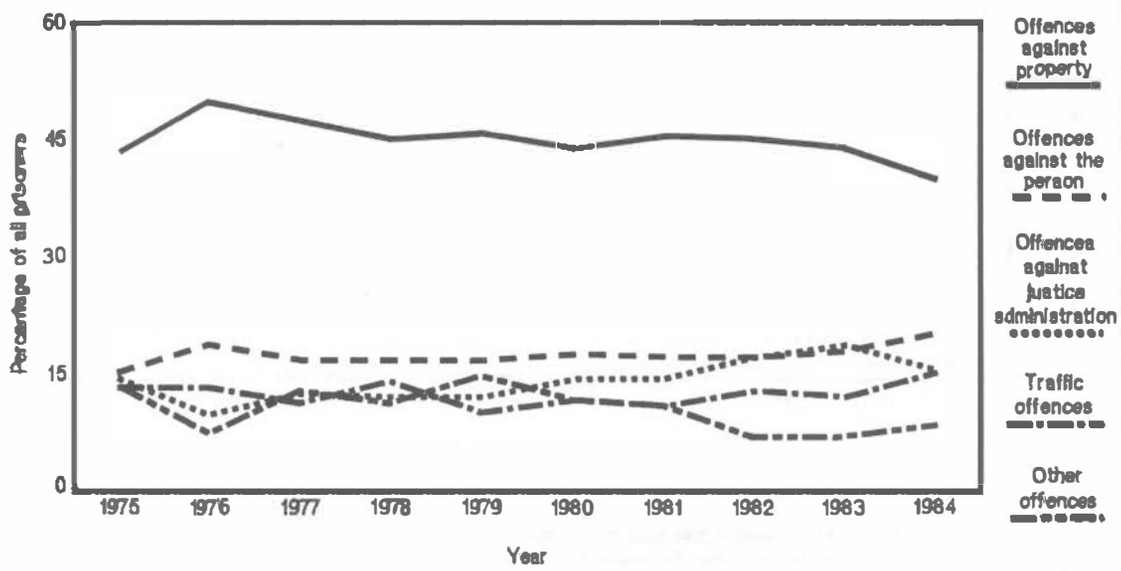
The conclusion that the high Maori imprisonment rate cannot be explained by the Maori offending rate is not new. This concern was one of the driving forces behind the establishment of the Offenders Legal Aid Scheme. The present Chief District Court Judge has attributed part of the difference to a lack of family and community support for young Maori people (The Dominion, 26 July 1985). The courts need evidence of such support to feel confident in imposing community-based sentences as an alternative to prison. This perception may explain judges' sentencing practices but it does not fully explain the situation. It may be that the courts require a better understanding of Maori social structures, and the support they can provide, in order to feel confident in imposing community-based sentences as an alternative to imprisonment for Maori offenders.

The reasons for imprisonment have shown little general change over the years. Offences against property are the major reason for imprisonment, followed by offences against the person, offences against justice administration, traffic offences, and a variety of other offences including drug offences and offences against good order (Infogram 7.8). However, property offences have declined in significance as a reason for imprisonment from 43% in 1975 to 40% in 1984. Offences against the person have increased in significance from 15% to 20% over the same period. With the implementation of the new Criminal Justice Act, this trend can be expected to continue.

Reasons for imprisonment change slightly with age. Young people are most likely to be imprisoned for offences against property, whilst older people are more likely to be imprisoned as a result of traffic offences and offences against justice administration. Offences against the person show little change in proportion despite changing age.

Most prisoners are sentenced to prison for a term of 6-9 months (Infogram 7.9). The length of sentence imposed docs not appear to vary according to ethnicity, and has shown little change over the last ten years. However, as prisons become the domain of an increasing concentration of violent offenders, the average length of imprisonment can be expected to increase.

Infogram 7.8 MAIN GROUPS OF OFFENCES RESULTING IN IMPRISONMENT (1975–1984)



Source: Department of Statistics, Justice Statistics 1975–1984.

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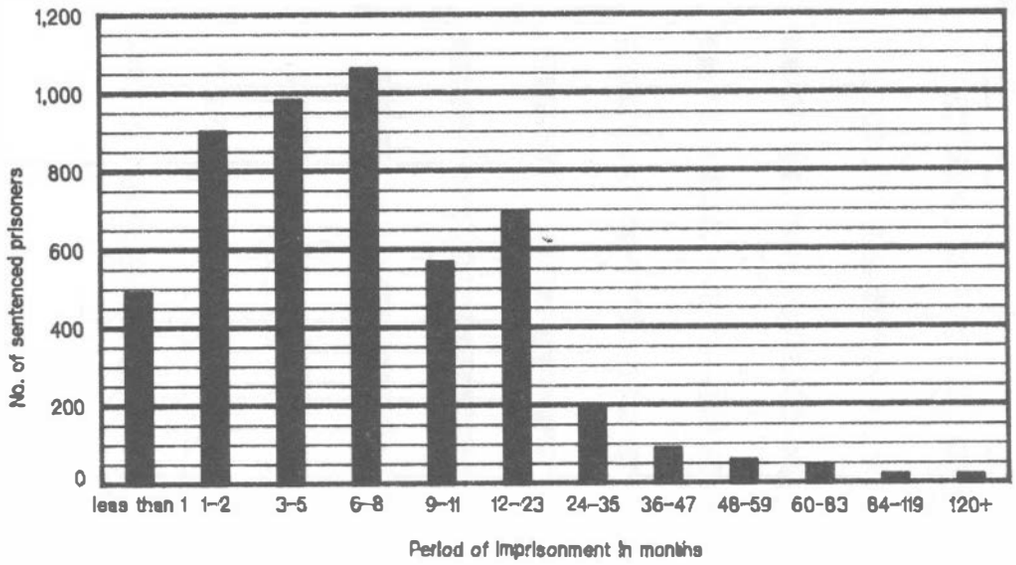
Infogram 7.9 PRISONERS BY LENGTH OF SENTENCE IMPOSED
(all sentenced prisoners, 1984)



Source: Department of Statistics, Justice Statistics 1984.

Resource usage

From 1975 to 1984 the number of people sentenced to imprisonment in New Zealand increased by nearly 21%. Numbers of people actually in prison on any given day increased by 15% and the number of staff required to manage them also increased by 15% (Infogram 7.10).

Demographic factors explain much of this increase. The proportion of 15 to 24 year olds in the population swelled during the period. They are the people most likely to commit offences and to receive prison sentences. The imprisonment rate has, however, increased at a rate not explained entirely by demographic factors alone, as has the offending rate. Other reasons need to be found for the increase and these might include the influence of social and economic factors (such as youth unemployment) and of legislative measures.

Between the 1973/74 and 1985/86 financial years there was a cost increase of 19% (in real dollar terms): in 1985/86 the total cost was $60,345,000. Nett costs per prisoner rose from $15,027 in 1978 to $18,965 in 1981, but had dropped to $16,112 by 1985. The Justice Department suggests that increases in staff numbers had reduced staff costs, by reducing the need for overtime services. Also, prison industries had become more productive, (Department of Justice, unpublished data).

Thus the prisons have become more efficient as they have coped with larger numbers at a reduction of cost per head. However they were still the most expensive element in the operational areas of penal policy (which are prisons, probation and periodic detention). In 1979 prisons accounted for about 90% of expenditure in

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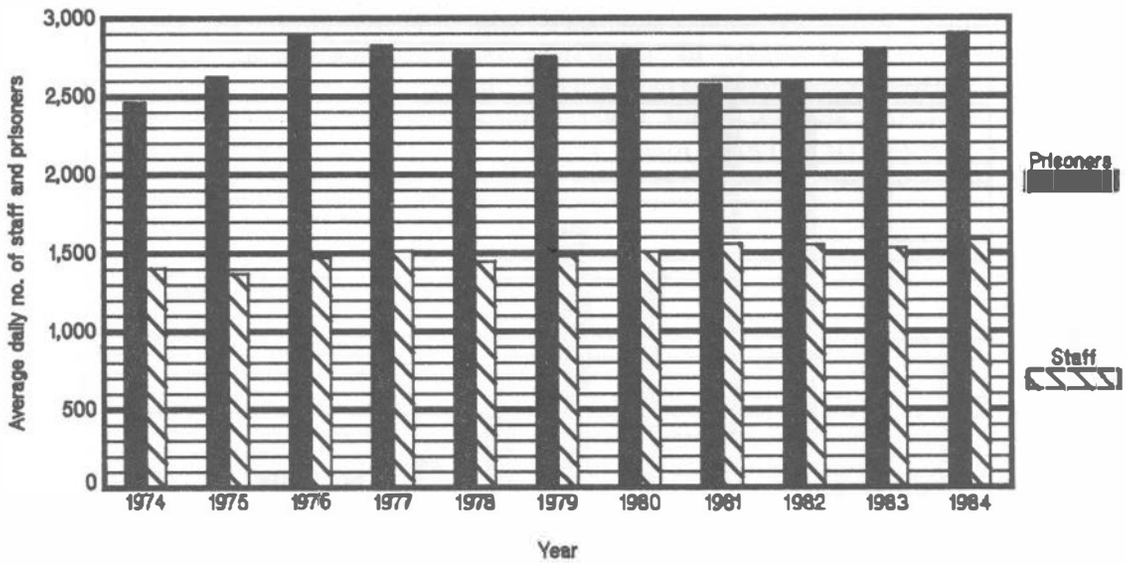
Infogram 7.10 RATIO OF PRISONERS TO PENAL STAFF (1974–1984)



Sources: Department of Justice, Annual Reports 1975-1985,
New Zealand Government, Expenditure Estimates 1975–1985.

this area. By 1981 the proportion of penal policy money spent on prisons had dropped to 77% of all expenditure but they dealt with only about 20% of the people involved (Penal Policy Review Committee, 1981).

The expense of prisons is, however, compounded by the fact that in many cases there are additional costs beyond those for custodial services. The families of prisoners may require maintenance from the social welfare system. In the financial year ending 31 March 1981, 224 Domestic Purposes Benefits were paid for this reason and by 1985/86 the number had increased to 281. For the year ended 31 March 1986, this amounted to total expenditure of $3,259,465. The full extent of these costs, however, needs to be balanced against the potential costs, both financial and social, of allowing certain offenders to remain in the community.

The total costs of imprisonment cannot be calculated because of a lack of quantitative information in many areas. In the year to 31 March 1986, there was a cost of $20,535 per prisoner in running medium security prisons. The cost of Probation Service support was $571 per ex-prisoner. Among the non-quantifiable costs might be the cost to a prisoner's partner of having to give up paid employment in order to care for children, or paying for childcare in order to start or maintain paid employment. Additional costs to a prisoner's family might include travel expenses and time costs in visiting the prisoner; pain, suffering and stigma incurred; and the impact on children of being brought up in a family with one parent in prison. It is even more difficult to quantify benefits to the community of imprisonment; for example, the community and personal costs saved through having violent offenders incarcerated.

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Effectiveness

The most desirable outcome for prisons would be that they deterred inmates and potential offenders from reoffending and offending. All the evidence indicates that they have been unsuccessful in achieving that goal. In 1980 nearly 46% of all the people sentenced to imprisonment had previously had a custodial sentence and by 1984 that proportion had grown to nearly 55%.

The penal policy of corrective training (a sentence of three months' duration including a rigorous pace of daily life and very strong discipline catering for young offenders) is one of the few penal measures to have been subjected to thorough evaluation. A study by Walker and Brown (1983) showed that 71% of trainees reoffended within 12 months of release. The sentence was shown to be ineffective in achieving positive changes in those subjected to it and, in fact, had negative outcomes. A majority of people taking part in the study reported that corrective training had made them more aggressive, more angry and less respectful of authority, all of these being attitudes which are likely to lead to further offending.

At various times prisons have been presented as having a rehabilitative function. There is little evidence to support that contention. Indeed, the study of corrective trainees suggests that the reverse may well occur. The argument that prisons, by forcing association of offenders, may act as "schools of crime" also has an obvious logic. Prisoners may also feel more comfortable in prison where they have to take little responsibility for their own lives.

The retributive or punishment function of prisons depends, in a negative sense, on the novelty of imprisonment to the individual. For many it is no novelty and for others the length of sentence may blunt the initial impact. By comparison with some other countries, such as the Netherlands, New Zealand imposes long prison sentences. However there has been some movement in recent years toward shorter sentences. In 1979, 66% of sentences were less than one year. In 1984, 81% were less than a year long.

Denunciation, or the public expression of disapproval for certain actions, is very important in the public's eyes. Letters to newspapers demanding harsher prison conditions and politicians' statements on the same issue are clear examples of this. However the influence of denunciation in preventing illegal acts is unclear, and research shows that the likelihood of getting caught is more likely to act as a deterrent than the actual punishment imposed (Young, 1981).

Finally, prisons have the goal of protecting society and its members from individuals whose behaviour has been judged criminal. Prisons do this by separating and containing criminal offenders from "normal" society. Preventive detention, as defined in the 1985 Criminal Justice Act, most explicitly embraces this goal. The Act states, "the High Court, if it is satisfied that it is expedient for the protection of the public ... may pass a sentence of preventive detention." (Criminal Justice Act, 1985 p. 44.) However, with the exception of preventive detention, prisons have a limited role in protecting society and its members from the activities of criminal offenders. Unless society has the ability, the resources and the collective will to contain all criminal offenders for indefinite periods of time, prisons will not prevent criminal offending.

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Acceptability

Prisons are not effective in meeting their goals but this does not seem to be the major determinant of their acceptability. The important factors here reflect the interests of particular groups; these interests are diverse and often shifting. The determination of what is an acceptable prison regime must always be prefaced by the question "acceptable to whom?" Discussion frequently arises in response to particular incidents such as rises in crime statistics and is often more emotive than informed. Few people have any knowledge of the reality of prison life, but for most this is no barrier to comment.

While some individuals and groups would argue that prisoners should suffer for their misdeeds, one can expect agreement that the programmes should at least seek not to damage the people subjected to them in such a way as to increase their chances of reoffending. The goals of the Penal Division of the Department of Justice reflect this and emphasise the need for secure, humane conditions and for the provision of resources which are likely to assist the offender's reintroduction into the community.

Prisons are charged with keeping prisoners in circumstances which are as humane as is consistent with the need for security. There are three levels of security in New Zealand prisons. The majority of prisoners are in medium security institutions (about 78% in 1983). Few people are kept in minimum security (about 15% in 1983) and even fewer are in maximum security prisons (about 8% in 1983). There are two aspects of prison security. The first is containment: at present most prisoners are not kept in close confinement and so effectively choose not to escape. In 1984 there were only 184 escapes amongst the 5,605 people sentenced to imprisonment; so the goal of physical containment seems to be met.

Secondly, prisons must protect prisoners from each other, and this is a major factor in determining the level of security to which a prisoner is allocated. There is little information available on the incidence of assault, robbery and other acts of violence which take place in prisons but it can be assumed that they are at least as common in prisons as they are in the wider community. The prison authorities seek to limit such behavior and the best available means of doing so is by surveillance. Prisoners can request to be put under "protection" if they fear for their safety from their fellows. Though this can mean the loss of almost all privileges and a virtually self-imposed solitary confinement, significant numbers opt for this course.

There are elements of the prison system in New Zealand which, by any standards, are of questionable acceptability. Firstly, there is the effect on those associated with the prisoner (usually family) who, though innocent parties, may suffer socially and emotionally. The effects on the prisoners themselves cannnot be ignored. The routines in prison are often monotonous and unstimulating. Payment for work performed is at nowhere near the level that would be expected for the same work in the community. Because of the need to provide as much work as possible to keep prisoners occupied, there is an emphasis on labour-intensive work, much of which has been superseded by technological changes in the wider society. Skills learnt are therefore often of limited marketability when the person leaves prison.

Several factors inhibit the functioning of New Zealand's prisons. The age and physical structure of many prisons make problems for providing even such basic facilities as toilets. They are also often much larger than is desirable for the

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development of effective programmes. Many of them are in isolated areas, making family and community involvement difficult. More than 20% of prisoners receive no visitors at all during their sentence and only 30% receive visits fortnightly or more often. The deterrents to visiting are seen as problems of transport and of the environment in which visits have to take place (Department of Justice, 1982b).

There are few supports available in the prison environment to deal with those who have psychological problems. Though the actual incidence of mental disorder amongst prisoners is not known, overseas studies accepted as having validity for New Zealand provide estimates ranging from 20% to 60% (Department of Justice, 1984b). Whether these people had a mental disorder at the time of offending or succumbed to one after imprisonment is not stated. There were 8 prisoner suicides in 1985 (7 in 1984). There were just 9 prison suicides in the previous 8 years. The number of attempted suicides and the rate of self-mutilation have also increased since 1984 (Department of Justice, 1986a).

Only limited specialist help is available in prisons and it has been suggested by a departmental working party that judges should not recommend the provision of psychiatric treatment as part of a prison sentence, as it is likely to raise hopes which cannot be met (Department of Justice, 1984b). The acceptance by the Department of Justice that there are large numbers of prisoners with mental disorders seems at odds with its policy so far of not accepting treatment as a valid part of the work of departmental psychologists.

Until recently many of these people would have been admitted to psychiatric hospitals, but with the reduction in secure units in hospitals this option has become less available. Responsibility for psychiatrically disturbed prisoners and remandees was the subject of considerable debate between health and justice authorities. Now the Department of Justice is looking toward providing its own psychiatric hospital service for prisoners, by building a psychiatric prison near the Paremoremo maximum and medium security prisons.

It was hoped that the changes introduced in the Criminal Justice Act (1985) would result in fewer people in prison, even fewer returning to prison, and a greater involvement of the community with prisoners. While it is too early to fully assess the success of these measures they do not seem to have made a major impact on sentencing practice (Department of Justice, 1986).

Some of the features of the new system will themselves create management problems. If sentencing practice follows its intended course, that is, with fewer property offenders receiving prison sentences and more violent offenders being imprisoned, then prisoners are likely on average to be more violent. There is likely to be a higher turnover in prison populations because of the provisions for early release. These factors and the need to involve families and communities are making new demands on prison staff.

The ability of community groups to participate productively with people either in or just out of prison, which is an important factor in the success of the Act's proposals, has been questioned. Most of the usual community service groups have been shown to have little understanding of prisons or of prisoners (Cree et al, 1985). The Probation Service has extended its role in informing and involving these groups.

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Key Points

* Numbers of people in New Zealand prisons have increased steadily over recent years.

* Almost half of all people received into New Zealand prisons are awaiting trial or sentence.

* Most sentenced prisoners are in prison for property offences.

* Most prisoners are male, Maori, and more than half are less than 25 years old.

* Maori people accounted for more than half of the total sentenced prisoners received during 1984. Though Maori people are more likely to be apprehended for offending, the proportion of Maori remand prisoners is greater than one would expect, given the Maori offending rate, and the proportion of Maori sentenced prisoners is proportionately greater again.

* Though they are still the most expensive component of our judicial system, the relative cost of prisons has been decreasing in recent years.

* The most desirable outcome for prisons would be that they deterred inmates and potential offenders from reoffending and offending. All the evidence indicates that they have been unsuccessful in achieving that goal.

* The effectiveness and acceptability of prisons is inhibited by the conflicting goals prisons are supposed to achieve.

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CHAPTER 8: RESIDENTIAL INSTITUTIONS FOR THE ELDERLY

Introduction

This chapter considers a variety of institutions which provide, or are allied to providing, residential accommodation for the elderly. They include geriatric hospitals, hospital-based assessment and rehabilitation units, and old people's homes. Elderly people enter these institutions as a result of experiences and events that are often unique to people of their age. These experiences include the culminant affects (physical, mental and social) of a variety of common degenerative diseases, the fear of suffering from such conditions and consequent dependency, and changes to living and caring arrangements (often related to the death of a spouse or to changed family circumstances).

Although the dependent status of many elderly people in institutions is frequently stressed, it must be noted that the experiences of ageing are diverse and vary from one individual to another. Whether an elderly person is institutionalised and where they are institutionalised depends not only on their level of disability but in large part upon their personal and social characteristics, including socio-economic status, family links, community links, ethnicity and sex. The majority of elderly people are never severely disabled or dependent and never permanently institutionalised. Only 6% of all people over 65 years, and slightly less than 20% of those over 75 years, depend upon institutional accommodation (Salmond, 1976; King et al, 1985).

The number of people aged over 75 years (the people who make the greatest demands upon institutional services) is likely to almost double by the year 2001. If the current rate of institutional provision continues, and in the absence of appropriate community-based alternatives, a doubling in residential facilities for this group may need to be provided by the turn of the century.

Geriatric hospital care

Since 1978 there has been both an absolute and a proportional increase in the number of geriatric beds available in private and public hospitals. In 1978 there were 4,673 available geriatric beds (160 for every 10,000 people aged 65 or more), compared with 7,293 (221 for every 10,000 people aged 65 or more) in 1984. This increase is due solely to an expansion of geriatric services in the private and voluntary sectors. The percentage of geriatric beds provided within these sectors increased dramatically from 34% of the total in 1978 to 54% of the total in 1984 (Infogram 8.1). Geriatric beds made up 74% of all beds provided in private and voluntary welfare hospitals during 1984.

There is an imbalance in admissions to both private and public hospitals by sex, which is age-related. Men aged between 65 and 74 years comprised 53.5% of admissions in 1984 compared with 46.5% of admissions for women of the same age. At 75 years or more, men accounted for only 37.5% of admissions in comparison with 62.5% for women. This trend is due to the longer life expectancy of women. Increasing age brings with it a greater risk of exposure to the culminant effects of degenerative disease, and consequent disability and dependence upon caring services.

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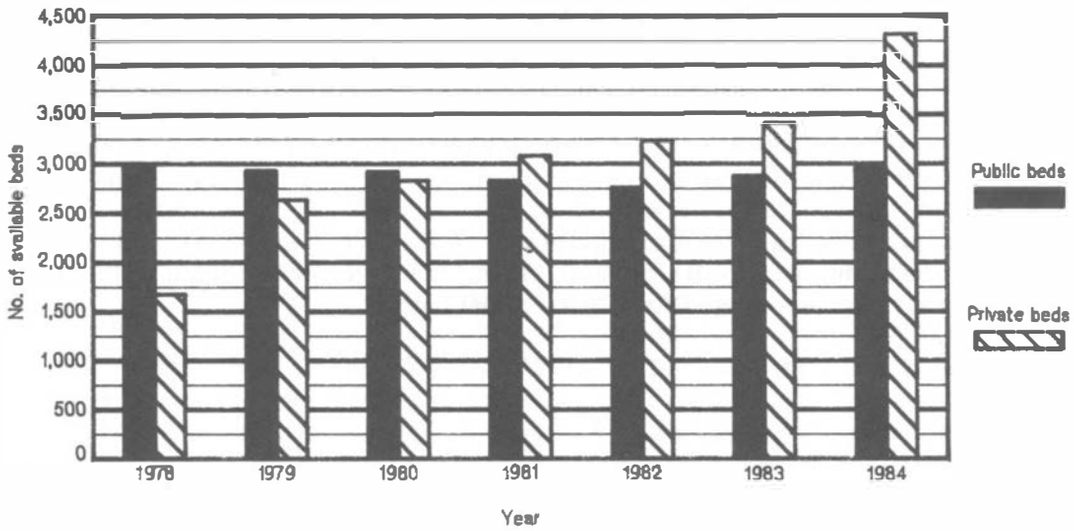
Infogram 8.1 AVAILABLE GERIATRIC HOSPITAL BEDS (1978–1984)



Source: Department of Health, Hospital Management Data 1978–1984.

It is difficult to draw a clear distinction between long-stay and acute hospital beds for some elderly people. The period of time spent by an elderly person in a general hospital is not necessarily related directly to the condition for which they are admitted. In fact the condition resulting in admission may be related to some other condition causing dependency. This is particularly so for sufferers of Alzheimer's disease and other forms of senile dementia, who may be admitted for treatment of a physical condition but whose length of stay in hospital is dependent upon the extent to which they are disabled by their dementia (Todd and Haines, 1983).

Within public hospitals, the majority of admissions are acute admissions. Admission to an acute bed can, however, be the first step towards long-term institutionalisation. A survey of 160 people receiving long-term geriatric hospital care in Canterbury indicated that almost three quarters of the sample required acute hospital beds before being placed in long-term geriatric care. Some of the disabilities of long-term patients were found to be a result of hospital admission itself: "34% of [the] sample of general medical hospital patients aged 70 years or more suffered from symptoms of depressed psychophysiological functioning (confusion, falling, not eating and incontinence) which were unrelated to acute medical diagnoses or treatment, but which appeared to be the direct side effects of acute hospitalisation per se" (Higgins, 1985, p. 649).

There has been an overall trend towards shorter periods of stay for elderly patients admitted to public hospitals evident since at least 1974 (Infogram 8.2). This is due, in part, to frail and dependent elderly patients being transferred

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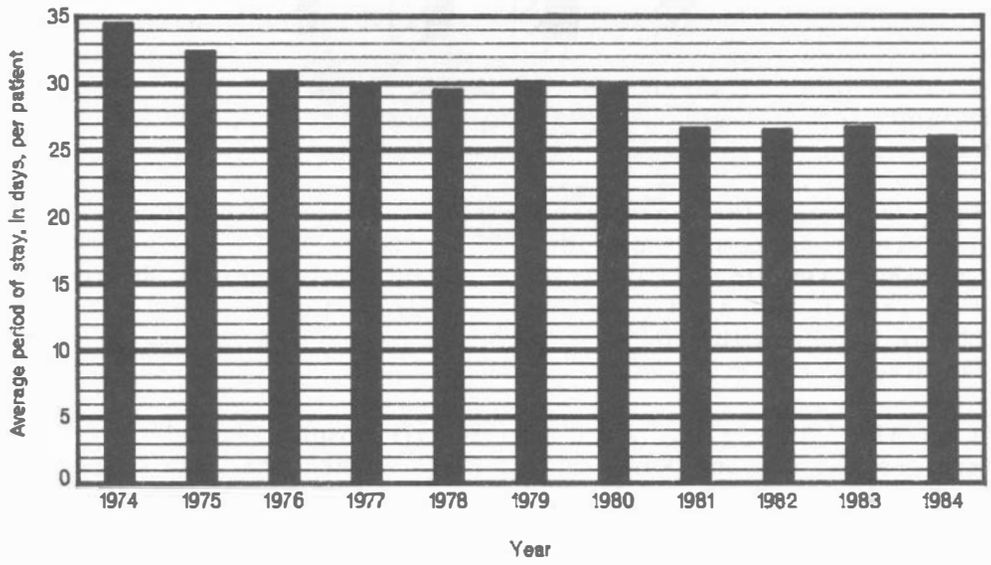
from public beds into other forms of institutional care, including private hospitals and rest homes. The process reflects a general trend in public hospital patient management practices towards placing greater emphasis upon patient throughput and independence. Patients who are left occupying long-stay public geriatric beds are considered to be very dependent upon the institutional services provided. In 1981 it was reported that of 48 public hospital patients surveyed in long-stay beds, all were there because of an "inability to cope" (Jack, 1981). Thirty-eight of these patients were considered to have severe to very severe handicaps.

Infogram 8.2 AVERAGE DAYS STAYED IN PUBLIC HOSPITALS BY PEOPLE AGED 65 YEARS OR MORE (1974–1984)



Source: Department of Health, Hospital and Selected Morbidity Data 1974–1984.

Within private and voluntary welfare hospitals, long-stay patients tend to be admitted for diseases of the nervous system and under the aegis of "supplementary" or miscellaneous classifications. During 1984, 3% of admissions were for degenerative and other diseases of the central nervous system, such as Parkinson's disease, which are often incurable. Admissions under the aegis of supplementary classifications increased from 3.9% of admissions in 1974 to 12.9% of admissions in 1984, of which more than 51% were related to social and household circumstances. This suggests that a lack of access to adequate care and support in the community is a contributing cause of admission. The majority of people admitted under these categories were aged over 75 (78%) and were women (62%). Information on length of stay is not readily available but it appears likely that many of those admitted were admitted on a long-term or even permanent basis.

Older people do receive significantly longer periods of care in private hospitals than in public hospitals, an average of "87.3 days in private hospitals compared with only 30.1 days in public hospitals" (Hyslop et al, 1983 p. 192).

One of the factors most likely to determine the length of hospitalisation of an elderly person, whether it be in a public or private hospital, is the availability

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and quality of care within the community. Those most vulnerable to long periods of hospital care are women living alone with little family or community support to call on, especially if there are problems of access to paid help, medical services and transport (Salmond, 1976; Koopman-Boyden, 1981). The 1981 census showed that 64,635 women aged more than 65 years lived alone, compared with 20,301 men. These are the people most at risk of staying for the longest periods of time in hospitals.

Assessment and Rehabilitation Units (ARUs)

In 1976 it was recommended that "full professional assessment" of people should be made before they are admitted to long-term institutional care (Salmond, 1976). It was argued that such assessment is essential if the appropriate institutional placement of the dependent elderly is to be achieved. At present, full assessment and rehabilitation units for the elderly are provided only within the public hospital system. ARUs have the objective of assessing the accommodation and treatment needs of dependent elderly people (with reference to physical, psychiatric and social factors) so as to recommend appropriate residential placement and treatment.

Over the last eight years there has been a steady increase in the number of ARUs, and beds in them, from 6 units providing 273 beds in 1978 to 19 units providing 642 beds in 1984. Despite this increase only half of all hospital boards provide ARUs. Those that do not, tend to be small and predominantly rural. One quarter of all ARUs are located within the Auckland region where 24% of people aged more than 65 years live.

A study of an ARU in the Otago Region, at Wakari Hospital, found there were two main criteria for admission (King et al, 1986): either the elderly person was unable to cope adequately in their normal environment; or it was believed an intensive programme of rehabilitation might improve their ability to cope. Of the 47 people encountered in the survey, two-thirds were aged 75 years or more, 62% were women, and 68% were either widowed or never married. Most people were admitted for physical reasons, reflecting the fact that many ARU referrals follow discharge from acute public hospital beds (Infogram 8.3). Only 14.9% of the people surveyed were independent in self-care and mobility. King found that 38% of the patients would represent a major challenge to services with a strong emphasis upon rehabilitation. Length of admission to ARUs ranges from one week for baseline assessment to five weeks for participation in a rehabilitation programme.

Despite the significant level of dependence of the people admitted to ARUs, a high proportion are discharged into the community, either to their own homes or to stay with relatives, upon completion of assessment. In the King survey, half of the patients were discharged into the community, 11% were discharged into residential homes, and 23% to long-stay geriatric hospital care; the destination of the remainder was unknown.

Old people's homes and rest homes

Since 1980, homes which have accommodated three or more people over the age of 65 years who are not related by blood or marriage to the householder, have had to be licensed as old people's homes. This regulation has not applied to private hospitals and other institutions under the control of the Department of Health and hospital boards.

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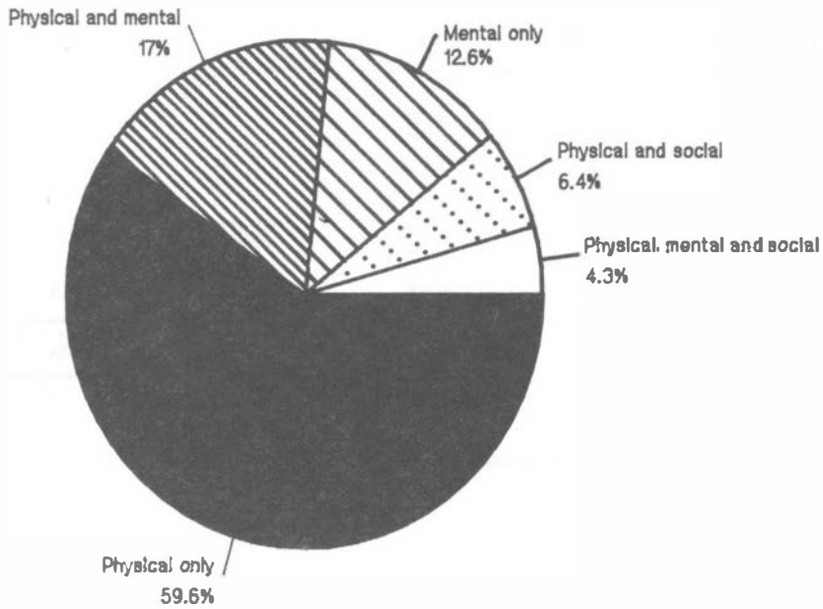
Infogram 8.3 REASONS FOR ADMISSIONS TO WAKARI HOSPITAL GERIATRIC ASSESSMENT AND REHABILITATION UNIT (Results of a survey conducted in 1984)



Source: King et al. Institutional Provisions for the Aged: a survey of one region. 1986.

Generally old people's homes in New Zealand are classified as either private homes (commercially operated), religious and welfare homes, or hospital board homes. The majority of beds (7,990 during 1985) were located in 180 religious and welfare homes. A further 5,185 beds were provided in 346 private old people's homes and about 870 beds were made available by hospital boards (Department of Health, 1985c, 1985d). Old people's homes range in size from 4 beds through to about 160 beds. The biggest, in terms of bed numbers, are those operated by religious and welfare organisations. Of the old people's homes operating in Auckland during 1985, homes provided by religious and welfare agencies accommodated an average of 77 people. Private rest homes, in comparison, were considerably smaller and acccommodated an average of 18 people.

In the four years between 1981 and 1985, the number of people living in all old people's homes in New Zealand increased by more than 30%, to a total of 13,915. Over the same period, the number of homes increased from 410 to 552 (Department of Health, 1983d, 1985d).

The residents of old people's homes tend to be more than 75 years of age, women, and non-Maori (Infogram 8.4). Widowhood and the absence of a close relative able to care for the older person are the main reasons for admission (Salmond, 1976; Jack, 1981; Todd and Haines, 1983).

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Infogram 8.4 RESIDENTS OF OLD PEOPLES' HOMES BY AGE, SEX AND ETHNICITY (1981)

Age Group	Total No.	% Male	% Female	% Maori	% non-Maori
65-69	495	49.5%	51.5%	1.6%	98.4%
70-74	942	37.2%	62.4%	1.8%	98.2%
75-79	1,540	29.9%	69.8%	0.8%	99.2%
80+	6,145	21.5%	78.5%	0.1%	99.9%
Total (65+)	9,122	26.1%	73.9%	0.5%	99.5%

Sources: Department of Health, Bed Occupation Survey 1981, 1983.

The fact that the majority of people resident in old people's homes are women, and that the proportion of women in them increases with age, is explained (in part) by the structure of the elderly population. Of people aged over 65 years, 58% are women: this increases to 63% for those aged over 75 years. Because of these demographic factors, and the tradition of women being younger than their male spouses, 36% of elderly women live alone compared to only 15% of elderly men, who more often have a spouse able or expected to provide ongoing home care for them (Department of Statistics, 1985c).

The small number of Maori people in old people's homes is, likewise, related to the younger age structure of the Maori population and a shorter life expectancy. Maori people over the age of 65 make up only 2.6% of the Maori population and only 2.2% of the total elderly population. By contrast non-Maori elderly comprise 10.9% of the non-Maori population and 97.8% of the total elderly population.

Access to, and the availability of, transport and community services (including health care) also determine whether an elderly person might choose or need to move into an old people's home (Koopman-Boyden, 1981). Socio-economic status is likely to affect the degree of choice available to an old person, especially in terms of the type of institutional facility available.

Resource usage

The provision of institutional accommodation for the elderly is an important and controversial issue and will become more so as the number and the proportion of older people increase. In the past, institutional care was provided almost exclusively by a partnership between the state and the voluntary welfare sectors. This partnership was cemented by state financial assistance to voluntary and welfare agencies, particularly for the building of new institutions. Recently the private sector has come to assume a dominant role in the provision of

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Infogram 8.5 MAIN SUBSIDIES AVAILABLE TO PRIVATE AND VOLUNTARY INSTITUTIONS CARING FOR THE ELDERLY (1984/85)

Subsidy	Approximate cost of subsidy
Private hospital geriatric benefit	$39.5 (million)
Geriatric patient special assistance scheme	$17.2 (million)
Grants to old people's homes and hospitals for buildings and staff	$ 6.1 (million)
Special rest home subsidy	$ 5.0 (million)
Special grants to private geriatric hospitals	$ 0.7 (million)
Total subsidisation	$76.9 (million)

Sources: New Zealand Government, Estimates of Expenditure, 1986.
Department of Statistics, New Zealand Year Book, 1986.
McBride, Address to the 4th national conference in geriatric medicine and gerontology, 1984.

institutional accommodation for the elderly, a role which has also been encouraged and supported by the state via a mixture of grants, loans and subsidies (Infogram 8.5).

State subsidies and grants to private and voluntary institutions caring for the elderly totalled at least $76.9 million during the 1984/85 financial year and represented an increase of 22% in real terms over the amount paid during the 1977/78 financial year. The prominent role that private and voluntary hospitals play in the care of the elderly reflects the availability of state subsidies. Since the inception of capital subsidies in 1950, at least 2,000 private hospital beds have been subsidised (Salmond, 1976). Between 1978 and 1984 there was a massive 258% increase in private geriatric beds which can be explained, in part, by the introduction of the Geriatric Hospital Special Assistance Scheme (1977) which allowed Hospital Boards to place patients who sought public hospital care into private hospitals when no public beds were available.

Ironically the Geriatric Hospital Special Assistance Scheme may provide an incentive for private hospitals to extend the period over which geriatric patients stay, if full subsidy can be obtained for patients needing less than hospital levels of care. The lack of provision for the continuing assessment of patients in

private hospitals receiving the subsidy makes this situation a real possibility. In fact, available research indicates that geriatric patients in private hospitals are less dependent upon institutional care than those in public hospitals, and many may be better placed in rest homes or other forms of sheltered accommodation as an alternative to long-term hospitalisation (Jack, 1981; Salmond, 1976).

Likewise, the staff salary subsidy for religious and welfare homes (introduced in 1978) had the objective of encouraging voluntary welfare institutions to care for more dependent residents and of thus relieving pressure on public hospital services. Available information suggests that, despite the intent of the staff salary subsidy, religious and welfare homes still cater for the least dependent residents (King et al, 1986).

To begin to address the questions raised about subsidies will require the availability of information similar to that collected for public hospital patients. Without access to reliable data on age, sex, ethnicity, reasons for admissions and length of stay, adequate conclusions are not possible. It docs, however, appear that the system by which the state subsidises the private sector lacks adequate checks and controls. The Board of Health's Committee on the Elderly has recommended a complete review of the whole spectrum of benefits, grants, subsidies, and regulations pertaining to the residential care of the elderly.

Effectiveness

During 1984, about 116,000 people aged over 65 stayed in institutions of one type or another. About 20,000 were residing in institutions on a long-term or permanent basis. Three-quarters of the long-term residents could be found in old people's homes with most of the remainder in private and psychiatric hospitals. Social factors (including the death of a spouse, isolation within the community and inadequate access to essential services) were commonly associated with permanent or long-term institutionalisation.

The effectiveness of geriatric care cannot easily be measured within a normal curative framework. Elderly people residing in institutions are a diverse group ranging from the relatively active and independent to those extremely dependent upon the caring services provided. In many cases, quality of life is a better measure of effectiveness than any notion of cure. It is thus unfortunate that information about quality of life is not more comprehensive and readily available.

Increasingly, and despite the intention of a number of state subsidies and benefits, the care of the very dependent seems to be becoming the public sector's main contribution to the long-term care of the elderly, with less dependent elderly being cared for by the private and voluntary sectors. The public sector's other major contribution is in the assessment and rehabilitation of elderly people. The needs of the dependent elderly can best be ensured by the provision of adequate assessment and rehabilitation, before residential placement.

Generally, ARU patients are highly dependent upon the provision of caring services. Dependency has usually been described in terms of capacity to provide for physical needs, for example the ability to wash, dress and toilet oneself. Using these criteria, many residents of old peoples' homes and hospitals might be described as inappropriately placed. However, as King et al point out, many

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people able to provide physical care for themselves are unable to provide their own social care: they cannot meet people and engage in the ongoing friendships and contacts that provide a sense of social well-being. Such needs are met for many people in institutions, but there may be better alternatives.

Instability and insecurity can increase the likelihood of confusion in the elderly, and thus institutional care or accommodation may result in the deterioration of an individual's health status. For people with senile dementia, the best type of care is thought to be community care where the patient is in familiar surroundings and likely to be less disorientated. However, policies which consider community care as an option must be aware that the provision of such care can be extremely demanding and stressful for the carer who is often a close female relative or voluntary worker. The caregiver may suffer from stress or other problems to such a degree that they are ultimately in need of care themselves. Institutional care may become the only option in the absence of an able carer in the community (Todd and Haines, 1983).

Acceptability

Within institutions for the elderly, there is a need to ensure that something more than a minimal standard of physical care is supplied. The social, psychological, emotional, and spiritual needs of residents must all be met. This requires imaginative programming on the part of those who administer institutions, and probably the use of a wider range of resources than has often been the case.

It has been argued by health professionals that the present standards for accommodation and care, and regulations for their enforcement, are not adequate to safeguard the rights of residents of old people's homes. Standards which are specified include minimum physical standards such as the size of rooms and the number of sanitary fittings. They specify that the equivalent of one full-time staff member in addition to the live-in manager must be provided for every five residents. Staff members, however, are not required to be specially trained in the care of the elderly and can include auxiliary staff such as cooks or cleaners. The home licence can be revoked by the Director-General of Health if the standard of care offered is unsatisfactory (Section 6 of the Health Amendment Act 1979), though this sanction is rarely used and only as a measure of last resort.

In recent years the ability of some private homes to provide the care needed by elderly people has been questioned. In particular, concern has been expressed at the low levels of staffing in some homes, the lack of trained staff, the abilities of some managers/matrons, the standards of basic physical care provided, the lack of leisure activities or things to do for the residents, and the over-use of medication (Jack, 1981; Kendrick, 1983). The regulations which govern old people's homes appear sufficient for those caring for the relatively alert and able but inappropriate for those caring for the disabled and dependent (Kendrick, 1983; Todd and Haines, 1983). Regulations governing standard of care and their enforcement must be such that dependent and frail people (particularly those not in a position to adequately safeguard their own rights) are protected and their care ensured. In a report on Alzheimer's disease published by the Mental Health Foundation, it was argued that it is irresponsible for the state to subsidise private old people's homes to the present extent without having the ability to ensure fully humane standards of care (Todd and Haines, 1983).

Key Points

* The numbers of people aged more than 75 years is likely to almost double by the year 2001. Given the current rate of institutional provision, and insufficient appropriate alternatives, a doubling in long-stay geriatric beds and other residential facilities for the elderly may be required over the next 15 years.

* Increases in the number of geriatric hospital beds have outpaced increases in the elderly population itself. Most of the increase has been in the number of private and voluntary hospital beds and can be seen, in part, as a response to the availability of state subsidies and benefits.

* Increasing age brings with it a greater vulnerability to degenerative conditions, consequent dependence and residential institutionalisation. These factors, coupled with family circumstances and the availability and quality of care in the community, are major determinants in the institutionalisation of the elderly.

* As a result of both longer life expectancy and the practice of many women being younger than their male spouses, the majority of elderly people in long-stay residential institutions are women.

* Periods of hospitalisation for elderly people are significantly longer in private and voluntary hospitals than they are in public hospitals.

* The majority of people assessed in assessment and rehabilitation units have been discharged from acute public hospital beds. There is no formal provision, or requirement, for assessment of patients in the private and voluntary sectors, or of those being cared for in their own homes within the community.

* The number of licensed old people's homes has steadily increased by more than 30% over the last five years. Over 13,000 elderly people live in these institutions, the majority living in religious and welfare homes or in privately operated rest homes.

* There is a need to review state subsidies to old people's homes and private hospitals to ensure that they are continuing to be used to meet defined objectives and are not prone to abuse.

* Information pertaining to quality of life may be one of the best indicators of the effectiveness of residential care for the elderly. Such information is not routinely collected or available.

* It may be necesary for an independent body or agency to act as an advocate for those elderly people residing in institutions who cannot voice their own rights and needs.

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CHAPTER 9: ISSUES AND POLICY IMPLICATIONS

Introduction

In this section, the issues arising from earlier chapters are discussed in terms of their policy implications; and recommendations for action are outlined. While some recommendations are specific to particular institutions, most are more general and have implications for all institutions.

Institutional procedures

Institutional goals are often not clearly stated, especially in the more established institutions, such as maternity hospitals, where their goals are assumed. This creates major difficulties in attempting to evaluate the performance of institutions, as the assumption of goals is likely to lead to error. This is not just a problem for the researcher: it must also present difficulties for service managers. All institutional services need to develop clearly stated goals at each level of their operation.

Problems can arise where circumstances (including social and economic circumstances) change but institutional roles are not clearly re-evaluated. Where an institution's role no longer fits current needs, its continued operation should be critically examined with the options of disbandment (if it has no other desirable role) or reconstitution (if it is thought it can meet other needs). An example of this is seen in the children's health camp movement, where a review has concluded that its methods of working need considerable revision if it is to respond to changed circumstances. It could be argued that health camps are not capable of the necessary changes and that more would be gained by disbanding them and reallocating their resources.

In many respects, residents of institutions are powerless or at least relatively powerless. In most institutions, the power to determine daily life and activity is in the hands of the institutional carers or controllers. Admission to some institutions explicitly involves a loss of rights: for example, prisoners lose the right to vote and committed psychiatric patients are regarded as unable to manage their financial affairs.

Although most state institutions have some form of external formalised controls aimed at protecting the rights of residents, such as visiting judges and committees, institutional admission may offer residents only limited protection of their rights. For example, the backgrounds and interests of individuals on the visiting committees may be more akin to those of the professionals operating the institutions. Visiting committees might therefore be less critical than they should be. For this reason some organisations, such as the Department of Social Welfare, are attempting to gather more representative and more active visiting groups. A further cause for concern is that the outside interests of residents are often not protected. The only statutory provision for this lies in the Aged and Infirm Persons Act and relates only to estate management. The Personal and Property Rights Protection Bill which is to be introduced to Parliament during the 1986/87 session, will, it is hoped, bring greater protection.

To protect the rights of residents, institutions should prepare clear statements of residents' rights and ensure that residents understand them. Those who cannot

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understand them should have advocates appointed to represent their rights within the institution and their interests beyond it. Further, all institutions should develop effective systems to safeguard the rights of residents, including having advocates from the residents' own social groups.

Changes currently occurring in the use of institutions will lead ultimately to changes in the populations within them. For example, there will be a greater proportion of prison inmates sentenced as a result of violent offending; there will be a greater proportion of people in psychiatric hospitals in the acute phases of psychoses; and the intellectually handicapped within institutions will be more likely to have profound, rather than moderate or mild, levels of handicap. The greater concentration of people with greater levels of need, whether it be for care or control, will have an effect on the environment within institutions. Consequently, management strategies employed in the past may not be adequate in the future, and will need to be re-thought.

Planning needs to consider management practices and in particular should consider staffing levels and composition. For instance, will staffing levels need to be relatively higher to meet the changed needs? Assumptions about the transfer of institutional resources to community services need to be tested from this perspective.

Collection and availability of information

In every institutional system we examined, there were problems with information. These problems concerned what information was and was not collected and, when collected, the way in which it was presented. Current systems of information collection tend to reflect an accounting approach to management and a clinical approach to the people involved. If the management of services is to be geared more effectively to the needs and characteristics of the people involved, then information must be collected on people as individuals and on the services provided, rather than just on administrative and clinical characteristics.

Information on people

The usual institutional method of collecting and ordering material according to the conditions which lead to admission makes it very difficult to build up any sort of picture of the personal and social characteristics of the people who are admitted. In some cases it is not even possible to determine the actual numbers of people involved. This is most obviously the case with hospitals but also applies to prison data.

Coupled with this are difficulties arising from the way the material is presented. Even when information on personal and social characteristics is available, it is often presented in a form which makes it difficult to build up a complete picture or to relate one characteristic to another. For example, sex can be related to age differences in some health statistics but not to ethnicity.

Changes in the way material is presented from one period to another further complicate the situation. For example, it is difficult to identify trends in some health data because variables, such as age, may be presented in different groupings from one period to another.

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These problems in methods of information collection are real impediments to change and improvement in institutional systems of care and control. At an abstract level they reinforce the impersonality of institutions by denying the human aspects of those admitted. Processes of information collection will shape the way that those directing institutions see the people coming into them, and can lead to a situation where they are seen not as people but as conditions. At a very practical level it inhibits the ability to see whether some people are more likely to be admitted to institutions than others, and whether this situation changes over time. Differences in the treatment options available to different groups in the population may be masked and the development of targeted alternative approaches hampered.

Information systems should be reviewed and modified to ensure that the problems identified above are overcome. Formal reviews of statistical systems such as the current review of health statistics, must consult widely to ascertain all users' needs.

Almost all of the available information is quantitative. It relates to the numbers of people admitted, their lengths of stay in days, months or years, and the reasons they are admitted. There is a need for a greater amount of qualitative research which provides information about the needs and experiences of the people involved. An area especially in need of this sort of research is the institutional experience of the elderly.

Research bodies such as the Medical Research Council and the Social Sciences Research Fund Committee should encourage and support research which relates to quality of life in institutions. A recent example of this type of research is a study of life in psychiatric hospitals (Dowland and McKinlay, 1985), where the emphasis was on the people living in those hospitals and their experience rather than on conditions and treatments.

There is a lack of longitudinal information about people and their lives. For example it is known how many people are admitted into hospitals each year but not how many times individuals are admitted into hospitals during their lives. Likewise it cannot be ascertained whether people sentenced to prisons experienced social welfare institutions when younger, or hospitalisation as infants. The work currently being carried out as part of the child development studies in Christchurch and Dunedin has provided some useful information about institutional experiences and the consequences, both immediate and cumulative, of the various personal, social and economic forces that affect people's lives. Such research should be continued.

Unfortunately, however, these studies have their limitations. In particular, the areas in which the studies have occurred have low Maori populations. Also, the studies provide information on very specific age groups. A similar study in an area with a higher Maori population would be of value. The same model could also be usefully applied to an ageing population. The extension of such research could also allow further investigation of the relationships between ethnicity and socio-economic status and their relative influences in institutional admissions.

Research organisations should encourage efforts to develop cohort studies, with special encouragement to those which will build on the knowledge already available.

There is also a lack of information collected at a regional level. Ideally,

regional information should parallel information collected at a national level. This seems particularly necessary for hospitals, given the regional population-based funding formula. It is also likely that individuals living in different regions have different institutional needs, as a result of regional phenomena, such as rural recession and internal migration. Detailed regional information would allow the social impacts of recession and population changes to be more fully understood.

Administrative information

There are problems in assessing the costs and efficiency of institutional systems because of the lack of definition in the public accounts. Within the health system, for example, it is not possible to readily, or confidently, distinguish inpatient hospital costs from outpatient services. Complications arise from the way central funds are distributed to regional bodies for expenditure without any central reporting of what services the money is actually spent on. Furthermore, it is not possible to assess all costs because costs normally associated with capital are not included. The Auditor-General has expressed concern about the forms in which public expenditure is reported. The way the costs of institutional services are reported gives weight to his comments.

Public accounts, especially health accounts, should be reviewed with the aim of greater clarity so that expenditure can be better understood and thus better planned for and allocated.

The Accident Compensation Corporation's information system is split into two parts which are not readily compatible. One part deals with payments and the other with the types of accidents incurred. While it is known how much the ACC pays to private hospitals, it is not possible to know what the money is paid for. No assessment can therefore be made of the cost-efficiency of the procedures involved. Further, information collected by the ACC does not give information on the characteristics of the people who receive ACC payments and for what conditions. This means that particular groups who are at risk of injury, and might benefit from preventive efforts, cannot be adequately identified.

The ACC should establish information systems where the constituent parts of its operations are combined into a coherent whole. This would allow judgements to be made about the returns obtained from specific areas of financial investment, and would also help in designing preventive programmes.

Within the private hospital system, it is not possible to determine the full extent of support from the taxpayer. As well as direct subsidies to private hospitals, patients in them receive goods and services (such as pharmaceuticals and radiography) that are paid for by the state. Tax concessions for medical insurance are also an indirect subsidy to the private hospital system. Without knowing the full extent of state subsidy, and where it goes within the private system, it is difficult to judge the efficiency of subsidisation and the case for continuing subsidisation.

Private hospital accounting systems should show all inputs, not only financial but also those made in kind, with a view to establishing the true extent of public support.

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There arc few instances where proper evaluations of institutional services have been carried out, or where evaluation procedures are built into administrative procedures. When new services arc developed, or existing ones modified, information and evaluation systems must be established as an integral part of the package. Funds and personnel should be designated for this purpose.

Information systems developed by different organisations often lack compatibility even though they may address somewhat similar areas. Thus ACC and Health Department data-collection systems are difficult to relate to each other. Wherever possible, organisations should make their information systems relate to those of other organisations working in the same area.

Maori rates of admission to institutions

This report has shown that Maori people arc over-represented in almost every type of institution studied. The only institutions Maori are not over-represented in are private schools and private hospitals (in part the result of general economic disadvantage), and institutions for elderly people (a rcsult of the shorter life expectancy of Maori people). In all other institutions Maori admission rates are increasing, even when total admission rates are remaining stable and non-Maori rates declining. It may be that community-based services are working more effectively for non-Maori groups than Maori. Efforts are being made to develop and support community-based systems of care and control that cater particularly for Maori people. However, this effort needs to be extended and existing systems need to be examined to sec whether they might be altered to be more effective for Maori people.

The main concern associated with the numbers of Maori in institutions is their generally disadvantaged social and economic position - a position which is associated with low rates of immunisation, poor infant health, greater risk of physical injury, diminished access to primary and preventive health services, high rates of alcohol intake, high rates of cigarette smoking, and a greater chance of apprehension for criminal behaviour. These factors are just some amongst a host of factors, and seldom operate individually. More often they are cumulative in effect. In the long term, this situation can be improved by major changes in the distribution of social and economic resources. Such changes would contribute to improved access to health care and other services in the areas where Maori people live, as well as providing many other benefits. In the short term, however, attention should be given to ensuring that Maori are given greater control over the resources directed to them so as to develop their own programmes of treatment and prevention. It is also important to ensure that adequate consultation occurs with Maori people as users, when new services are developed.

A second area of concern relates to the appropriateness of institutional care or control for Maori and the way in which decisions relating to admission arc made. Very few people have a choice about admission to an institution: even where the facility exists for voluntary admission, a professional must be satisfied that admission is appropriate. Few of the people who make such decisions arc Maori or have any particular understanding of Maori culture. Assumptions are made about the appropriateness of institutional care from a predominantly non-Maori cultural perspective. Differences do exist, for example, between Maori and non-Maori attitudes to sickness and the body. Likewise within the Maori community there are structures for care and support not normally available within the non-Maori community.

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Such ignorance of Maori culture and society results from "a bias in our social and administrative institutions that automatically benefits the dominant race or culture, while penalising minority and subordinate groups" (Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1986, Appendix p.26) and has been termed institutional racism. It needs to be addressed by every institution and system of care and control. Attention must be given to the way in which the systems' own procedures encourage either the over-representation or the exclusion of Maori people. These institutional biases occur because the systems are designed within one cultural perspective and administrators undervalue, or simply will not recognise, the validity of other cultural viewpoints. The Department of Social Welfare, however, has provided a model for other agencies in the commitment it has given to implementing the Ministerial Advisory Committee's recommendations.

Agencies need to ensure that their staff have the experience and training necessary to work with Maori people. Too often such training has been seen as appropriate for those who supervise the day-to-day running of services but not those, such as doctors and judges, who decide who should be admitted to institutions. Institutions that train professionals should make their courses relevant to Maori people. The "small steps [which have been] taken to embrace taha Maori within professional training programmes ... need to be greatly amplified" (Abbott and Durie, 1987, p.27). Any such programmes should occur with the consultation of Maori people. In the short term, policies of affirmative action to increase the numbers of Maori in professional positions are essential. Professionals and other service workers must be given training which heightens their awareness of the importance of cultural values.

Social and economic disadvantage and institutional racism, which account for the high admission rates of Maori into public hospitals, social welfare homes, health camps, prisons and psychiatric hospitals also result in Maori people being under-represented in admissions to private hospitals and boarding schools. To a lesser extent the younger Maori age structure and shorter life expectancy are also factors in the number of Maori admissions to private institutions, namely those catering for the elderly. Economic disadvantage is evident from the low coverage of Maori people by private medical insurance. Institutional racism is evident in the under-referral of Maori accident victims to private hospital care. Unfortunately the ACC does not record ethnicity, so biases within the system cannot at present be adequately examined.

The Health Department should examine reasons for the under-referral of Maori people to private hospitals, especially given the level of public subsidisation to private hospitals through both the Health Department and the ACC.

There is a need for administrators of private services to examine their organisation's practices and procedures in order to identify and correct those which result in institutional racism. This is especially so for private institutions which are subsidised by public monies.

Children in institutions

Children rarely, if ever, have social, psychological, or educational problems which can be separated from their family circumstances. Institutions should involve families and not just individual children in their programmes in order to achieve lasting positive results. Any that cannot involve families because of

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distance should reconsider the appropriateness of their service.

Children are admitted in large numbers to hospitals but the facilities available to meet their needs are few and often poorly developed. This is not a new conclusion, as the long-standing discussions on children's wards at Wellington and Auckland Hospitals testify, but the length of time it takes to get action raises questions about the real priority given to children's health in New Zealand. Administrators and politicians need to examine their commitment to child health and ensure that resources match rhetoric.

Of special concern are the alarming hospital admission rates of Maori children in comparison with non-Maori children. This has not received the attention it should warrant. An example is seen in the report of the Board of Health's Committee on Children (1982) which made no recommendations relating specifically to Maori children. The emphasis on child deaths rather than on child sickness that is evident in many studies may not be advantageous in reducing hospitalisation, as it may reduce the awareness of the incidence of illness and thereby reduce the effort put into developing effective programmes of health promotion. Research is needed to determine ways of overcoming the deplorable levels of infant hospitalisation, especially the discrepancies between Maori and non-Maori rates.

Current preventive health services targeted at children should be reassessed. New Zealand invests a great deal of money in preventive health care for infants, most of which is channelled through the Plunket Society and general practitioners. Perhaps the continuing and even increasing rate of hospitalisation indicates that the type of preventive service provided is not as effective as it might be and that it is in need of reassessment, especially in relation to Maori requirements. Preventive health service administrators should examine their practices, in consultation with Maori people, to identify more effective ways of serving their clients. Issues of location and access, including the influence of fees charged, must also be considered.

Institutions and communities

There is a need for closer links, and a greater sense of partnership, between institutions and the communities they serve. Institutions are most effective when they are an integral part of the community and used where needed, rather than being isolated from the community and used as the final stage in a process of care or control. Wherever possible the barriers between institutions and communities need to be dismantled. Developing such a system is a complex process and requires changes of attitudes by both community members and institutional staff. Institutions whose location causes difficulty for residents in maintaining contacts with their families and communities are in need of change now.

As a first step towards such change, government departments and other organisations operating institutions (especially institutions for children), which result in the isolation of their residents from families and communities should reassess their appropriateness.

In advocating changes in institutional functioning there is a need to be aware that institutions are sometimes major employers, especially in small towns or rural areas. Their closure, or decline, may have profound effects for a community's viability. Institutions should not be kept open merely to provide employment but, when changes are necessary, consideration should be given to those

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in the community as well as those inside institutions. Proposals for change need to be accompanied by adequate consultation and involvement of all affected.

Consideration must also be given to the impact on families, as well as on communities, of changes in institutional functioning. While it may be in an individual's best interest to be cared for in the community, such care may only be possible by reducing the capacity of other people to lead full and active lives. It is unfair to the individuals involved, to their families and communities, if people are moved out of institutions when adequate support services and resources are not available in the community. The reality of a community's capacity and willingness to care for its members must be determined, not assumed.

The economic costs to the state of providing institutions are considerable but, overall, their share of total government expenditure appears to be dropping. There is little evidence to suggest that community-based services require a lower resource commitment than institutional services. While community care can result in savings in government expenditure, such savings are often borne by unpaid carers in the community who may suffer from stress, loss of freedom and loss of income.

Policy-makers and professionals must consider the demands on families when determining the appropriate placement of dependent people. Family members should be part of the decision-making process and their needs, as well as those of dependent people, must be considered. In the future, institutions are likely to have a greater role in providing relief, professional backup and support to carers in the community. For this reason institutional and community care should not be considered apart. Each has a role in the care of the dependent. There is, however, a need for greater co-ordination and management of resources between the two.

Demographic changes

New Zealand's population is ageing and this will have implications for institutional services, particularly because of the numbers of people who will be over the age of 75 at the turn of the century. Because of the high dependency levels among this age group, an expansion of institutional services is almost inevitable in the absence of appropriate alternatives. There needs, however, to be a recognition that the demographic changes which will have the greatest impact will occur after the year 2000. The need, immediately, is not for the provision of services but for an examination of alternatives and the planning of appropriate services for the future.

The opportunity should be taken now to develop standards of care which have as criteria the enhancement of the lives of those being cared for. Standards should include not only physical requirements but also levels of social and occupational stimulation. The problems of providing such services in small facilities need to be addressed through co-operative efforts among service providers.

The Department of Health, through the Board of Health's Committee on the Elderly, should investigate the future needs of the elderly for institutional services. In particular, emphasis should be given to ensuring that those services meet adequate standards.

Both social and physical needs change over time. Investment in assessment services for the elderly, which can properly determine the nature and level of

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need, will reduce the incidence of future institutional misplacement, thus reducing strain on old people and their families and probably reducing costs to the wider society. Assessment services must be seen as a priority in health planning.

Present methods of funding institutional services for the elderly have the potential to increase the likelihood of institutional misplacement by, for example, giving a financial motive for the retention in private hospitals of people who may not, in fact, need hospital levels of care. It has also been suggested that because of the availability of subsidies, the taxpayer is providing rest home owners with an income for oversupplying the market, no less than farmers were previously so rewarded and with similar results. The Board of Health's Standing Committee on the Elderly has proposed that funding be based on an individual's need rather than on the type of service provided. Such a change in funding is capable of ensuring that services are both cost-effective and efficient in providing appropriate care, and should be implemented.

To date, New Zealand has not had to meet the needs of a significant population of older Maori people. Few Maori people are to be found in institutions for the elderly. In the future, this situation may change dramatically as the Maori population ages. This event must be prepared for now to ensure that communities have structures of support, at appropriate levels, which will maintain their elderly with dignity. Given the expense of caring for the elderly and the general economic disadvantages of the Maori, there is a need in this area for careful planning which emphasises quality of life.

With the ageing of the population, there may be an expectation that resources can be diverted from age groups which are in decline. This should not be accepted uncritically. There will in fact be no, or little, decline in the numbers of those in younger age groups. Further, the reality may be that any freed resources can best be used by improving the services already offered, that is, by placing the emphasis on the quality of the services provided. Furthermore, social and economic factors may outweigh demographic characteristics in some situations. An example of this would be the belief that because the number of people in the age group which contributes most prisoners is expected to decline, so should the number of prison beds. Age is only one factor in offending and continued unemployment may be more influential in the foreseeable future. Policy-makers must be wary of demographic determinism in their planning and take into account the varied impacts of social and economic forces.

Conclusion

Traditional institutions and their roles arc overdue for reappraisal because of the blurring of objectives over time, and because of the accretion of functions. Furthermore, the increasing emphasis on community services means that there must be better integration of institutional services into community functioning. The roles and objectives of institutions must be redefined to reflect this changing relationship. Within the redefinition there needs to be greater emphasis on the people served, rather than on the conditions dealt with or treated.

Greater individual focus will create a need for an improved assessment of individual clients which must involve those about them, especially their families. The diversity of the people requiring care and control must be recognised and their ethnicity, culture and values respected. The needs and preferences of

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people must be the prime determinant of the service provided, within the constraints of resource availability. To develop services which are responsive to diversity will require changes of attitude, and of practice. Such changes will necessitate the collection of information different from that currently available.

The situation of Maori people in relation to institutions is of concern in itself, and urgent steps are needed to change not only institutional processes but also the social conditions leading to inflated rates of institutional admission. The situation of Maori people is also the most clear-cut example of the need to respond to different people in different ways.

While new relationships are being developed between institutions and communities there will be transitional difficulties. The move toward community care is not likely to reduce costs, and in the medium term may lead to increased costs because of the need to maintain dual systems. Overall, community care should be at least as effective as institutional systems, but this is dependent on careful planning. The real value of community-based services lies not in cost savings but in the increased capacity to retain dependent people in as normal an environment as possible.

Moves to community care should not occur without concern for the needs and capacities of those who will be required to carry most of the load as carers in the community. The impact of economic change on their availability as carers, and on their resources, must be appreciated. There must also be an awareness that changes in institutional functions can have widespread effects on the communities in which the institutions are situated and which they serve.

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