HOME from HOME?

Report on Boarding Out Schemes for Older People in Ireland
MEMBERSHIP OF COUNCIL

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Prepared for the Council by Robbie Gilligan with the assistance of Susan Keogh

THE NATIONAL COUNCIL FOR THE AGED
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ACKNOWLEDGEMENTS

Without the cooperation of the elderly people, their carers and the organisers of the schemes whom it was our privilege to meet in the preparation of this Report, it would have been impossible to bring it to fruition. They made a deep and lasting impression on us. We hope that they will consider our description and analysis of boarding out schemes a true reflection of their experiences and an adequate compensation for their trust in us.

We owe a great deal to those responsible for administering the schemes who welcomed our interest and gave so generously of their time and we also wish to thank those in the health services in Northern Ireland, Britain and the United States, who responded so willingly to our queries.

Our grateful thanks go to Ruth Halpenny, Claire Cunningham and the Council's secretarial staff for their assistance.

Susan Keogh was responsible for the gathering and collation of the data which forms the basis of this report. Her energetic application to this task greatly facilitated the final drafting of the Report.

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Dublin 2  
November 1985.
INTRODUCTION

The National Council for the Aged is happy to present "Home from Home?", a report on boarding out schemes for the elderly in Ireland as a contribution to the debate on the policy for the long-term care of dependent elderly in their own communities. At present, more than a quarter of the elderly in long-stay institutional care in this country are there primarily for social reasons. This is an indictment both of our care programmes and of our society and there is growing recognition that ways must be found to retain in the community, those dependent elderly who in the past, through lack of adequate community-based services, would have had to have recourse to institutional care.

Given the differing circumstances which render elderly people vulnerable to homelessness, a range of options to deal with such circumstances must be available. The boarding out of such elderly in compatible homes is one such option. It represents the possibility of providing long-term care to frail and dependent elderly in their own communities in a form that is acceptable to them and which avoids the trauma of a complete departure from their familiar surroundings and at a cost which compares favourably with other types of care.

This report has explored the extent of boarding out schemes for the elderly in Ireland and has considered the main issues involved. While at present, boarding out schemes are not extensively used in Ireland they are an option which merits greater consideration by policy makers and practitioners in the health services and it is our hope that this report will assist in that consideration.

The Council is most grateful to Robbie Gilligan of Trinity College who, with the assistance of Susan Keogh, kindly prepared this report for us.

National Council for the Aged
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November 1985
CHAPTER ONE

THE BOARDING OUT OF OLD PEOPLE: A BRIEF HISTORICAL REVIEW

An International Perspective

The idea of boarding out of adults has a long history. Its use is first recorded in 1250 in Gheel in Belgium, where families took mental patients into their homes for care. This tradition was maintained right down until the nineteenth century when it came under medical supervision. Around this period also, the concept is reported to have been adopted in Scotland, Germany, France and Switzerland. In the United States in 1885, the first state adult foster care programme was launched in Massachusetts. In the 1950’s, adult fostering schemes were reported in Norway, and the Netherlands. In Britain in the fifties and early sixties there were as many as fifty schemes for the boarding out of old people. Such provision seems to continue to flourish in quite different countries, from the UK where local authorities have taken increasing responsibility to the US, where it is estimated that 15,000 old people are placed, to Yugoslavia, where a 1972 survey found widespread use of boarding out for the elderly in the Republic of Serbia, a largely agricultural region.

A brief history of the idea in Ireland

There is evidence, in Ireland, of support for the idea of boarding out of adults over the years. In 1898, the example of the Scottish use of boarding out for psychiatric patients led to suggestions for its adoption here, but this did not materialise. The Mental Treatment Act (1945) gave powers for the use of boarding out in this field and laid down requirements for such arrangements. This does not appear to have spurred much activity. During the sixties, the reports of three official committees, the Commission of Inquiry on Mental Handicap (1965), the Commission of Inquiry on Mental Illness (1966) and the Interdepartmental Committee on the Care of the Aged (1968), all supported the idea and called for its use. In an editorial on Geriatric Services in 1965 the Journal of the Irish Medical
Association advanced a particular view of the function of boarding out in tackling the housing problems of the elderly:

Perhaps some thought might be given to unorthodox, albeit temporary, remedies such as boarding out unmarried old people, who form such a large portion of the dependent aged, in holiday resorts that may be empty for a large part of the year, transferring them in the summer to hospitals slack at this time.12

In 1979, a sub-committee of the South Eastern Health Board recommended the examination and trial use of boarding out.13 In 1980, a sub-committee of the Eastern Health Board endorsed the idea of boarding out of elderly persons with private families.14 The National Council for the Aged in 1983 considered that “the boarding out of elderly persons in a suitable environment should be encouraged.”15 Most recently the Minister for Health has observed that “there appears to be great scope for boarding out elderly people with neighbours in many rural areas.”16

Applying the Idea in Ireland

Adult boarding out as a practice, rather than as a concept, has emerged rather later in Ireland. In the sixties, the boarding out of old people was attempted on a small scale in Dublin17 and began on a slightly larger and much more enduring basis in Westmeath18 in the same period. In the seventies and eighties schemes have emerged in Counties Cavan, Clare, Donegal, Leitrim, Longford, Mayo, Monaghan and Offaly, of which all but Clare survive (See Appendix 3 for some background to the Clare scheme). Table 1.1 provides details of the starting dates and duration of those schemes known to the researchers. An intriguing aspect of the current schemes (and one which poses difficulties for researchers) is the variation of forms of boarding out schemes. The reader will find it is a term used for care and accommodation provided in a family to one old person or to a small to medium sized group. It may even be applied to quasi-nursing home care. In a study of this nature we have felt bound to keep to organisers’ definitions. We accept as ‘boarding out’ what they so describe.

References:

TABLE 1.1: DURATION OF SCHEMES FOR THE BOARDING OUT OF THE ELDERLY IN IRELAND

1963 - 1984

E - Estimated Dates of Duration. We have been unable to establish exact dates.
2. Ibid.
3. Ibid.
CHAPTER TWO

ISSUES IN PROVIDING LONG-TERM CARE FOR THE DEPENDENT ELDERLY

The most prominent feature of the Irish population, that 50% are under 25 years of age, tends to obscure important underlying trends relating to another important group in society - the elderly, who make up 369,000 or 10.7% of the population. While other Western industrialised nations can expect a relative 'greying' of their population, a contrary trend is evident in Ireland, where the proportion of those over 65 is projected to fall until the year 2000. Nevertheless the total number of old people is growing at a rate of 2,000 per annum and with increasing longevity, the absolute numbers of frail and dependent elderly who survive into very old age will increase quite dramatically. In the period 1981-91, the over seventy-fives will increase by approximately 13.4% and the over eighty's by 18.8%. These latter trends have quite serious implications in terms of provision for the health and social care of these increasingly dependent people. The elderly are already disproportionately heavy consumers of health and social care. Inevitably this tendency is most marked among the oldest and most frail. Thus, even to maintain current levels of service will require growth in levels of provision just to keep pace with additional demands derived from increases in the relevant age groups.

The Minister for Health has commented recently on the implications for the health services of projected population growth, which in the case of the very old is projected to increase demand for long stay beds by as much as 13%.

"The challenge in the years ahead will be to maintain the levels of service for those who need long term care while at the same time meeting the increasing demand created by a growing population and rising health expectations ... to maintain existing patterns of consumption in the health services would require a significant increase in real terms of expenditure on the services. Since the share of the nation's resources devoted to health is high by international standards, and particularly high given our
level of economic development, any increase in the proportion of national resources spent on the health services cannot be contemplated lightly. Other sectors — education, job creation, income maintenance — need resources as much as or more than the health services.7

Despite these problems with maintaining or expanding current levels of service, policy-makers may also have to face the issues that existing patterns of institutional care may be inadequate. There is under-provision of certain forms of care in some instances and at least some disquiet about standards of care.8 "The quality of and the location of many of the (long stay geriatric) places publicly provided are poor."9 Whatever about the difficulties, substantial numbers of old people live out their lives in institutional care of one kind or another. Approximately 12,000 are living at any one time in long-stay geriatric units, provided by the public, voluntary and private sectors.10 In addition, a further 5,000 or so old people are accommodated in psychiatric hospitals.11 Thus without adequate resources to improve or extend this level of service to these people and the increasing numbers projected to replace or join them, there emerges a fairly bleak scenario for the quality of long-stay geriatric care in the future.

One possible way of circumventing the dilemma this poses is to seek to provide care for as many dependent old people as possible in the community, rather than in institutions. In fact in terms of numbers served, the form of care already by far the most significant is that provided by women as daughters, in-laws, sisters or neighbours. "Family care remains by far the predominant source of community care for older persons, estimated in the US to save the equivalent of billions of dollars nationwide. There are probably five demented patients in the community for every one in care."12 13 Many thousands of women, silently and unsung and at great personal cost, carry single-handedly, often with many other domestic responsibilities, the care of frail elderly relatives or neighbours. This care may be provided in the informal carer's own household, or be given each day in the old person's home. But a policy that is predicated on the continuing and necessarily wider availability of this reserve army of informal carers is likely to be at serious risk of failure. Many old people are childless.13 In addition, the trend towards smaller families means fewer children. Economic pressures may force these children as adults to emigrate and/or female children may by choice or economic necessity become active in the labour force.14
Another alternative to institutional care may be domiciliary care by statutory or voluntary bodies, that is the delivery of sufficient support and services to the old person to enable him/her to remain at home even where substantial changes in dependency are being experienced. But very often it may be that domiciliary care can only delay rather than prevent admission to institutional care. Given the uneven and relatively limited scope and quantity of domiciliary services provided by voluntary and statutory bodies, it inevitably happens that these services may be unable to provide and sustain services at the level of intensity required by significant increases in dependency. It is also important to remember that deterioration in the elderly can occur very suddenly. A fall down the stairs, resulting in a fractured femur, may in one day reduce a person from a robust and gregarious citizen to a feeble, despondent and passive patient.

The topic of this Report — boarding out — represents another option in providing for the long term care of dependent old people. Boarding out entails the placement, usually with a non-relative in a private household, of an old person, with the carer receiving some reward for his/her care of the person placed. It is not yet clear to what extent boarding out can provide for advanced states of dependency where a person may be doubly incontinent or suffering from dementia, for instance.

The physical drudgery, vigilance and sheer patience required in such instances may be beyond all but the most exceptional carers involved in boarding out. An important mitigating factor in such circumstances may be the carer's loyalty and commitment that have been previously generated, if the relationship is of long standing and has pre-dated any marked physical or mental deterioration. It seems reasonable to hypothesise that a carer's tolerance may be influenced by such factors, as well as by their own personal strength, qualities and support and their other responsibilities.

Boarding out may be able not only to contribute to a possible solution of dilemmas in terms of cost and quality posed by institutional care. In the Irish context, the frequent remoteness and dispersal in rural areas of the elderly population presents a challenge. O'Mahony has observed:

"The demographic history of these areas is such that relatives of the elderly often reside in Dublin or England, thus weakening the informal caring systems and leaving the elderly more dependent on statutory provision ... The general pattern (of pro-
vision) which emerges is of a concentration of services in urban areas with a diminishing level of service provision according to the degree of remoteness from an urban service centre."

Boarding out may also be able to serve the distinctive service needs of rural areas. It may be able to satisfy long-term care needs locally, an idea attractive in principle, both in terms of cost and client preference. Nevertheless, it is impossible to conceive of boarding out replacing other forms of provision. Rather, it could complement them, provided it achieves a more definite status as one accepted and approved option in the repertoire of possibilities to be considered when deciding on long-term care arrangements for the elderly.

References:
4. Ibid.
6. Ibid.
8. See Eastern Health Board (1982), Long Stay Accommodation Provided by Private Nursing Homes and Voluntary Bodies, Dublin, for a frank discussion of problems in quality of care in private sector and under provision in public sector in this region.
13. See Power, B. (1980), *Old and Alone in Ireland*, Society of St. Vincent de Paul, Dublin, for finding that 53% of those interviewed were childless.
15. See Power, B. (1980), *op cit.*, for findings which demonstrate relatively low visiting rates by voluntary/statutory services to this particular vulnerable category.
CHAPTER THREE

BOARDING OUT OF OLD PEOPLE IN IRELAND: AN OVERVIEW OF CURRENT SCHEMES

This chapter provides a brief overview of boarding out of old people in the State. It describes eight schemes currently providing such a service which were identified by researchers.

These eight schemes, in Cavan, Donegal, Leitrim, Longford, Mayo, Monaghan, Offaly and Westmeath, operate under the auspices of four different Health Boards (See Table 3.1). The longest surviving scheme, that in Westmeath, dates back to 1965; the most recent, that in Donegal, commenced in 1982.

On the evidence available in November 1984 there were then 144 people boarded out, twenty-two of whom are under 65 years. A total of sixty-three carers share responsibility for the day-to-day care of these people. The precise distribution between different schemes of people placed and their carers is given in Table 3.2. Carers receive a payment per person placed with them which ranges from £18.50 per week in Longford to £50.00 per week in Donegal. (See Table 3.3)

The contribution expected of the elderly resident varies considerably between the schemes. (See Table 3.3)

Responsibility for organisation lies with different professionals in different schemes, in four instances with the superintendent public health nurse, in three with a social worker or a senior social worker health nurse, in three with a social worker or senior social worker, and in the remaining case with the matron of a geriatric hospital. (See Table 3.2)

* Information on the ages of eight people placed in the Longford Scheme is not available.
TABLE 3.1: THE EIGHT HEALTH BOARD AREAS AND COUNTIES WITH SCHEMES

Health Board Boundary
County Boundary
County with current scheme
### TABLE 3.2: SELECTED COMPARATIVE DATA ON CURRENT BOARDING OUT SCHEMES

<table>
<thead>
<tr>
<th>SCHEME</th>
<th>HEALTH BOARD</th>
<th>YEAR STARTED</th>
<th>NO. IN PLACEMENT (Nov 1984)</th>
<th>NO. OF CARERS</th>
<th>NO. OF PEOPLE PLACED UNDER 65</th>
<th>SCHEME ORGANIZER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan</td>
<td>North-Eastern</td>
<td>1973</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>Superintendent Public Health Nurse</td>
</tr>
<tr>
<td>Donegal</td>
<td>North-Western</td>
<td>1982</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Leitrim</td>
<td>North-Western</td>
<td>1972</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Community Care Personnel</td>
</tr>
<tr>
<td>Longford Mayo</td>
<td>Midland</td>
<td>1974</td>
<td>34</td>
<td>7</td>
<td>11*</td>
<td>Matron of Hospital</td>
</tr>
<tr>
<td></td>
<td>Western</td>
<td>1978</td>
<td>61</td>
<td>23</td>
<td>9</td>
<td>Superintendent Public Health Nurse</td>
</tr>
<tr>
<td>Monaghan</td>
<td>North-Eastern</td>
<td>1974</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Superintendent Public Health Nurse</td>
</tr>
<tr>
<td>Offaly</td>
<td>Midland</td>
<td>1974</td>
<td>16</td>
<td>5</td>
<td></td>
<td>Senior Social Worker</td>
</tr>
<tr>
<td>Westmeath</td>
<td>Midland</td>
<td>1965</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>Superintendent Public Health Nurse</td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td></td>
<td>144</td>
<td>63</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

*Data on ages not available for eight people placed in Longford scheme.
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Weekly Payment to Carer</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan</td>
<td>£22 minimum</td>
<td>Health board pays £22 weekly under Home Help Scheme. Old person may pay a negotiable sum in addition directly to carer.</td>
</tr>
<tr>
<td>Donegal</td>
<td>£50</td>
<td>Old person gives all of pension save £20 to carer. Health board tops up the amount so that carer receives £50 in total.</td>
</tr>
<tr>
<td>Leitrim</td>
<td>£36 minimum</td>
<td>Old person pays £30—£35 per week directly to carer. Health board pays an additional £6 to carer.</td>
</tr>
<tr>
<td>Longford</td>
<td>£18.50</td>
<td>Health board pays £18.50 to carer and charges old person same amount as is levied on pension of person in institutional care.</td>
</tr>
<tr>
<td>Mayo</td>
<td>See notes</td>
<td>Old person pays carer 50% of weekly pension directly and Health board adds £20 per week.</td>
</tr>
<tr>
<td>Monaghan</td>
<td>£22 minimum</td>
<td>Health board pays carer £22 per week and old person may pay an additional negotiable amount directly to carer.</td>
</tr>
<tr>
<td>Offaly</td>
<td>See notes</td>
<td>Old person gives 75% of pension to carer directly. Health board pays an additional amount (i) £15 in respect of placement in large unit (ii) £12 in respect of placement in a private household and (iii) £6 in respect of placement in bedsit accommodation with a family directly to carer.</td>
</tr>
<tr>
<td>Westmeath</td>
<td>£5—£12 (see note)</td>
<td>Health board pays monthly to carer amounts ranging from £20—£48. Old person may make additional negotiable contribution.</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

FOCUS ON FOUR SCHEMES

This chapter presents profiles of four of the eight schemes, in Cavan, Donegal, Longford and Mayo. They are selected for fuller examination for a number of reasons. Firstly, they seem important either in terms of numbers of people served or in terms of their prospects for development. Secondly, they seem to vary significantly in their origins and organisation and to represent a possible spectrum of approaches. Thirdly, each of these four schemes are under the auspices of one of the four health boards providing such a service. Finally, these are the schemes which our initial enquiries unearthed, thus allowing sufficient time for them to be researched more fully. (Limited information regarding the operation of the four schemes not covered here, i.e. Leitrim, Monaghan, Offaly and Westmeath can be found in Appendix 2.)

While the schemes vary considerably in their organisation, the four counties in which they are based share interesting similarities in terms of demographic and economic background.

When compared with national averages, they share (i) predominantly rural populations and (ii) higher dependency ratios, including high proportions of elderly people. (see Table 4.1). Three of the counties are in the lowest four of the national rank order for county income per capita. The remaining county, Cavan, is also poor, having the seventh lowest county income per capita. Medical card coverage tends to be high in these counties, which provides further and more recent confirmation of their relative poverty (see Table 4.2).

These four schemes have emerged therefore in counties which share unfavourable patterns of demographic and economic structures.

The Cavan Scheme

County Cavan, together with County Monaghan, makes up the Cavan-Monaghan Community Care Area, which is one of three such areas in the North-Eastern Health Board Region. The Cavan boarding
TABLE 4.1: SELECTED DEMOGRAPHIC DATA FOR SELECTED SCHEME COUNTIES

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>TOTAL POPULATION</th>
<th>RURAL POPULATION AS % OF TOTAL</th>
<th>POPULATION 65+ AND AS % OF TOTAL</th>
<th>DEPENDENCY RATIO 0—4 and 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayo</td>
<td>114,766</td>
<td>94,071 (82%)</td>
<td>18,247 (16%)</td>
<td>47.7%</td>
</tr>
<tr>
<td>Donegal</td>
<td>125,112</td>
<td>100,486 (80%)</td>
<td>17,485 (14%)</td>
<td>45.2%</td>
</tr>
<tr>
<td>Cavan</td>
<td>53,855</td>
<td>47,015 (87%)</td>
<td>7,417 (14%)</td>
<td>42.5%</td>
</tr>
<tr>
<td>Longford</td>
<td>31,140</td>
<td>24,592 (79%)</td>
<td>3,946 (13%)</td>
<td>42.8%</td>
</tr>
<tr>
<td>National</td>
<td>3,443,405</td>
<td>1,528,620 (44%)</td>
<td>368,954 (10.7%)</td>
<td>41.0%</td>
</tr>
</tbody>
</table>

**TABLE 4.2: SELECTED ECONOMIC AND SOCIAL DATA FOR SELECTED SCHEME COUNTIES**

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>INCOME PER CAPITA (1973) RANK ORDER (1—HIGHEST TO 26—LOWEST)</th>
<th>MEDICAL CARD COVERAGE % OF POPULATION</th>
<th>MEDICAL CARD COVERAGE RANK ORDER (1—HIGH to 26—LOW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayo</td>
<td>24</td>
<td>70,397 = 61%</td>
<td>2</td>
</tr>
<tr>
<td>Donegal</td>
<td>25</td>
<td>78,490 = 63%</td>
<td>1</td>
</tr>
<tr>
<td>Cavan</td>
<td>20</td>
<td>22,902 = 42%</td>
<td>16</td>
</tr>
<tr>
<td>Longford</td>
<td>23</td>
<td>15,428 = 49%</td>
<td>4</td>
</tr>
<tr>
<td>National</td>
<td>Dublin 1/Leitrim 26</td>
<td>1,280,758 = 37%</td>
<td>1 Donegal 63%—27 Dublin 24%</td>
</tr>
</tbody>
</table>

out scheme began in 1973 when the superintendent public health nurse arranged the discharge of a local Catholic man from St. Felim's Hospital to the care of his neighbour, a Protestant clergyman. There have been a total of fifty-one people placed since that first placement twelve years ago.

The maximum number of old people placed under the scheme at any one time has been twenty-two. Currently there are fifteen people, men and women, ranging in age from 71 to 99 years (see Appendix 1). Of the current placements the majority are of fairly recent duration, although one dates back to 1977 (see Appendix 1).

In some instances, housing need may be the primary cause of placement under the scheme.

(i) The back wall of a 75 year old woman's house fell in and rats began to infest the house. She went to live with her home help.

(ii) A 73 year old man who, when discharged from long-term residential care, had no home to go to, went to live with a neighbour.

(iii) A woman aged 88, who was homeless, went to live with a former employer.

In other instances medical and social problems are precipitating factors in placement.

(iv) An 84 year old man, who was unfit to live alone due to his frail state, moved in with his male home help.

(v) A 75 year old woman, who has spinal arthritis and could no longer manage alone, moved in with her second cousin.

(vii) An 85 year old woman, who was beaten and robbed in her own home, became too afraid to remain and then moved in with her neighbour.

There has never been any need to publicise the scheme or undertake specific recruitment in order to attract carers. In fact, most of the arrangements are made informally and spontaneously, often on the initiative of a neighbour acting as an informal carer and independently of any intervention by a professional or health board worker. All of the fifteen people now in placement had lived with their carers before their relationship was given formal recognition by the board, and they were deemed to be officially boarded out. This 'unofficial' relationship prior to formal recognition in the current cases may have lasted anything from one day to ten years. One of the carers is actually a second cousin to her boarder, but none of the other old people are related closely to their carers. Seven of the carers were neighbours to old
people, but had never received a home help allowance for any care they had given while the old person was living independently, or during the time the old person was living with them, prior to being recognised as officially 'boarded out'.

Typically in this scheme, a placement evolves when an old person goes to live with a willing neighbour or home help due to a deterioration in his/her circumstances, e.g. health or accommodation, or to a fear of remaining alone. The informal carer, or the local public health nurse on their behalf, then contacts the director of community care informing him of the new circumstances and seeking support. The director of community care refers the query to the superintendent public health nurse who monitors the overall operation of the scheme.

She asks the local public health nurse to investigate and to complete an application form on behalf of, or with, the prospective official carer, giving all the pertinent background, including details of the old person in respect of whom they are claiming the allowance, and of the quality and degree of relationship between the applicant and the old person. If the superintendent public health nurse takes a positive view of this report and gives her approval, she passes the application to the director of community care for a final decision. Once formal approval has been given the carers become eligible for payment. The Cavan scheme is thus unique in that the prospective carers apply to board out a specific old person who is usually already living with them, resulting in a one-to-one ratio between carers and old people.

The ages of the current carers range from 28 to 65 years (see Appendix 1). The majority of these carers are in their fifties, female and married. At present two of the carers are male and single. This involvement of males in full-time caring is something else that is unique to the Cavan scheme. One of the men had actually been a home help to the old person and the other man a neighbour. Both of these carers are in their early fifties. Their involvement in caring seems to challenge the traditional view of caring as a 'female' occupation. Of the thirteen women who are carers, eleven are married and two are widowed. In addition to the fifteen carers currently recognised and active, a further thirty-six have participated as carers in the past.

The carers receive the equivalent of twenty home help hours payment weekly i.e. £1.10 x 20 = £22.00 weekly (see Table 3.3). The funds for payment are drawn from the home help heading of the community care budget. Payment is made only on authorisation from the superintendent public health nurse. She is kept informed of the
placements by local public health nurses who visit participating households at least monthly, more frequently if necessary. Day care provision is limited in Cavan and is confined to St. Felim's in Cavan town. Since the old people are widely dispersed, it is not practical for them to avail themselves of this service, thereby precluding some possible respite for the carers. In keeping with the particular and relatively private nature of their commitment, carers seem to have little contact with each other in the Cavan scheme. Indeed it seems many may not even be aware of each other in the Cavan scheme.

The Cavan scheme is significant in a number of respects.
(i) There is a one-to-one ratio between carers and old people.
(ii) Most of the people placed are able to continue living in their home area.
(iii) The scheme largely entails the official recognition of the existing arrangements between the carer and the old person.

The Donegal Scheme

County Donegal is one of the two community care areas in the North-Western Health Board region.

The Donegal boarding-out scheme started in 1982 and is the newest and smallest of the four schemes studied in this chapter. Since its inception thirteen placements have been made, mostly in the north of the county. There are ten people currently placed with five carers. The scheme grew out of the home help service. In fact, the first two carers were home helps initially, and then after having developed a special concern and affection for their respective old people, decided to take them into their own homes. The scheme organiser is a health board social worker who works specifically with the elderly. Her interest in such provision grew out of concern for elderly who were on a waiting list for long-stay/care accommodation in the county.

Those placed range in age from 77 to 90. There are equal numbers of men and women. All five of the men are under 83, whereas all but one of the women are over 83. (see Appendix 1).

The need for care is identified by the local public health nurse, who refers the old person for consideration for placement to the social worker. In order to process such a referral, the social worker prepares a report on the social and financial circumstances of the person
referred. In collaboration with the senior social worker, a decision is made as to whether a placement should go ahead. Where an old person is reluctant about the prospect of being placed, their wishes are respected.

The ten people currently in placement seem to have relatively high levels of medical and social needs, e.g.:

(i) Woman (86), poor eyesight, leg ulcer, incontinent;
(ii) Woman (79), stroke victim, skin condition, incontinent;
(iii) Woman (84), needed supervision after an operation;
(iv) Man (77), 'bent double' with arthritis, suffers from depression;
(v) Man (80+), heart condition, incontinent.

In three of the cases in this scheme, the family/carer and old person came together informally and then approached the health board for payment and/or approval. (This form of informal matching is also evident in the Cavan scheme). Where the prospective carer and the old person do not already know each other, the social worker considers pre-placement contact as very important, and always tries to arrange that the old person visits the carer’s house before being placed.

Old people who are placed will be on the register of the local public health nurse. A person with active nursing needs will have them attended to on the same domiciliary basis as others in the community. In Donegal, day centre provision is confined to day hospitals. Because of the geographical spread of the county and the dispersal of population, transport to day care represents a real challenge. Consequently, those currently on the scheme only attend a day hospital once a week, and even, perhaps, once a fortnight.

The social worker tries to get the old person's family to visit, and in a case where there is no family, to get previous neighbours to call. Some relatives visit, and one or two call very often. Placements are made as near as possible to the old person’s original home.

All of the Donegal scheme carers are women and all are married. Two of the carers are in their 30's, two in their 40's, and one in her 50's. Two of the women have children, one having two, both under the age of 5, and the other having six of school going age. Most of the carers had some prior experience of working with the elderly. As stated, two were home helps, and two others had gained relevant experience in England. Three of the carers have one person placed with them, one carer has two people, and the remaining carer has five placed with her. Someone interested in becoming a carer must
complete the scheme's application form. The social worker prepares a social report to the senior social worker including her recommendations as to the applicant's suitability. Where the senior social worker supports the application, she will submit the report to the director of community care for final approval.

Carers receive a weekly allowance of £50 per week. This is the highest rate in any of the schemes, but may in part reflect the apparently greater incapacity of old people placed in the Donegal scheme. The £50 payment is made up in two parts. The pensioner must hand over to the carer all of his/her pension, less £20, and the Board tops up this amount so that the total is £50. No publicity to attract applicants has been used to date. This is mainly due to the fear that increased publicity might lead to increased offers of service. The risk then might be that the social worker on her own could not cope with the expanded scope and expectations of the scheme in addition to her existing workload.

The Donegal scheme has some interesting characteristics:
(i) The guaranteed rate of payment to carers is the highest of all eight schemes.
(ii) All of those placed are over 75 years of age and seem to have many medical and social needs.

The Longford Scheme

The county makes up, with Westmeath, one of the two community care areas in the Midland Health Board region. In Longford town St. Joseph's Hospital provides more than half the county's health board geriatric long-stay places. In addition to its 165 beds, the hospital also arranges 'extra mural' night care for a further 34 elderly people who are otherwise its patients. This night, or bed and breakfast care, is provided under the auspices of the county's boarding-out or "Guest House" scheme, which is run from the hospital. There are currently seven households in the scheme, offering a total of forty-four places, ten of which are vacant at present.

Three of these "Guest Houses" households are situated in the town of Longford (population 4,500) and four within a radius of three to four miles of the town.

Old people who take part in this scheme spend their day in the hospital. Around 7pm each evening they are transported by hospital minibus to their respective guest houses, where they spend the night.
After breakfast they are returned to the hospital, where their personal wardrobe and most of their belongings are kept. Besides breakfast and a cup of tea on their arrival in the evening, which are provided by the Guest House carer, all other meals are provided within the hospital.

Other needs related to self-care or medical and nursing care are also met by hospital staff.

In general, placements in this scheme seem to be precipitated by predominantly social factors, for example unsuitable or remote accommodation, poor self-care skills, lack of social or family support. In order to be considered for the scheme, an old person must first be admitted to St. Joseph's where they can be assessed for suitability by the medical officer whose approval for placement arrangements is always required. Possible candidates must be ambulant and continent. Nevertheless, despite this requirement, a number of those placed experience serious health difficulties, such as blindness, stroke, or mental disabilities.

The actual matching of an old person to a Guest House carer may fall in practice to the ward nurses or sister involved in the patient's daily care. Their detailed knowledge of the patient, his/her prospective co-residents and carer, helps them in their attempt to achieve a compatible placement. However, it is not always possible to find the right "mix" in every instance. For example, one old man with particularly special needs has spent at least some time in all of the participating Guest Houses.

There is incomplete information available to the researchers regarding the ages of people placed on the Longford scheme. Of the twenty-six old people (fourteen men, twelve women) for whom ages are available, eleven are aged 75 and over. Only one of the group, a man, is in his eighties (Appendix 1). The Longford boarding out group differs from the other groups in two respects. They are generally younger, with a bigger proportion under 65 years. Also the trend observed of younger ages in men and older ages in women placed in the Donegal and Cavan schemes is reversed here.

In terms of its origins, the scheme has some interesting parallels with the Mayo scheme. Both in some sense owe their existence to pressure on institutional accommodation. The Longford scheme began in February 1974 as a practical response to an imminent shortfall in bed places occasioned by a move from larger obsolescent quarters to more modern but smaller accommodation. The then matron used her personal contacts to find householders in the community who were
willing to take displaced hospital residents on an overnight bed and breakfas
basis. As the scheme has evolved, publicity or other efforts to attract new participants have not been found to be necessary since ‘word of mouth’ in the community seems to produce a steady level of interest and enquiries.

The overall operation and the assessment of applicants are overseen by the matron in conjunction with the health board social worker attached to the hospital. However, neither the matron nor the social worker are optimistic about the future development or even the continuation of the scheme. Only two placements have been made in the past year (see Appendix 1) and they foresee a trend whereby the increasingly frail state of new admissions to the hospital will preclude their consideration for the scheme, since their physical state, even after rehabilitative care, will fail to satisfy the scheme’s criteria. Despite this relatively pessimistic appraisal of the prospects for the scheme, it seems to continue to function well. Many of the placements are remarkably enduring, some people having been in the same placement for nine or ten years.

Of the seven guest houses in the scheme, six are run by married couples and the remaining one by a single woman and her bachelor brother. The couples range in age from late twenties to late sixties. Five of the families have children, in three cases children of school-going age (Appendix 1).

The guest-house owner seems to receive little detailed information about his/her prospective resident, although the new resident is likely to have formed an impression of his/her new carer from reports from his/her peers in the scheme.

Currently five guest house owners have three people each, one has nine and another has ten.

The Longford scheme provides care for thirty-four patients on an overnight care basis. Certain aspects of the scheme are of interest:

1. The model of care applied differs from those in other schemes since the patients day-to-day care and management is not devolved to the carers but remains largely the responsibility of the hospital from which all placements originate. This close integration with the hospital permits a high degree of continuity of care, where illness or other circumstances require the patient’s return to full-time hospitalisation, whether on a temporary or a long-term basis.

2. The people placed seem younger and possibly fitter when
compared to those in placement elsewhere. There is a higher proportion below 65 years on this scheme also.

The Mayo Scheme

County Mayo is one of three community care areas in the Western Health Board region. Its boarding-out scheme, which started in 1977, grew from the concern of the superintendent public health nurse about the lack of adequate provision for emergency social admissions of old people to institutional care. The geriatric service in the county were unable to satisfy the demand for long-term beds and also were experiencing difficulty in catering for emergency admissions. The superintendent public health nurse realised the potential for boarding-out as a means of easing the demand for long-term beds and thereby freeing provision for emergency care.

While three old people were placed in 1977, the scheme proper got underway in 1978. It has become more formalised in the last three years or so. Currently in this scheme there are sixty-one old people placed in twenty-three households. In three of these households there are more than eight old people placed together.

The twenty-five women and thirty-six men placed range in age from 43 to 93. Nine of them are under 65. Fifteen are aged between 65 and 74 and thirty-seven (60%) are aged 75 years and over (see Appendix 1). In general the men placed tend to be younger than the women.

The reasons for placement in the Mayo scheme vary, and include social and medical factors, e.g.

(i) a 75-year old woman who, after suffering a fractured femur, was unable to return to her home to live independently;
(ii) an 85-year old man who was living in an extremely remote area and was considered to be at risk by the public health nurse.
(iii) a 78-year old man who had suffered brain damage and whose family could not accept him home from hospital.
(iv) a 74-year old woman who was boarded-out because the roof of her house had collapsed;
(v) a 59-year old man who, having returned from England after many years, found himself to be homeless;
(vi) an 82-year old woman whose companion was hospitalised and who was afraid to live alone.

The committee overseeing the geriatric long-stay admissions in the
county considers referrals to the scheme. Its membership includes the medical officer and matron of the main geriatric hospital in the county (which has assessment and rehabilitation beds), the consultant geriatrician in Castlebar General Hospital, and the director of community care and superintendent public health nurse for Mayo. Where the committee favours boarding-out of a particular person, careful thought will be given to 'matching' the old person and the carer in the light of available knowledge. Geographical proximity and personal compatibility may be among the factors considered. Where possible, the person will be placed in their own district or in one similar (e.g. in terms of style of farming). In some instances, the carer may live in the same village as the old person did; in fact in five cases the carer was actually a next-door neighbour. Of the thirteen people from the Ballina district in the scheme, twelve are in placements in that same district.

Each person placed is put on the list of the local GP. In addition, the local public health nurse will visit as required on the same basis as other old people on her register.

Twenty-three of the old people placed attend day care centres on a five day week basis. They are required to make a contribution towards the cost of their transport to and from the day care centre. The remaining thirty-nine who do not attend do so either by choice, or because of the lack of local facilities.

Of the current sixty-one placements, only six are of five or six years standing, but a further fourteen placements are of three and four years standing. Thirty-one of the placements are less than two years old (see Appendix 1).

In the Mayo scheme there are twenty-three approved carers who care for the sixty-one old people in the scheme. There are a further eleven approved carers who have no placements currently. Some of these have had placements in the past.

All of the carers formally appointed are women and they range in age from 26 to 65 (see Appendix 1). The majority (15) are between 40 and 60 years of age and hence women approaching late middle age are predominant, although one woman, a widow, is herself 65 years old. There are seventeen married women, four widows, a single woman and a nun acting as carers. Of the fourteen carers who have children living at home, seven carers have one child, two carers have two children, four carers have three children and one carer has six children.

A prospective carer must contact the health board office in Castlebar
if they wish to be considered for the scheme. They will be sent an application form (see Appendix 4) which seeks details of family and accommodation. When this application is processed they may be invited for an interview with the director of community care and the superintendent public health nurse. If they are still considered as being potentially suitable, the local public health nurse will be asked to investigate their circumstances in more detail.

Before the carers can be approved finally, a fire officer and a health inspector must visit the home and approve its safety and hygiene standards (see Appendix 4). Only on successful completion of all these stages can the director of community care give his final approval. Currently there seems to be a steady interest in the scheme among potential carers. In the past the board has successfully used advertisements in local newspapers as a means of attracting applications (see Appendix 4).

Payments to carers is made in two parts. The pensioner is required to pay, directly to the carer, half of his/her weekly pension. In addition, the Western Health Board pays £20 weekly to each approved carer, per current placement. These payments are made under a specific heading in the board's community care programme budget. The monthly payment by the Board is authorised on receipt of a report from the local public health nurse confirming the continued satisfactory operation of the placement.

To date, there have been two meetings between participating households and the staff concerned. These meetings were felt by the superintendent public health nurse to be successful and more are intended. The availability of staff time for organising such meetings seems a major constraint.

Two points in relation to the Mayo scheme seem worthy of comment:

1. Mayo's boarding out scheme is the largest in the country in terms of the numbers of old people, carers, and professionals involved. It has grown remarkably rapidly. In 1977 there were three placements. In 1984 (only seven years later) there were sixty-one. A scheme of this size and rate of growth makes significant demands in terms of time on professional and administrative staff concerned, especially in the absence of possibilities for additional staffing. The future growth of the scheme seems likely to depend on how the staff can continue to cope, given the size of the scheme, with its assessment and approval procedures and its day-to-day administrative tasks.
2. As in Longford, the scheme does not cater for people solely on the basis of their age. Nine people under 65 with special mental or social problems are also served.

This chapter has described in some detail the organisation and operation of four schemes for the boarding-out of old people currently in existence. In the following chapter some of the experiences of those involved will be outlined.
CHAPTER FIVE

CASE STUDIES OF THE BOARDING OUT EXPERIENCE

This chapter gives some glimpses of the experience of boarding-out as seen from the vantage point of the people directly concerned, the old people and their carers. This is done to reflect the quality of life of those involved, acting as a balance to the drier and more formal data about the schemes contained in Chapters Three and Four.

The material, which is presented in the form of case studies, is derived from (a) research notes of interviews conducted in person and by telephone with professionals involved in the organisation of the schemes, (b) analysis of administrative records and (c) interviews with six old people and two carers. The material is selected to demonstrate various aspects of boarding out which will be explored in Chapter Six.

"Preserving Relationships"

Pat and James

Pat was coping well, caring for his mentally handicapped 43 year old son James, despite his eighty-two years of age. They lived happily together in a rural district.

In August 1984, Pat fell ill and had to be hospitalised. It was recommended that James, who was now alone, be boarded-out on a trial basis during his father's time in hospital. James was boarded out with a family who live six miles from his home.

In September 1984, Pat was ready to be discharged, but it was thought by the hospital staff that he would be unfit to look after his son on his own. One option might have been separate placements, perhaps arranging to place Pat in a long-stay welfare home and James in a residential centre for the mentally handicapped. It seems reasonable to assume, however, that such a permanent disruption of their relationship would have a devastating effect on both men. A happier and more imaginative solution was found. Both men are now re-united, living together in James's 'foster home' with six other
co-residents.

Boarding out has been clearly of great value to this family, preserving their relationship and allowing Pat to continue caring for his son, but with the support he now needs.

"A New Lease of Life"

Mary

Mary, aged 79, lived with her brother on a small farm in a rural area. She has suffered from severe arthritis for many years and was cared for by her brother, John. In 1982, Mary suffered a stroke and her brother found it impossible to cope, despite the help of a local clergyman and his wife.

Eventually, the clergyman, acting on John's behalf, had Mary's name placed on the waiting list for residential care. At this point, Mary's dependence and need had increased further; besides the arthritis and stroke she was now also suffering from a skin rash.

Mary was first boarded out on a trial basis. The carer who took her had already four old people in her care, but told the social worker, who expressed reservations about the demands posed by a fifth person, "I can try". The carer, who is in her late thirties, returned with her husband and two children from England some years ago. Both husband and wife had a strong interest then in fostering old people. The placement is successful and Mary seems to thrive. She especially enjoys her relationship with the baby of the house. "It's a new lease of life for her: she loves and lives for the child", the social worker says. The gains have not just been in relation to Mary's psychological state: physically things have improved also. Her serious skin rash has cleared and her incontinence of bowel, a consequence of her stroke, has eased considerably.

Visit to a Guest House

May: Carer

May's 'Guest House' is a bungalow in a residential area of town. Three old people are boarded-out on a night time only basis with her family, spending the major part of the day in the health board hospital,
which is ten minutes drive away.

May is a woman in her mid-fifties. Her husband is retired. Their four children, all in the twenties, live away from home, two being married.

May heard about the scheme through a friend and wrote to the Matron of the hospital in 1978, offering to take old people on a bed and breakfast basis. Since then she has had about six long-term placements as well as some short-term placements.

Currently, she has three men in their seventies boarded out with her. The three of them share the same bedroom, which has four single beds, a wardrobe and a few chairs. The men have the use of a separate toilet and wash-hand basin. The residents keep very little in their room, leaving most of their clothes and personal belongings in the hospital.

However, recently one of the old men asked May if one of his favourite jumpers could be washed and kept in the guest house for fear it might get lost in the hospital laundry. All the residents' clothes and bed linen are normally washed by the hospital. The men receive their weekly bath in the hospital, as well as clean clothes, haircut, chiropody etc. May does not receive a lot of information about the old people before they come and has never had a meeting with an old person prior to placement. She is unsure about what the old person is told before they arrive either. At first, as her daughter explained, it was difficult to know just how much a part of the family the old person would or should become. The family began by bringing the elderly into the sitting room in the evenings, but after a few difficulties in persuading one old man to go to bed late in the evening, they no longer encouraged it. May's daughter explained that the sitting room was one of the few places where her family could meet together, and their privacy as a family was important as well.

There were other issues that the family had to face.

Sometimes the residents did not get on very well together and there was the occasional clash of personalities. In one instance, the disharmony became so uncomfortable that it had to be arranged that one of the elderly people should leave.

May has a phone, an important link between the Guest House and the hospital. She can ring if any of the elderly people are ill, or if help is needed. She is reassured in the knowledge of having twenty-four hour support from the hospital. In one case, an old man placed with her collapsed after only one week and lost the power of both legs. She had felt unprepared for such an emergency, and still feels that perhaps
she could have done more for the man in that situation if she had been better prepared. May would like to share these and other experiences with other carers and she felt it would benefit her to meet and chat with them, even if she feels she would need encouragement to “open up”, given what she describes as her shyness.

Did May see gradual changes in the old people who were boarded out with her? At first she said she did not, but then commented that it was the neighbours who seemed to spot any improvements. The neighbours would comment on how they had lost their ‘stooped’ look and ‘how well’ they looked! Her daughter said she could not believe how institutionalised some of the old people were at first, and how long it might have taken them to begin again to resume responsibility even in seemingly trivial matters. She gave the example of Liam and how in the morning, if the family are out, he has to let the two other old people out of the front door, lock it, and then let himself out the back door. This simple operation was extremely difficult for Liam to master at first, as a result of his previous experience of long-term institutionalisation. Now it is an effortless part of his morning routine.

Residents make their own beds, and occasionally a cup of tea, but May or one of her children, if at home, gets the breakfast ready in the morning at about 8.30 a.m. She also has a special Christmas party for her guests.

“Brotherly Concern”

Thomas

Thomas is of a big build and is now in his mid-eighties. He suffers from a heart condition and is incontinent. Thomas’s brother, Richard, had tried his best to care for him, but eventually found he could no longer cope. Thomas was then boarded out in 1983. His carer is a married woman, with two children aged 5 and 2. There are four others boarded out with Thomas, another man aged 82, and three women, aged 79, 89 and 90.

Thomas's brother, Richard, calls to visit him in his new home and quite often is able to spend the weekend with him. These weekend stays enable Thomas and Richard to maintain their close relationship and helps reassure Richard about Thomas’s welfare.
Robert

Robert is 82 and has spent his life farming. There had been some strain in relations with his children, some of whom are now in England.

When he grew frail, one of his daughters, Rose, took him to live with her and her family. This arrangement did not endure, however, as she found it hard to cope both because of his ‘fainting fits’ and her own experience of the menopause.

Robert was hospitalised and when the time came for discharge Rose was unable to have him come back to her home. Robert found it difficult to accept that his daughter would not be taking him back. He was finally placed, contrary to his expressed preference, in a foster home. His was the first placement in this particular foster home, so it was not easy either for the carers or for Robert.

At first Rose found it difficult to visit her father, but her feelings were recognised by the carer, who did her best to support and encourage Rose to visit. Now Rose visits very often, bringing clothes and other items to her father and having him to Christmas dinner and other special days.

Robert’s fainting fits have gradually disappeared and he has settled in well to his new home.

“Relatives — Keeping Up Contact”

Jim and Patricia

Jim and Patricia are boarded out at night in the same private Guest House. They receive bed and breakfast and then spend each day in the hospital from which the scheme is run. Their carers are an unmarried woman and her brother, who have a farm and a small bungalow.

Patricia, a quiet woman, finds that boarding breaks the monotony of her day, and that it also means that she can be back in the area where she was reared. Patricia is eight years in the same household, and is very much ‘one of the family’. She sometimes makes the tea in the evenings and spends the rest of her time watching T.V. or talking
to the carers. She shares her bedroom with another woman, who is also boarded out.

Jim enjoys the 'trip out' from the hospital and thinks boarding out is a great idea. "It keeps me in touch" he says.

When he gets home with the two women they will make the tea together, if the carers are out. Jim enjoys the television and the company of the group in the carer's sitting room. He has been hospitalised many times because of chest trouble and when this happens he is always anxious to get back to the same household.

Jim and Patricia say 'it's a long day' leaving for the hospital after breakfast at 9.00a.m., spending all day at the hospital and returning at 7.00p.m. (after tea) to the guest home. Despite the regular commuting and, in winter, the discomfort of travelling in the cold, neither said they would prefer to be in the hospital all the time.

Having given an indication of the human dimension of boarding out schemes, in the case studies, the next chapter will address itself to some of the issues thus raised. These clearly require consideration if policies, procedure and practice relating to the boarding out of old people are to be responsibly developed.
CHAPTER SIX

TOWARDS A POLICY: ISSUES FOR CONSIDERATION

The eight boarding out schemes have emerged as local attempts to serve local need. They are fascinating not only as examples of imaginative responses to the needs of the elderly but also as an indication of how social policy and practice may grow 'from the bottom up'. The fact however that something seems to have emerged successfully at local level may not be enough to convince planners and resource managers of the wisdom of promoting such measures on a national basis.

It is beyond the scope of this preliminary study to provide a definitive answer to the crucial questions faced by national policy makers, confronted as they are both by increases in the numbers of frail and dependent elderly and a possible shrinkage in the army of female informal carers available to serve this expanding need for long-term care. The question in the context of this report is 'Does boarding out represent a viable national option in the planning of long term-care for the elderly?'

What we can do is to suggest lines of enquiry which we think should be followed if the question of the potential of boarding out is to be adequately considered. The preliminary evidence available certainly convinces us that boarding out is an important policy option in the provision of long-term care of the elderly. It leads us to believe that boarding out can satisfy, in principle at least, some of the criteria which we would suggest should be used to assess the quality and viability of long term care arrangements for old people. These criteria include the following:

(i) Does the mode of care secure the old person's basic need for nutrition, shelter, physical safety and health care?

(ii) Does the mode of care respect the psychological needs of the old person by:
   - valuing and preserving links with his/her past?
   - promoting some element of choice in the person's living arrangements, both in terms of where he/she lives and in terms of his/her daily routine?

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permitting him/her to enjoy as fully as possible normal life experiences in his/her daily routine, e.g. daily outings, conversation with neighbours, contact with children, access to newspapers?;

— avoiding the grosser aspects of stigma associated with some forms of long-term care?

(iii) Does the mode of care provide for varying levels of dependency in the individual over time and between different old people?

(iv) Is the mode of care feasible organisationally, i.e. in terms of administrative, financial and manpower considerations, and in terms of achieving a consistent and acceptable quality of care?

Based on the necessarily limited evidence of our own research findings, our contention is that boarding out can satisfy these criteria. It can satisfy the basic needs of nutrition, shelter and safety (see different schemes). It can meet health care needs (see Donegal scheme particularly and Case Studies — ‘Mary and Robert’). It can act to preserve and value past links (see Cavan scheme and Case Studies ‘Pat and James’, ‘Thomas’ and ‘Robert’). It can allow some element of choice (see Donegal). It facilitates a more normal daily routine (see all schemes and Case Studies ‘Mary’ and ‘Jim and Patricia’). Old people seem pleased to be placed, which suggests that they do not experience it as a stigmatising arrangement (Case Study ‘Jim and Patricia’). The extent to which boarding out can provide for the more frail and dependent remains uncertain, but the Donegal experience seems to provide prima facie support for a relatively optimistic estimate of its potential in this regard. Boarding out certainly presents challenges organisationally but it seems that these can be met given the range of creative responses to these issues already to be found in the different schemes.

We believe, then, that boarding out needs to be explored more fully as a national policy in providing for the long term care of old people. We also believe that its real scope and value can only be judged after its more general application in practice and after much fuller consideration of the questions of policy, procedures and practice it raises in the context of appropriate institutional and community care planning. It needs to be tested more widely because at present old people boarded out represent only something less than 1% of all old people in institutional care.

Without expansion, its status may therefore remain too marginal
for realistic appraisal. Side by side with such development in practice, attention needs to be given to a whole set of issues that arise if boarding out is to be pursued as a national policy option. The following questions we suggest should form part of the agenda for such a review of boarding out for old people. They are grouped under three headings. Each question is followed by a brief elaboration of its significance.

The Old Person Placed

(i) How are old people to be selected for possible placement?
   — The schemes seem to use different criteria for judging eligibility. Some apply stricter requirements regarding physical health than others. The evidence of some of the placements in the Donegal scheme would seem to suggest, for instance, that older and frailer people may be placed quite successfully. Greater sophistication in the assessment of dependency in the candidates for placement and of the capacity of their prospective carers would provide a firmer basis for such selection.

(ii) How much choice should an old person have in his/her prospective placement and how is this to be given effect?
   — If old people are genuinely to be involved in decisions about their destiny, presumably they must be consulted first, in principle, about the idea of boarding out, possibly meeting a typical carer or another old person already in placement. If the old person accepts the idea of being boarded out, then they should have the opportunity to meet with and visit their own prospective carer before everything is finalised. Besides its importance in preserving the dignity of the old person, these preparations can safeguard against future difficulties:
   “Where possible the persons concerned should meet, preferably more than once, before placement is completed. All this involves trouble and delay but haphazard or hurried placement is seldom successful. Too many failures get boarding out a bad name. Some failures are probably inevitable but the number will be considerably reduced if adequate care is taken in placement”.

(iii) How is the old person placed to be protected from exploitation,
abuse or even unwitting insensitivity to their needs?

— Old people in placement may be in a peculiarly isolated and powerless position. Their vulnerability requires a special vigilance and alertness to possible problems. Indeed one health board has quite deliberately declined to launch a scheme on these very grounds, regarding boarding out as a ‘hazard’ to frail and vulnerable old people which it was not prepared to contemplate. Any full blooded policy to promote boarding out for the elderly must address and allay these justifiable anxieties. In the field of child care, there is a long tradition of statutory regulation in order to protect the welfare of those boarded out. It can be argued plausibly that school-age children, who can signal distress or have it observed in the daily routine of school and the like, are much less prone to be the anonymous, isolated and impotent victims of abuse than the potentially housebound old person. It is important also in this context, however, to remember that boarding out has no monopoly regarding risks of abuse. There can be no guarantees against the perpetration of quite insidious abuse within one’s own family or in institutional care.

(iv) How can an old person signal if they are in difficulty in a placement?

— Are opportunities created for a fully private conversation between the old person and the professional responsible for monitoring the placement? Without such a provision the old person may feel inhibited or threatened in terms of revealing their true feelings when a professional visits a carer’s home.

(v) How much work is required to enlist the good will or active support of an old person’s relatives towards a placement?

— Even where, for genuine reasons, they are unable to care, relatives may have serious reservations about the boarding out of the old person in another family. Similar reservations have been found with parents of children in foster care. If the person or child goes to a family, this seems to indicate more sharply and publicly the apparent failure of their own family. Nevertheless old people may not feel free to settle into their new ‘family’ until they are sure of the understanding of, and approval for this by their loved
ones.
Quite apart from its influence on the placement itself, contact with relatives remains an essential means of preserving links with the past which are of such importance psychologically for old people as they struggle to cope with new surroundings and preserve the fragile threads between the familiar past and uncertain future (Case Study 'Robert').

(vi) How integrated should the old person become into the life of the carer's family?
— Some of the Case Studies suggest considerable variation in the extent to which the old person placed becomes part of the carer's family. Some seem to share fully the companionship of the family, while others appear to lead a relatively independent and separate existence. Should expectations in this regard be established by both parties in advance of placement? There is much to recommend the following statement. "Acceptance as a member of a family often gives the elderly person that sense of being wanted and having a place in the community which is so important to happiness and well-being".

(vii) How much should an old person have to contribute towards the cost of their carer's payment and how exactly should this money be transferred?
— Expectations regarding the amount to be contributed by the old person differ between schemes. The question also arises as to whether the old person should pay his/her contribution to the Board or to the carer directly? The latter may seem less cumbersome but may become a source of friction in what is always a delicate transaction in even the most cohesive of family relationships.

(viii) Can boarding out serve other needs of old people besides those of long-term care?
— Experience in Britain and Northern Ireland would suggest an important role for short-term placement in families as a form of rehabilitative care after hospitalisation or as a form of respite care to give relief to the regular full time-carer. This latter use of short-term placement often allows caring relationships to be sustained that would otherwise have broken down, thus necessitating the old
person's admission to long-term institutional care. The emotional and physical relief afforded by these episodes of respite care can protect the regular carers from exhaustion and preserve their morale and commitment.

Carers

(i) What criteria should a carer (and his/her family) have to satisfy in order to be selected?
- The calibre of the carers and the support of their families are crucial to the success of individual placements and of whole schemes. Errors in selection may cause a lot of unhappiness or worse, not only for the old person, but also for the carer and his/her family. It might seem prudent therefore, to set standards of suitability for prospective carers. The precise criteria applied in existing schemes were not easy to establish.

(ii) What steps should a selection procedure for carers contain?
- How many officials' consent should be required? Should the final decision be taken by an individual or a committee and on whose recommendation? Are references to be required and taken up? (Garda clearance and employer and clergy references are often required by many agencies engaged in the placement of children in fostering or adoption.)

(iii) What methods should be used to attract applications from possible carers?
- Much scope seems to exist for the use of the mass media, provided the administrative organisers have access to the necessary skills and support for the design and dissemination of publicity and information material. In this regard, quite a deal of experience has been accumulated by services for the elderly in Britain and elsewhere in recruiting for short-term placement schemes. The public relations experience of the Fostering Resource Group in the Eastern Health Board would seem to represent a considerable national resource not only for those concerned with children's services.

(iv) What levels of payment should be made to carers?
- There is an extraordinary disparity between the different levels of weekly payment received by carers in the current schemes. (see Table 3.3) This seems difficult to justify. There
seems a strong case for adopting national rates as in the case of allowances for the boarding out of children. Also, as with children, it should be open to boards to pay special needs premia where these are appropriate.

(v) Should relatives automatically be excluded from consideration as (paid) carers?
— Too rigid an insistence on the non-relative status of carers may preclude quite constructive options in planning for the long-term care needs of an old person. This is a difficult issue since it raises what are seen as so many moral questions about filial and kinship responsibility, but perhaps there should be openness to examining each case on its merits and/or to devising a set of criteria for assessing such situations. The experience of the Westmeath scheme where relatives act as carers may offer valuable guidance in this regard. (see Appendix 2)

(vi) Should pre-existing placements be eligible for payment of the boarding out allowance?
— These kinds of arrangements are particularly significant because they represent the spontaneous expression of informal care which is independent of any organised effort. Nevertheless, they pose considerable problems for the professional. He/she is presented with a fait accompli. In such circumstances it can require an especially keen and discerning eye to observe and judge the quality of, and motives for, the arrangement in question.

(vii) What kinds of support should be available to a carer?
— The carer is undertaking for quite modest reward work that, by definition, is likely to be emotionally and physically demanding. It is important, for his/her own sake and that of those in their care, that morale and commitment remain high. They should not feel isolated or left ‘to get on with it’ by themselves. They need to feel supported, valued and to have regular contact with professional workers as well as a means of ready and immediate back-up in an emergency.

Arrangements to support carers might include:
— visits at least monthly by the professional worker responsible for liaising with the carer;
— access to day care for the old person in order to provide the carer with ‘time out’. A report to the South Eastern Health
Board has observed that in terms of ensuring the success of boarding out arrangements "the presence of a day centre to which the boarded out person can go during the day is a critical factor".15

— some preparation or training for their role. In Leeds17 and Pennsylvania,18 for instance, there are specific programmes to train prospective carers. There are parallel developments in the child care field here sponsored by the Department of Health.19

— opportunities to meet with fellow carers in order to share knowledge and experience and to derive mutual support and encouragement from one another. This has already begun to happen in Mayo with worthwhile results.

—the opportunity to withdraw from the scheme either temporarily or permanently. In this regard it has been observed that "Health authorities should make it clear to a person who is taking in a boarder that alternative arrangements will be made if the boarder becomes ill or if the placement is not a success, or if the person wishes to go away on holidays".20

General Questions Regarding Boarding Out

(i) Can boarding out be promoted on grounds of economy in addition to other grounds?
— The answer seems to be 'yes', though it is extremely difficult to estimate the real costs of all forms of placement other than those of maintenance because of problems in calculating underlying costs of administration and organisation of placement, capital costs etc. On the available data, boarding out appears considerably cheaper (see Appendix 5). A further analysis of this question should be made.

(ii) How is boarding out to be defined?
— There seems to be blanket use of the term to cover quite different models of care. There are also very important differences in the number of people placed. When, for example, does boarding out cease and private nursing home care begin? Is boarding out being used in certain instances as a device to circumvent the current embargo on the approval of new private nursing home places?21
(iii) What needs and what levels of dependency can and should boarding out serve?

— "Boarding out can be a very desirable solution for the problems of certain elderly people — for those who are no longer fit to live alone but do not need hospital care; for those living in social isolation which may lead to a breakdown; for hospital patients who no longer need hospital care but have nowhere to go, or whose relatives are unable to look after them, or who are not fit to return to living alone. It can help to ease the demand for institutional beds and a shortage of suitable living accommodation for the aged. It can provide a more natural substitute for their own homes than institutional accommodation. It can also be useful as a short-term arrangement to enable families caring for elderly relatives to take holidays, or to cope with an emergency or illness in the family. For hospital patients fit for discharge, boarding out can provide a half-way house between hospital care and return to independent life in the community."  

Seventeen years after these observations were made they seem still to retain their validity and relevance. It may still be difficult to state definitely the extent to which the needs of dependent old people may be served by boarding out initiatives.

There is at least indirect evidence that boarding out is possibly being called to serve needs which might more appropriately be considered the responsibility of the housing authorities. Any use of boarding out which might serve to conceal weaknesses in housing provision for the elderly must be regarded ultimately as a serious disservice to their interests. This is particularly true of those who live alone, whose fortunes seem inextricably bound up with the quality of their housing.  

(iv) What criteria should be used in 'matching' an old person and carer?

— "If boarding out is to be successful there must be most careful selection of the persons to be boarded out and of the persons to receive them. There must also be most careful matching of the persons involved. The persons in charge of placement must have an intimate knowledge of
the personality of the person to be boarded out, of his likes and dislikes, of his habits and possible idiosyncrasies; they must also have an intimate knowledge of the personality of the person willing to receive a boarder, of her/his likes and dislikes and of the way of life of the household. This is perhaps the single most sensitive and important decision in the boarding out process. On it hinges the success or otherwise of the arrangements. Perhaps current scheme organisers should be invited to submit their observations on this question with a view to the preparation of detailed guidelines for circulation by the Minister for Health?

(v) Should there be a maximum number of placements permitted in any one carer’s household?
   — It seems prudent in terms of preserving the quality of care that there should be such an upper limit. One scheme organiser told us that she thought that four placements was the maximum desirable per household. Her view is supported by research into family care placements in New York State. “Several (administrators) interviewed stated that in order to create such a family atmosphere, there should be no more than four patients to a home.”

(vi) What types of knowledge and skills should a professional worker have in order to cope with the demands of running a scheme?
   — The following seem to us to be the minimum set of related prerequisites: a knowledge of the ageing process, of age related illnesses and disease and their physical and social implications, of reactions to loss and grief, of local attitudes and customs, and of marital and family dynamics as a means of gauging the emotional climate in the carer’s household, as well as skills in counselling, negotiation and organisation.

(vii) Should boarding out schemes for the elderly be confined to the elderly or should they be considered as adult boarding out schemes?
   — The fact that at least 15%* of placements identified were of non-elderly persons seems to answer this question. The

* The ages of people in placement in Longford are not available in eight instances.
researchers would suggest that schemes should be regarded as providing boarding out for adults, many of whom, in practice, will be elderly. There is clear scope for boarding out adult mentally disabled people. It seems logical to concentrate all boarding out organisational effort for different categories of people in the one area in the same scheme.

(viii) Is boarding out of old people a phenomenon which will be largely confined to rural areas?

— While current patterns of activity seem heavily concentrated in rural areas, there seems to be no reason in principle why boarding out cannot be implemented in larger urban centres also. The incentives for its use may be more obvious in widely dispersed rural communities, but the heavy demand for long-stay places should encourage its adoption in urban areas too.

(ix) How are staff involved to get support in their work?

— Morale of staff can be easily eroded in the helping professions. Constant exposure to the pain of human suffering and unmet need, together with frustration caused by lack of resources and time available, render some workers very vulnerable. Workers in this field suffer the additional burden of isolation from others working in similar schemes. It seems highly desirable that there should be at least an annual get-together of staff involved in such schemes, as well as sufficient regular support from their managers.

(x) What kind of organisational arrangements are required within health boards for the administration and operation of such schemes?

— In the case of anything other than a very small scheme, the researchers believe that some worker(s) must be given responsibility for the scheme as their major or sole duty. Otherwise the development and quality of the scheme is likely to be seriously impaired. These schemes resemble complex "organisms" and are unusually demanding in terms of an organiser's time and skill.

(xi) Can there be a role for larger voluntary bodies in the organising of boarding out placements?

— There is a variety of evidence which can support the idea
of involving voluntary organisations in this work. While there is no tradition of an involvement by voluntary bodies in the fostering of children, there has been extensive involvement by voluntary bodies — adoption societies — in the field of adoption. In the U.K., where the voluntary sector, by comparison with Ireland, seems less influential, voluntary bodies are nevertheless allowed play an important role in the placement of adults and children in foster care. In its programme of care for the elderly, the Liverpool Personal Service Society runs what is acknowledged to be one of the most successful boarding out schemes in Britain.

If voluntary bodies are to be given a role in this work, clearly they must satisfy certain standards. They must, for instance, employ staff member(s) with sufficient professional competence and provide adequate administrative back-up. A formula, which might prove attractive in this regard, would be the ‘contracting out’ by a health board of this service for a given area to a voluntary body. Such a contract might be reviewed every three years and would be subject to adequate performance according to agreed criteria by the voluntary organisation. In this way a service of quality would be provided and the flexibility and capacity for innovation associated with the voluntary sector would be maintained. Health Boards contemplating such contracting out arrangements should be required to seek the Minister's approval.

(xii) What fire safety standards should apply to family homes approved for use in boarding out?

— Practice in this regard seems to vary between schemes, although the Mayo scheme requires explicit authorisation from the local fire authorities. It takes little imagination to appreciate that this is a question of prime importance and therefore one that seems to require national guidelines and regulations.

(xiii) What kind of arrangements regarding insurance are necessary or desirable in order to protect the interests of all the parties involved?

— The researchers did not establish the present position in the different schemes in this regard, but believe that it is
a question requiring attention. (In the boarding out of children, foster parents are not permitted to hold policies in respect of their foster children)"

(xiv) Are payments made to carers in respect of persons boarded out to be considered as taxable income?
- It seems desirable that a policy in this regard be negotiated centrally with the Revenue Commissioners and that the policy should cover not only routine payments but also special additional premia which might be payable in particular circumstances. (Allowances for foster children are not taxable).

In this Chapter the case has been advanced for further testing in practice of boarding out as an option for the long-term care of old people. It has also been argued that there is a need for policy development in this area and a detailed set of questions has been suggested as a basis for such a process.

In the next and final Chapter the researchers reach their conclusions and some recommendations are put forward.

References

1. See Chapter 2 for a discussion of these questions.
3. Personal communication from a Programme Manager, Community Care.
   (Earliest attempts at such regulation seem to date back to 1862. See Robins J. (1980), Chapter 12, The Lost Children, Institute of Public Administration, Dublin.)
8. Report of an Inter-Departmental Committee (1968) op. cit.

(A scheme of this kind is run in the Coleraine, Ballymoney and Moyle District of the Northern Health and Social Services Board in Northern Ireland. Carers are offered £68.00 per person placed per week.)


11. For instance the Adoption Board requires Garda clearance for applicants before it grants an Adoption Order to adoptive parents and the Eastern Health Board has a similar requirement in respect of applicants wishing to foster children.

12. For example (i) information leaflets and publicity material used by Camden Adult Care Scheme, Adult Care Section, London Borough of Camden Social Services Department, Willing House, 356-364 Grays Inn Road, London, WC1X 8B4 or (ii) material used in Leeds scheme (for address see note 17).

13. Fostering Resource Group, Eastern Health Board, 1 James Street, Dublin 8. The FRG has used newspaper advertising, features in newspaper and on television and radio, participation in parades, stalls in supermarkets and videos to market its “product”, i.e. child(ren) for placement.

14. These rates are set from time to time by the Minister for Health in accordance with Statutory Instrument No. 67 of 1983.

15. Details of the numbers of instances where these additional payments are made may be found in *Dáil Debates* Vol. 352, No. 8, Columns 1983-4 10th October, 1984.


17. Leeds Family Placement Scheme, Leeds Social Services Department, Merrion House, Merrion Way, Leeds.

18. In Pennsylvania, 20 hours of training is provided over four separate days. Domiciliary Care Programme, Department of Ageing, Harrisburg, Pennsylvania.

19. The Department of Health has funded the use of adult education material in the preparation and training of foster parents, e.g. National Foster Care Association (1980), *Parenting Plus*, London.


National Social Services Board, Dublin.

22. Report of an Inter-Departmental Committee (1968), op. cit.


26. It has been successful in large urban centres in the UK for instance, e.g. Leeds, Liverpool, London.


28. In 1983, 87% of adoption orders were made in respect of placements arranged by voluntary adoption societies.


CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS OF THE NATIONAL COUNCIL FOR THE AGED

This final chapter provides a summary of the findings of the study, outlines conclusions which the researchers have drawn from their work and then offers a set of recommendations for action, based on the foregoing.

Summary of Findings

(i) A total of 144 people, elderly and non-elderly are presently placed in eight boarding out schemes. Twenty-two of these are under 65 years of age.*

(ii) A total of 63 carers, all but two female, provide care for those boarded out. (Thirty of these carers are aged between 40 and 59).

(iii) Five of the eight schemes are in Connaught-Ulster, the remaining three in West Leinster.

(iv) All of the schemes are confined to largely rural areas.

(v) On the data available which refers to maintenance costs borne by health boards, boarding out appears to cost less than other forms of long-term care (see Appendix 5).

(vi) Many of the schemes seem to have emerged as local ad hoc responses to problems caused by shortages of institutional places.

(vii) Schemes have grown in a policy vacuum. Despite the endorsement of boarding out and specific guidance offered by the Care of the Aged Committee Report and other official documents, we have found no evidence of direction and encouragement at a national level to promote boarding out.

(viii) Organisational arrangements regarding staffing, payments to carers, and procedures concerned with the selection, assessment, matching and monitoring differ widely between schemes.

*The ages of people in placement in the Longford scheme are not available in eight instances.
(ix) The actual models of boarding out implicit in the practice of schemes, seem to vary. Schemes vary in the extent to which professionals are active in the matching process, from those where matching is essentially a predetermined fait accompli to those where it is the result of decision making by professionals. There also seems to be differing views of the function schemes are to serve: they may be seen as 'mopping up' demand that is surplus to the supply of institutional places or they may be seen as providing an additional option in the repertoire of long stay geriatric care. There are also differences in the burden to be carried by the carer, ranging from the provision of bed and breakfast only, through care punctuated by episodes of external day care, to full time care seven days per week.

(x) There is little, if any, contact between schemes.

Conclusions

Despite the constraints of time and depth on the study and of the level of knowledge of the 'state of the art' in this country, we feel able to offer certain conclusions. We would contend that boarding out seems to represent a very attractive policy option in the field of long-term geriatric care for a number of reasons.

(i) It may be cheaper to provide a place in boarding out care than in residential care. (see Appendix 5)

(ii) It involves no capital cost to the public authorities.

(iii) It permits a more effective use of resources than does institutional care. A boarding out place is created and survives only to serve a specific need. If the need ceases it becomes redundant and no further cost is incurred.

(iv) A boarding out place is more mobile than a place in institutional care. It may be possible often to find a placement in a remote district near to the old person's residence but far from the nearest institution.

(v) It represents a service ideally suited to use in rural areas which increasingly pose a challenge in terms of adequate provision of health and social care.

(vi) It can enable the ideal of community care to be given very concrete expression by allowing whole families share responsibility for, and contribute to, the welfare of elderly members of their community.
(vii) It can enable old people to remain within the district that is familiar to them and minimise the disruption they experience in their move from home.

(viii) It can enable old people to receive a degree of personal attention that, given the best will in the world, may not be attainable in institutional care.

(ix) It enables the old person to remain in touch, through the caring family, with the routine, rhythm and cycles of ordinary life in the community.

(x) It helps keep the needs of dependent old people, by their visibility in neighbours' houses, more prominent in the minds of the community.

(xi) It helps children, who may otherwise be deprived of it, to have direct personal contact with old people and to contribute to their care.

No policy option is without possible risks or disadvantages. Among those associated with boarding out may be (i) the possible isolation and vulnerability of an old person, (ii) an unsatisfactory motivation or behaviour on the part of the carer or (iii) the carer's possible lack of competence to cope in certain emergencies.

We would suggest that, given adequate precautions, at least some of these difficulties can be avoided and those that remain are not confined to boarding out and may also arise if the old person is living alone, with his/her family or in an institution.

RECOMMENDATIONS OF THE NATIONAL COUNCIL FOR THE AGED ON BOARDING OUT SCHEMES FOR THE ELDERLY.

1. The Minister for Health should invite each health board to further promote and develop adult boarding out schemes in order to broaden the range of options available for the care of dependent elderly people in the community.

2. The Minister should ensure that adult boarding out receives full consideration in the forthcoming review of services for the elderly to be carried out by the Department of Health. Particular reference should be made to establishing methods of assessing and evaluating the potential scope of boarding out in the provision of care for elderly people. Such assessment and evaluation should take both medical and social dimensions into account.

3. The Minister should prepare and publish guidelines governing the operation
of boarding out schemes for the elderly. These guidelines should include a working definition of boarding out and should cover matters such as:
(a) Procedures for the adequate supervision of boarding out schemes in relation to the selection, deployment and training of staff.
(b) Procedures for the selection and matching of persons to be boarded out with families who are acting as carers.
(c) Appropriate levels of payment to families acting as carers.

4. Health boards should seek the assistance of voluntary bodies, where appropriate, to help identify:
(a) Elderly persons who would be suitable for and likely to benefit from being boarded out;
(b) Families who would be suitable for recruitment as carers.

5. The Minister for Health should ensure that any review of legislation or regulations governing institutions caring for the elderly should include reference to boarding out schemes, making the distinction between such schemes and private nursing home care, which is also in some instances subvented by health boards.

Reference
1 O'Mahony, A. (1984), *op.cit.*
APPENDIX 1
Additional Data on the Four Schemes described in Chapter 4

_Age of carers with active placements in the selected schemes_

<table>
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<th>AGE BRACKET</th>
<th>20 - 29</th>
<th>30 - 39</th>
<th>40 - 49</th>
<th>50 - 59</th>
<th>60 - 69</th>
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<td>2</td>
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<td>3</td>
<td>15</td>
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<tr>
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<td>-</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Longford</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Mayo</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>TOTAL CARERS IN AGE BRACKET</td>
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<td>14</td>
<td>16</td>
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Year those currently in placement entered these schemes with total number of current placements for
the years 1977 to November 1984

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<td>10</td>
<td>18</td>
<td>13</td>
<td>61</td>
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*All 10 placements have been made since 1982.
±Information not readily available

Ages of People in Placement in the selected schemes at November 1984

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<tr>
<th>AGE</th>
<th>35 – 44</th>
<th>45 – 54</th>
<th>55 – 64</th>
<th>65-74</th>
<th>75 – 84</th>
<th>85 – 94</th>
<th>95 – 104</th>
<th>TOTAL NUMBER IN SCHEME</th>
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<td>61</td>
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<tr>
<td>TOTAL NO. OF SAME AGE</td>
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<td>10</td>
<td>28</td>
<td>50</td>
<td>13</td>
<td>1</td>
<td>TOTAL PLACED (AGES GIVEN) 112±</td>
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</table>

*There is a total of 34 placed, but data on age is available for 26 only.
±Total number placed = 120, but 8 ages are missing. See Longford.
APPENDIX 2

Background information on other schemes,
Leitrim, Monaghan, Offaly and Westmeath.

Leitrim

County Leitrim with County Sligo makes up one of the two Community Care areas in the North-Western Health Board. It has a population of 27,609, 94% of whom live in rural areas. It has the highest proportion percentage of old people in any county, 17.6% of its population being over 65 years of age.

The Leitrim boarding out scheme started in 1972, when a guest house owner took an elderly man in to live in her household. The maximum number that have been placed at any one time since the inception of the scheme is 10, most of whom have been placed in similar guest house accommodation. There have been placements in private household also.

At the moment there is only one rural placement. The person placed is a man in his seventies, and he lives in a self-contained unit beside his carers' home. His carers are a married couple with children, with whom he lived, on and off, for the last twenty-eight years. The carers receive £6.00 a week from the health board for their work, and on top of this, their boarder gives them a sizeable proportion of his pension.

The relationship received 'formal' recognition in 1976, and since that date, weekly health board payments have been made.

The Leitrim boarding out scheme under the community care programme is being phased out and no new placements are planned.

Monaghan

Monaghan has a population of 5,192 of whom 12.3% are aged 65 and over. Counties Monaghan and Cavan together make up one of three community care areas in the North Eastern Health Board region. Monaghan's scheme is one of the smallest of those being discussed, but in many respects is very similar to their Cavan scheme.

The scheme, which began in 1974, has never had more than three
old people placed at any one time. Unlike County Cavan, publicity has been used. In 1983 an advertisement was placed in the local newspaper in an attempt to recruit host families. There was a good response, but on investigation the local public health nurse found only one applicant to be suitable. At present only one man is being boarded out. He is 75 and has social problems.

Most of the elderly who have been boarded out in the past through the scheme have been ambulant, continent and healthy. Most have been in their seventies or eighties. Old people are referred to the scheme by neighbours and through St. Mary's, Castleblaney, the local Health Board long-stay unit in the county.

The carer involved at the moment is a married woman in her forties, who has four school-going children. There is no register of carers kept, but carers to date have mainly been married, middle-aged women. There have been no male carers and apparently few unmarried female carers. Those interested in becoming carers must first complete an application form. The processing of applications, rates of payment and means of supervision are the same as in County Cavan.

Offaly

Offaly with Laois makes up the second of two community care areas in the Midland Health Board. The population of County Offaly is 58,312, 65% of which lives in rural areas, a smaller proportion than in any of the other counties with schemes. Slightly less than 10% of the population is aged 65 years and over.

The Offaly scheme began in 1974, with the use of advertisements by the health board to recruit host families. There was a reasonable level of response, but the eventual number of appropriate applicants was found to be low. Ten years later the senior social worker still reports finding difficulty in attracting suitable applicants.

In the scheme, which has three parts, there are sixteen people, all aged 65 and over, placed:

(i) Three people are in self-contained units attached to separate private households. (These self-contained units are similar to bedsits.)

(ii) One person is in one private household and

(iii) Twelve people are in another.

Some placements are of four and five years standing, others have been made in the last year. (The definition of boarding out applied
in Offaly varies widely, not only within the scope of the local scheme, but also when compared with the other schemes."

All applications for admission to long-term care (including referrals for boarding out) are considered at a meeting attended by the superintendent public health nurse, senior social worker, matrons from three welfare homes and a secretary.

The rates of payment under the scheme are made in two parts, and vary with the forms of care. The householders of Castleview House, where the twelve old people are boarded out, are paid by the health board at the rate of £15.00 per week per person, the private household receives £12.00 per week, and the three householders who have three people in self-contained accommodation receive £6.00 per person per week. In addition, the pensioners contribute 75% of their pension directly to their carers. The local public health nurse and social workers, work together to supervise the scheme. In terms of day services, if they exist close by, the elderly person is welcome to attend. The three old people in the self-contained units attend a day centre in Tullamore.

**Westmeath**

County Westmeath, with County Longford, comprises one of the two Community Care areas in the Midland Health Board. It has a total population of 61,523, 55% of whom live in rural areas, and 10.3% of whom are elderly. This proportion of elderly people is marginally lower than the national figure of 10.7%.

The Westmeath boarding out scheme is the longest surviving scheme in the country. It began, on a trial basis, in the spring of 1965, and in that year eight persons were boarded out. Dr. Michael Flynn, the instigator of the new scheme, wrote at the end of that year: “From the experience gained in the short time of its operation, it would appear to be well worthwhile and it has the prospect of placing a percentage of old people in the more favourable environment of a private household rather than in an institution”.

The following figures indicate the expansion of the scheme in the 5 year period from 1966 to 1970 inclusive (see Table A):
Now, almost twenty years later, the scheme is still in operation, and currently six people are boarded out. The scheme is similar in operation to the County Cavan scheme described in Chapter Four, as the carers and old people come together informally before they receive 'official' recognition from the health board. No publicity, therefore, has been used to recruit foster families.

Of the six people, three men and three women, currently placed, two are under 65 years of age. Two of those placed have a history of psychiatric illness and two of the others suffer from mild mental handicap. The length of placement varies from 12 years to just over a year (see Table B):

### Table B

<table>
<thead>
<tr>
<th>Old Person</th>
<th>Year Placement Commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1972</td>
</tr>
<tr>
<td>2</td>
<td>1974</td>
</tr>
<tr>
<td>3</td>
<td>1981</td>
</tr>
<tr>
<td>4</td>
<td>1981</td>
</tr>
<tr>
<td>5</td>
<td>1982</td>
</tr>
<tr>
<td>6</td>
<td>1983</td>
</tr>
</tbody>
</table>

All of the placements have been made close to the old person's original home.

Four of the carers are related to the person placed with them, one is a sister, another a sister-in-law, one a nephew, and the other a first cousin. The fifth carer is a neighbour, and the sixth is a past employer of the person placed. Payment by the Health Board to the carers varies from £20.00 to £48.00 a month. They also receive a sum of money from their boarder, and this amount is negotiated between the two parties.
The local public health nurse is usually the first to recommend payment, and if the superintendent public health nurse agrees, she endorses it and passes it to the director of community care for approval. A financial report from the community welfare officer is necessary also. The local public health nurse makes a fortnightly visit to her superintendent on the progress of the placement and, subject to this report, payment is made. There are day services available, but the six persons placed in the Westmeath scheme do not attend. The Westmeath scheme will be twenty years old this year.

APPENDIX 3
The Clare Scheme 1978 — 1982

Clare

In 1978 a pilot scheme for boarding out elderly patients was introduced in St. Joseph's Hospital, Ennis. The aim of the scheme was to alleviate the demand for beds in the hospital. In that year, approximately ten patients were boarded out on a bed and breakfast basis in private houses in the vicinity of the hospital. The scheme was generally successful after some initial difficulties, but was discontinued in 1982 for four main reasons:

(i) Opposition from some Board members.
(ii) Lack of suitable patients from a medical viewpoint to participate in the scheme.
(iii) Lack of willingness by suitable patients to avail themselves of the facility.
(iv) Lack of suitable homes to place patients in.¹

¹ Personal communication with Programme Manager, Special Hospitals, Mid-Western Health Board.
APPENDIX 4

Selected Documentation From Mayo Scheme
Bord Slainte an Iarthair
Western Health Board

1. Text of advertisement placed by the Western Health Board

We are seeking accommodation for old people who are at present in the Board's hospitals and who no longer require medical or nursing care. Persons who are willing to offer accommodation to such people should write for application forms and details of rates of payment to the relevant Director of Community Care and Medical Officer of Health hereunder;

DR. J. SOLAN, Director of Community Care & M.O.H.,
Hibernian House, Eyre Square, Galway. Tel: (091) 86841.
DR. R. POWER, A/Director of Community Care & M.O.H.,
County Clinic, Castlebar, Co. Mayo. Tel: (094) 22333.
DR. M. GLACKEN, A/Director of Community Care & M.O.H.,
Community Care Offices, Roscommon. Tel: (0903) 8518.

2. Boarding out scheme (Adults)

Application by householder for inclusion in the above Scheme

PART A: To be completed by the householder

NAME: __________________________________________
ADDRESS: __________________________________________

AGE: __________________________________________

OCCUPATION:  

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NAME OF SPOUSE: ____________________________________________

OCCUPATION OF SPOUSE: ______________________________________

STATE OTHER RESIDENTS IN HOUSEHOLD

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

N.B. Specify if any other person boarded out privately

HOUSE: (a) No. of Storeys?

(b) No. of Bedrooms?

(c) State year in which house was built:

(d) Give details of toilet facilities:

(e) State type of heating used:

I agree to accept care for any person assigned to me by the Western Health Board.

SIGNED: Date:
PART B: To be completed by the Public Health Nurse

I have examined the above home and I recommend acceptance/rejection of this home for Boarding Out purposes.

SIGNED: 
PUBLIC HEALTH NURSE
DATE: 

PART C: To be completed by the Health Inspector (If required by D.C.C. & M.O.H.)

On examination I have found this home to be satisfactory/unsatisfactory for normal domestic residential purposes from a public health point of view and the following number of placements (state number) can be made before being in contravention of the Housing Act, 1966.

SIGNED: 
HEALTH INSPECTOR
DATE: 

PART D: To be completed by the Fire Officer

I have examined the above home and regard it as safe/unsafe in the event of a fire.

SIGNED: 
FIRE SAFETY OFFICER
DATE: 

PART E: To be completed by the Director of Community Care & M.O.H.

The above home is hereby approved for inclusion in the Boarding Out Adults Scheme.

SIGNED: 
DIRECTOR OF COMMUNITY CARE & M.O.H.
DATE: 

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APPENDIX 5

Average Weekly Costs to Health Boards of Selected Forms of Long-Stay Geriatric Care: November 1984

(i) District (Long-Stay) Hospitals (estimated average) (1) £267.67
(ii) Health Board Long-Stay Geriatric (estimated average) (1) £159.00
(iii) Health Board Welfare Homes (estimated average) (1) £ 85.90
(iv) Private Nursing Homes and Centres (maximum at 1.7.84) £ 40.25
(v) Boarding Out (range of payments) (2) £6—£30

(2) Table 3.3
<table>
<thead>
<tr>
<th>Hospitals/</th>
<th>Health Board(^1) Geriatric Hospitals/Homes</th>
<th>Health Board(^1) Welfare Nursing Homes</th>
<th>Voluntary(^1) Approved Nursing Homes</th>
<th>Other(^1) Private Homes</th>
<th>Psychiatric(^2) Hospitals and Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>% residents 65 and over</td>
<td>89.3</td>
<td>91.6</td>
<td>75.3</td>
<td>91.4</td>
<td>35</td>
</tr>
<tr>
<td>Total Residents 65 and over</td>
<td>6476</td>
<td>1280</td>
<td>2335</td>
<td>2268</td>
<td>4933</td>
</tr>
<tr>
<td>Total Residents</td>
<td>7253</td>
<td>1398</td>
<td>3101</td>
<td>2482</td>
<td>13984</td>
</tr>
</tbody>
</table>

APPENDIX 7

Methodology of Study

The study had three main goals — to describe, in a preliminary way, the current 'state of the art' in relation to the boarding out of old people in Ireland, to explore some related developments abroad and to examine some of their implications for the current situation here. A research project in two phases was mounted in order to complete the study.

The first, preparatory, phase lasted for four months from the date of commissioning the study until early October 1984. The second, more intensive, phase commenced then and lasted some ten weeks. This was undertaken by the researcher; Robert Gilligan together with research assistant, Susan Keogh.

The first phase of the research project, from June to early October, entailed the following work, on a part-time basis, by the researcher.

(i) Correspondence with the chief executive officers of the eight Health Boards seeking information on boarding out schemes under their auspices.
(ii) Identification and preliminary survey of relevant literature.
(iii) Written contact with selected schemes in the United Kingdom and the United States.
(iv) Attendance, by invitation, of researcher at Eurolink Age, Leeds Social Services Department meeting on Short-Term Family Placement Schemes for Elderly People in September 1984.
(v) Exploratory visits by researcher to two schemes.
(vi) Attendance by research assistant designate at British Association of Social Workers Conference on Adult Family Placement in June 1984.

The second phase, from early October to mid-December, consisted of:

(i) Single visits by the research assistant to three schemes (one two-day visit and two whole-day visits), involving interviews with personnel responsible, analysis of files/records and interviews (in two schemes) with some selected participants,
arranged with the assistance of boarding out scheme organisers.

(ii) Telephone contact with all schemes to elicit information about their operation and to obtain additional data in the case of schemes visited; (in some cases written contact was also made).

(iii) Scanning of the available relevant literature in relation to boarding out generally and to the long-term care of old people in Ireland.

(iv) Follow up of leads which researchers happened upon in Irish schemes no longer in existence or of schemes previously unreported to us.

(v) Writing up of this report.
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The National Council for the Aged was established by the Minister for Health in June 1981. The terms of reference of the Council are 'to advise the Minister for Health on all aspects of the welfare of the aged, either on its own initiative or at the request of the Minister'.

To date, the following reports have been produced:
1. Day Hospital Care, April 1982
3. First Annual Report, December 1982
4. Community Services for the Elderly, September 1983
5. Retirement Age: Fixed or Flexible (Seminar Proceedings), October 1983.