

**NATIONAL COUNCIL
FOR THE AGED**

**CHOICES IN
COMMUNITY CARE:
DAY CENTRES
FOR THE ELDERLY
IN THE EASTERN
HEALTH BOARD**

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"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, and in particular

on methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,

on ways of meeting the needs of the most vulnerable elderly,

on ways of encouraging positive attitudes to life after 65 years and the process of ageing,

on ways of encouraging greater participation by elderly people in the life of the community,

on models of good practice in the care of the elderly,

and

on research required to plan and develop appropriate services for the elderly."

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**CHOICES IN COMMUNITY
CARE:
DAY CENTRES FOR THE ELDERLY IN
THE EASTERN HEALTH BOARD**

By
Janet Convery



NATIONAL COUNCIL FOR THE AGED, 1987
REPORT NO. 17

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Foreword

Today more than ever it is important to ensure that local communities make adequate provision for the welfare and social support of older people. Without such support the more vulnerable elderly will often experience increasing difficulty in coping. As hospital beds and wards shut, such people can no longer have recourse to institutional care, the usual safety valve under such circumstances.

The needs of elderly vary very considerably. Each local community must plan to provide a range of supports and services to enable its old people maintain an optimum level of health, dignity and independence at all times.

The National Council for the Aged believes that day centres for the elderly have an important role to play in this regard. Because it is clear that the full potential of day centres for the elderly has not been realised in the past, the Council commissioned this study and is anxious that serious consideration be given to the issues raised in it.

The Council is concerned that voluntary organisations appreciate the important role that day centres can play and that community care policy makers and practitioners agree the objectives and functions of day centres, particularly in relation to the other community services provided by day hospitals and clubs. A day centre which provides physical care and protection, in addition to monitoring and social contact for example, will require appropriate staffing and adequate funding.

The Council is indebted to Ms. Janet Convery for preparing this report on its behalf. It congratulates her for a thorough and comprehensive study of day centres in the Eastern Health Board. It is hoped that the report will make for improved day centre services everywhere.

The Council acknowledges and thanks all those who helped and supported Janet in this endeavour. It also wishes to thank its own staff, Mr. Bob Carroll, Secretary, and Mr. Michael Browne, Research Officer, for their contribution to the production and publication of the report.

L. J. Tuomey, Chairman
National Council for the Aged,
Corrigan House, Fenian Street,
Dublin 2.

September, 1987.

Comments and Recommendations by the National Council for the Aged

1. Introduction

It is widely accepted by policy-makers and service-providers that caring for elderly persons in the community requires the provision of an integrated range of services, from the availability of appropriate housing to the availability of continuing nursing care for those who require it. It is also recognised that admission to acute hospitals and/or to long-term institutional care becomes necessary for some elderly persons because of a lack of ready access to appropriate support services in the community. The present study, *Choices in Community Care: Day Centres for the Elderly in the Eastern Health Board*, is an important and timely one in the context of the need to develop an integrated and comprehensive range of community-based services for elderly persons. The description of the development and functioning of day centres in the Eastern Health Board area, together with the broader discussion on the role of day centres in the provision of community care, contained in the report, bridges a significant information gap in this area.

The report points to the potential of day centres for the elderly to play a much more significant role in supporting the elderly in the community than is the case at present and indicates various ways in which this potential may be realised. It is the view of the National Council for the Aged that the planned development of day centres for the elderly should be considered in the broader contexts of (i) community care for the elderly and (ii) the role of the voluntary sector in the provision of community care services for the elderly.

2. Community Care and the Elderly — the Need for a Co-ordinated Approach

The dimensions and complexity of providing an integrated community care service for the elderly can be more clearly understood in the following context:—

- (i) Current population projections (Blackwell 1985) indicate an increase in the order of 27,000 in the number of persons aged sixty-five years and over by the year 2006. Almost all of this increase will be in the category seventy-five years and over with two-thirds of the increase, i.e. 18,000, in the category eighty years and over.
- (ii) Increasingly relatives caring for the elderly in the community are themselves likely to be advanced in age.
- (iii) The bulk of the increase in the elderly population, referred to in (i), will be in the Eastern Health Board area.
- (iv) It is now becoming increasingly accepted that providing care for elderly persons in the community may not be as economically attractive as was sometimes thought.
- (v) There is an urgent need to experiment and introduce innovative developments at community level which break through the barriers of conventional forms of care. Effective, practical initiatives at community level are needed immediately if the "move to community care" is to be realised.
- (vi) An overstretched community care service or the fact that elderly persons seek institutional care because of lack of back-up for care at home rarely result in the same type of banner headlines as does the actual or threatened closure of hospital beds.

The Council considers that there has been a general lack of planning and funding for community care structures for the elderly within the overall context of social policy development. The Department of Health recognises that many of the social support services "are very much underfunded and must in the future be seen as priority areas for development" (Department of Health 1986, p. 58). The National Social Service Board (1986) refers to:— "the need for a community planning framework to maximise the effectiveness of resources, achieve consistency and co-ordination, and progress towards the successful achievement of aims." (p. 12). A more purposeful planned funding and development of community care structures for the elderly is, of course, likely to require a re-deployment of existing resources and a consequent reduction of

institutional services. It also requires "a shift from programme management to management by geographic area" (Department of Health 1986). This has obvious implications which require to be anticipated and addressed.

It is the view of the Council that an effective community care system for the elderly can be brought about only if appropriate co-ordinating mechanisms are introduced. Such mechanisms would include the setting up of a structure for joint planning for the elderly at local level, involving health authorities and housing authorities, hospital programmes and community care programmes, the statutory sector and the voluntary sector. Such a structure would aim to integrate and fully support the efforts of the voluntary organisations and those of the family caring network. The Council has already proposed the establishment of pilot co-ordination projects along the lines referred to above. (National Council for the Aged 1985). The Department of Health (1986) has pointed to the need for a much more active planning function at community care area level.

The Council also believes that there is a need for more planning at central government level aimed at developing mechanisms to facilitate the co-ordination of services for the elderly at local level. In this context the Council welcomes the proposal for re-organisation by the Department of Health which envisages "a much stronger commitment to planning throughout the system" (Department of Health 1986, p. 36). Such planning should be based on the premise that local knowledge, local discretion and local linkages are more likely to provide services which are more efficient and more humane than a more centralised approach. It should also aim:

to achieve not only co-ordination of operations within and as between bodies, but also some form of rational allocation of resources and priority setting within and between the organisations to achieve the optimum territorial 'mix' of operations for the sake of take off into sustained development (Muintir na Tire 1985, p. 53).

For such a development to take place the Council considers that a new emphasis and focus on local democracy is required in the Republic of Ireland with a related emphasis on service provision through multi-purpose, integrated, local bodies as distinct from single-purpose bodies discharging separately a wide range of often overlapping functions. The

experience in some areas indicates that an integrated response at local level to some of the needs of the elderly is possible. However, it is unlikely that such developments will become widespread unless there is a radical central government policy shift towards planning for welfare provision for the elderly at local level, where it would become a local responsibility, susceptible to local response and local decisions and funded accordingly. Innovation at local level is unlikely to become widespread without such a shift in emphasis and resources. It requires not only charismatic and committed local administrators, but also, and more importantly, a re-vitalisation of the concept of local responsibility. This requires to be initiated at the highest level, i.e. by government itself.

3. Integrating the Voluntary Sector

In recognising the key importance of day centres in supporting the elderly in the community, the Council also recognises that the development of day centres, particularly in times of economic stringency, is likely to be dependent on developments in the voluntary sector. However, the Council is very much aware that such developments are unlikely to occur automatically, since there is no clear national policy framework within which voluntary organisations can develop. There are substantial blocks to be overcome if the voluntary sector is to be used to its full potential. The National Social Service Board (1986) has pointed out that:

Despite common practice in paying tribute to its work, the voluntary sector has been largely taken for granted, its contribution has not been extensively quantified or evaluated nor has sufficient attention been paid to its difficulties and future development needs which are now increasingly urgent (p. 18)

and again

there is no coherent policy regarding the funding of the voluntary sector, nor formal arrangements for communication, consultation, co-operation or co-ordination across the statutory sector. (p. 18).

The Department of Health (1986) has identified the need to introduce arrangements which will lead to greater cohesion between the statutory and the non-statutory sectors.

The Council, therefore, considers that the statutory health authorities

should adopt a much greater planning and enabling role in relation to the development of day centres by voluntary groups. This requires the development of a comprehensive policy for the involvement of voluntary organisations in the provision of health and social services in Ireland. Such a development would, in the Council's view, stimulate vital growth in the voluntary sector and would result in a more purposeful and significant role for voluntary organisations in the provision of the community care services than that which exists at present. The Council wholeheartedly agrees with the proposal of the Department of Health (1986) to introduce a system of representation of the non-statutory sector on health boards and also with the proposal to develop a mechanism for the establishment of contractual relationships between health boards and non-statutory agencies providing services on their behalf.

The planned development of the voluntary sector should be stimulated and organised by professional catalysts at both national and local level and should build on the experience and analysis of voluntary development which has occurred elsewhere. In particular, the Council believes that the report of the Wolfenden Committee on the British Voluntary Sector contains useful guidelines for a similar analysis in the Irish context. There is a crucial need to define what is meant by voluntary action and to categorise the various levels of voluntary activity to be found throughout the community. The terms "voluntary organisation" and "voluntary sector" are used to cover a wide range of activities and groupings outside the statutory sector.

The National Social Service Board (1986) categorises voluntary organisations and non-statutory bodies as follows:

A non-statutory welfare organisation is a body, either religious or lay, engaged in the provision of personal social services which is usually funded mostly by the State, staffed largely by paid professional workers and is governed by an independent board or management committee, the members of which usually act in a voluntary capacity.

A voluntary organisation is a body involved in the provision of personal social services which is non-statutory, independent, non-profit making and uses volunteers to a greater or lesser extent, though it may also employ some paid staff. (p. 14)

The Council considers that it is only when an adequate definition and categorisation of voluntary activity has occurred that the scope and

potential of a particular local voluntary group can be adequately identified and channelled. It is also the Council's view that a more effective development of the voluntary sector at local level *vis-à-vis* the needs of the elderly requires the establishment of what the Wolfenden Committee term local intermediary bodies whose functions it would be to stimulate planned development in the voluntary sector and to liaise with the statutory sector. The National Social Service Board has proposed the establishment of regional resource centres, of which one of the aims would be to "help to develop greater understanding and co-operation among local organisations." (National Social Service Board 1986 p. 26).

The present report clearly points to the need for a planned development of day centres for the elderly in the community. Such a development is, in the Council's view, unlikely to occur in the absence of:—

- (i) A charter for voluntary services which would provide a framework for communication and co-ordination between the voluntary sector and the statutory sector;
- (ii) A mechanism for the planned integration and co-ordination of all services for the elderly at local level;
- (iii) Catalysts who would work at local level in stimulating and supporting voluntary activity;
- (iv) Systematic and planned funding mechanisms for voluntary groups;
- (v) Full access by voluntary bodies to information relating to the procedures, plans and budgets of statutory authorities.

4. Recommendations

The National Council for the Aged, on the basis of the foregoing discussion, wishes to make the following recommendations in respect of the future development of Day Centres for the Elderly.

4.1 Planning and Development of Community Services for the Elderly
The Council recommends that the Department of Health Working Party on Health and Welfare Services for the Elderly should have regard to the following points with a view to issuing policy guidelines for the planning and development of community services for the elderly:

- (i) the clarification of the respective roles of statutory bodies (health

boards and local authorities) and voluntary organisations in the development and provision of services for the elderly in the community;

- (ii) the detailing of desired objectives for individual community services for the elderly;
- (iii) the identification of mechanisms for innovation and inter-agency collaboration at local level;
- (iv) the expansion of the role of the Department of Health in the planning and evaluation of services for the elderly;
- (v) the clarification of the two-way responsibility to each other of health boards and voluntary bodies;
- (vi) the identification of and dissemination of information on innovative models of community care for the elderly;
- (vii) the possibility, in view of the changing population structure, of redeploying resources from childrens' services to services for the elderly.

4.2 Local Joint Services for the Aged Committees

The effective development of day centres for the elderly requires the establishment of a co-ordinating mechanism at community care level which will integrate the voluntary sector in the planning of community care services for the elderly.

The Council recommends that each health board community care area should establish a Local Joint Services for the Aged Committee comprised of representatives from the health authority, the voluntary sector and the housing authority, whose function it would be to systematically plan the development of services for the elderly in the area. (For a detailed discussion of the role and function of such committees seen National Council for the Aged, *Institutional Care of the Elderly in Ireland 1985*, section 4.2.10).

4.3 Legislation

Under the Health Acts 1947-1970 health boards are required to make available a wide range of services for children, including medical care for infants, nursing services, immunisation services, pre-school medical examinations, school health examinations and treatment services including dental, ophthalmic and aural services, for various categories of

children. Health boards are not at present obliged to provide services for the elderly similar to the obligation to provide child health services. Consequently, services for the elderly may not always get sufficient priority in the allocation of resources.

The Council recommends that existing health legislation should be amended to explicitly charge health boards with statutory responsibility for providing selected services for certain categories of elderly persons in the community. The Council envisages that the provision of certain day centre services for elderly persons at risk would be an integral part of such a responsibility.

4.4 Funding Procedures for Day Centres

Statutory funding procedures to voluntary organisations providing day centres should be formalised and rationalised according to the following criteria:

- (i) Standardised grant application procedures should be established.
- (ii) Clearly defined criteria for grant eligibility should be developed and publicised.
- (iii) Funding commitments on the part of statutory bodies should be clearly specified from the outset in any new development by a voluntary agency.
- (iv) Funding levels to voluntary organisations providing day centres should cover the following:
 - (a) the payment of day centre supervisors;
 - (b) the financing of transport arrangements for those who require it;
 - (c) finance to enable centres to provide a minimum level of service;
 - (d) the provision of adequate insurance cover.
- (v) There should be a standardised approach within health boards to charging day centre users.
- (vi) In some instances contracts for the provision of day centre services for the elderly should be drawn up between the health

board and the voluntary agency providing the service on the board's behalf.

4.5 Strategic Planning and Development of Day Centres within Health Boards

- (i) A separate development budget should be allocated by each health board to community services for the elderly.
- (ii) Costed short-term and long-term day centre plans should be developed in detail by local health boards. This should be done in consultation with voluntary organisations and with the local housing authority.
- (iii) A person should be appointed in each local community care area to stimulate service development and to co-ordinate the work of all agencies, statutory and voluntary, working with the elderly in the area.
- (iv) The possibility of locating day centres in sheltered housing complexes should be explored by health boards, both in existing schemes and as new complexes are built. (This would appear to be particularly appropriate in the case of the Eastern Health Board and Dublin Corporation).
- (v) The views of elderly persons in a particular catchment area and the potential uptake of day centre services should be ascertained prior to the establishment of a day centre in the area.
- (vi) Health boards should develop a mechanism at community care level whereby agencies providing day centre services would be enabled to make a purposeful input into the planning and development of services. Such an input would be based on their experience of the needs of day centre users.

4.6 Day Care Programmes

- (i) Agencies providing day centres should explore ways of developing the non-medical aspects of day centre care, by, for example:
 - (a) helping staff to develop skills and experience in social, educational and occupational programmes for elderly clients;
 - (b) examining innovative day centre programmes that have

been developed in this and in other countries. Health boards should encourage and support such initiatives.

- (ii) Health boards should provide relevant training courses for present and potential day centre supervisors to enable them to develop skills in programme planning and in individual case management.
- (iii) Health boards should make available to day centres trained personnel in areas such as chiropody, occupational therapy, physiotherapy, speech therapy and nursing, so that such services can be available on a regular basis for all day centre users who require them.

4.7 Staffing of Day Centres

The Council recognises the central role played by volunteers and by part-time staff in the management and operation of day centres for the elderly and sees a continuing important role for this type of provision. However, the Council considers that the effective development of day centre services in the long-term will require a structure that will provide for the systematic employment of core day centre staff on a permanent basis.

The Council recommends that health boards should encourage and fund such a development.

4.8 Role of Voluntary Organisations

While the role of the statutory sector is crucial to the effective development of the voluntary sector, voluntary organisations themselves also have an important role to play, particularly at the local level. The Council recommends that voluntary organisations should invest more time and resources in order to more clearly identify the needs of the elderly in an area and the potential resources to meet such needs. This would ideally be done as part of the work of the Local Joint Services for the Aged Committees referred to in 4.2 above.

Specifically, voluntary organisations providing day centres for the elderly should collect standardised information on their work with clients and on the outcomes of their work in order to both improve their own standards and practice and to identify gaps in provision.

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Finally, I would like to thank my family for being so supportive and tolerant of the perpetual student in the house.

CHAPTER ONE

Day Centres in Context

Introduction

There are several reasons for undertaking a study about day centres for the elderly at this time. Increasingly, public attention has been focussed upon the needs of various categories of elderly people, including those who live alone, and, most recently, the rural elderly.¹ Organisations like ALONE and the Society of St. Vincent de Paul² have highlighted incidences of elderly people who fall through the so-called social welfare net — extreme cases which jar the sensibilities and raise questions about the adequacy of present housing, health and social service provision to the elderly. Public consciousness is now being raised with regard to the special needs of the elderly in much the same way that the special needs of children were “discovered” in the 1960s. The concept of elderly people “at risk” has been established and concern for this group registered publicly.

Recent demographic studies have revealed that, while the total proportion of elderly people (aged sixty-five years or older) in Ireland has been decreasing, the absolute numbers have risen (from 329,000 in 1971 to 378,900 in 1985).³ Furthermore, statistical projections⁴ suggest that the proportion of very elderly (aged seventy-five years or older) in the population will increase, i.e. we can expect our elderly population to live longer than previously. The elderly as a group make the heaviest demands upon our health and welfare services: as people grow older (particularly after age seventy-five) health deteriorates and vulnerability increases from several perspectives. Carroll⁵ suggests five categories of elderly who merit the special attention of those formulating social policy and planning services: the most elderly (over seventy-five); those who live alone; those dependent solely upon State pensions for their income;

those living in substandard housing; and those with major health problems, particularly those being cared for by relatives. Day centres are one response to the needs of the growing number of vulnerable elderly and their families, and, as such, deserve to be examined.

There are also economic considerations that justify a closer look at day centres for the elderly at this time. There is evidence to suggest an overreliance on hospital care in Ireland,^{6, 7, 8} which may at least partly explain why health care services have been more expensive here (as a percentage of GNP) than in other countries where non-institutional methods of treatment and provision have been employed.⁹ Recently there have been calls to reduce Government expenditure on health services, particularly in the hospital sector.¹⁰ Elderly people occupy a disproportionately high percentage of hospital beds in Ireland: if hospital wards are to be closed for financial reasons (currently the subject of considerable controversy) questions must be asked about alternative methods of treatment, including day care.

There are social reasons as well as economic which point to the need to consider non-institutional forms of care for the elderly. Several studies^{11, 12, 13} have suggested that elderly people have been inappropriately admitted into institutional care in Ireland when their needs might have been better met if alternative (community) services had been an option. As early as 1968 *The Care of the Aged Report* (1968) noted the desirability of keeping elderly people in the community: recommendations were made in that report to strengthen domiciliary and other community services, including day centres. The National Planning Board¹⁵ reiterates the need to shift resources into community care, and the National Council for the Aged (1983) emphasises the need for improvement of services to enable "... as many elderly persons to remain in the community for as long as possible".¹⁶ The deleterious effects of institutionalisation have been argued by many, including Goffman,¹⁷ the most famous critic. That residential care will always be required for a certain small percentage of elderly is generally acknowledged, but so is the belief that ways should be found to maintain the vast majority of elderly at home. The disorientation and alienation created by a move to an institution, the disengagement from the mainstream of ordinary life, the rapid physical and mental deterioration that may be associated with institutionalisation are all factors that contribute to the case for alternative forms of care, i.e. the maintenance of elderly people in familiar surroundings. Most elderly people themselves express the strong desire to remain in their own homes.¹⁸ Community care

services (including day centres) can prolong the independence of elderly people and improve the quality of their lives. From this standpoint, day centres merit attention.

It is sometimes suggested (but not substantiated by data) that families are no longer willing to look after their elderly relations and neighbours. Factors such as the increased number of women in the workforce (i.e. the decrease in the number of women left at home to care for dependent elderly relations), the trend towards nuclear family units, and the increased mobility of younger families away from ageing parents are usually offered to support this hypothesis. But Moroney¹⁹ and (in Ireland) Carroll²⁰ dispute this suggestion and observe that the burden of care still falls largely on families and neighbours who willingly continue to care for dependent elderly, often at great personal cost. Most of these carers are women and many are themselves elderly. The evidence suggests that it is not unwillingness to look after the elderly, but the lack of support services to families caring for elderly relations that in many cases leads to a breakdown in caring arrangements and thus the demand for institutional care. As our elderly population gets older, the need for support services will increase: the current and future provision of services to the elderly and their families, including day centre services, needs to be explored in this context.

A final reason for undertaking a study of day centres involves the fact that it offers an opportunity to analyse the nature of the relationship between voluntary providers and statutory sponsors in one specific area of service provision to the elderly. Since the statutory and voluntary sectors similarly share responsibility for other services for the elderly (as well as services for other client groups), observations drawn from the research may well be applicable to the social service and health service system as a whole.

Aims of the Study

This study aims to provide a social policy analysis of day centres for the elderly in the Eastern Health Board Region. It is not a survey of day centres but does provide an overview of present services. It identifies and evaluates the present and potential role of day centre services in care of the elderly and explores issues relevant to the funding, development and of delivery of services up to now. A consumer view of services is not included in this study, except very briefly in Chapter Three. It is

hoped that it will provide basic information which will help to shape the direction of future care policies.

A Case Study is included to examine in some detail the way in which the day centre "system" works in one instance. While no statistically significant conclusions can be drawn from a sample of one, it is hoped that some problems and issues of general interest will emerge.

The research for this report was undertaken as part of a Master's Degree programme in the Social Science Department at University College Dublin, and was carried out primarily during the period from January 1984 to December 1985. Data were collected from personal interviews, written correspondence, visits to day centres in the Eastern Health Board and Belfast, and from an extensive search of the literature. The author also has personal experience as a worker in two day centres in the Eastern Health Board which enhanced her understanding of the present system of services. Details about the methodology employed are outlined in Appendix 1.

History

Day centre services for the elderly are a recent phenomenon dating back to less than twenty years ago. There is no record of when the first day centre as we know it was actually opened in Ireland: day centres are recommended in the 1968 *Care of the Aged Report*,²¹ but without specific reference to any that might have existed at that time. The Report appears to have done much to raise public consciousness about the special needs of the elderly.

Until the 1960s, there were no special social services for the elderly apart from income maintenance services which developed from the Old Age Pension Act of 1908.²² Charitable activities by the clergy and by civic organisations, including the distribution of money, clothes and meals (e.g. "penny dinners" in the inner city) had been organised for several decades: although they were not aimed at meeting the needs of the elderly in particular, old people were among the needy recipients of such charity.

One long time advocate of the elderly in Dublin recalls a meeting that took place in 1950 with a view to starting a non-denominational organisation to work at meeting the special needs of elderly persons.²³ At that time, she believes that there was no committee in Dublin that worked solely with the elderly. Mrs. Felix Hackett, Vice-Chairman of the Red Cross and Dr. Margaret Merrick (a medical doctor who worked

among the poor in Thomas Street at that time) were among those who attended that first meeting. They approached the Archbishop of Dublin, John Charles McQuaid, who advised them to attach themselves to the Irish Red Cross organisation which was already non-denominational. This they did, and the Dublin Old People's Committee was set up as a sub-committee of the Irish Red Cross Society in 1950.

Groups were set up in Crumlin and Rathmines initially with another group being established in Sandymount in 1952: catchment areas conformed to those of the Red Cross Society. Work that evolved out of these groups was done under Red Cross auspices, although the Red Cross never actually funded their activities. The Rathmines group (with another organisation from Trinity College Dublin) bought a small house in Harolds Cross and opened a home for elderly tenants who were provided with their own room, key and a midday meal at minimum rent. Dr. Merrick was instrumental in running their first house. They later bought a place in Terenure (called Merrick House after Margaret Merrick) and paid for a "district nurse" to visit the elderly in the area. From these efforts evolved a day centre in Terenure which still operates.

The Sandymount group initially undertook personal visits to elderly people in the area and had no premises of their own until 1962. An Old People's Club was started in 1963 and in 1967 the health authorities asked if they would organise to give dinners to local elderly people. Six hundred pounds was given to decorate and equip a kitchen and dining room: meals at that stage were cooked at Lakelands Convent and brought to the Club. This was the beginning of the Sandymount Day Centre that now operates a full service four days a week and some evenings.

The two Red Cross day centres would have been among the first centres to be developed for the elderly in the Dublin area.

There may also have been parallel developments along denominational lines during roughly the same period. One director of community care²⁴ recalls that "sometime after 1965-66" County Medical Officers were asked by the Department of Health to call a meeting of leaders in each parish to ask them to set up an Old Folks Committee in their parish. At least the skeleton of a committee still exists in parishes around the country. He believes that many community services for the elderly developed out of these early meetings. Although documentation of these events is lacking, it seems clear that the need for services for the elderly had been definitely established by this time.

The day centre "model" which evolved from these early experiences

dominates the present system of services for the elderly. Voluntary groups have continued to take major responsibility for developing and operating day centre services. The Health Board plays a critical role in helping to finance services but has only minor involvement in programme development and delivery in most cases.

There remains no specific statutory mandate for the development, funding or delivery of community services for the elderly. Current financial support to such services is granted under a provision in Section 65 of the Health Act (1953), a general statement which permits health authorities to assist any body that is providing a service "... similar or ancillary to a service which the health authority may provide."²⁵ Section 65 does not make particular reference to the elderly (or any other client group). The *Care of the Aged Report* (1968), still recognised as the main policy document relating to the elderly, recommended that the powers granted to health authorities under Section 65:

... should be extended to enable a health authority to assist financially, or in any other way, a voluntary body providing a service for the aged which is in general accord with services designated by Regulations for the purpose by the Minister of Health.²⁶

Guidelines for policy were spelled out in the Report and recommendations made for the new development of specific services for the elderly, including day centres.

As recommended in the *Care of the Aged Report*, Section 65 has been interpreted to sanction the support of community services to the elderly since the 1960s, although the original "enabling" legislation still remains.

Thus Health Boards are not statutorily obliged to fund or provide community services for the elderly (in the way they are obliged to provide services to children, for example), and expenditure on services for the elderly is discretionary. Some of the implications for service providers and users are discussed later.

Growth in the Number of Day Centres²⁷

The biggest growth in day centre development in the Eastern Health Board Region took place in the early 1970s. An Eastern Health Board officer notes that during this period, there were already many organisations operating a service for the elderly at some level, e.g. social clubs, visiting schemes, once-a-week dinners, outings, etc. These groups were

“picked up” by the health authorities and given encouragement and financial support to develop these services further. Premises were at that time less of a problem than they are now: there were more buildings available for use or conversion to day centres (church halls, old school buildings, community centres, etc.); more money was available for the renovation or construction of new buildings; and standards of acceptable hygiene and safety were lower. Circular 40/68,²⁸ which gave Health Boards the power to give grants to voluntary bodies without having to get permission from the Department of Health, undoubtedly was a positive influence on day centre development.

Another increase in growth which took place in the late 1970s has since levelled off considerably. This study identified one new day centre in the Eastern Health Board Region which opened in 1984, two that were at the point of opening in 1985 and plans for one more being negotiated.

The emphasis placed on the various needs of the elderly may have changed over the short history of day centres for the elderly. Many of the people interviewed for this study felt that the initial aim of day centre programmes (or the services from which they developed) was to improve the nutrition and physical well-being of the elderly — to compensate for the general deprivation suffered by many elderly people at that time. Now it is felt that elderly people are generally much better off in terms of income and living standards, and day centres are valued more for the social benefits they offer to clients.

Great Britain²⁹

There are many similarities between the British day centre system and the Irish system. The largest number of day centres in Britain were developed at about the same time as here — the 1970s, and services today are unevenly distributed. Many British day centres operate on much the same scale as Irish day centres, although there are exceptions which are bigger and have much more comprehensive programmes. Paid professional staff are generally more widely available than in Ireland. As in Ireland, the responsibility for overall service provision is shared between the statutory and the voluntary sector. However, in Britain, the statutory share is considerably greater with close to half of all day units being provided directly by local social service departments. In the voluntary sector, three very large national organisations (Age Concern, the Women’s Royal Voluntary Service and Help the Aged) are the major

providers of day centre services for the elderly in Britain and this is another significant difference. In the Eastern Health Board, local committees are the predominant providers.

The United States³⁰

As might be expected, the United States experience offers more contrast to the Irish day centre system. Day services for the elderly have developed there in two "streams". Senior centres were developed to meet the social and occupational needs of the elderly, and day care programmes were developed to meet the needs of the more frail and dependent elderly, including psychogeriatric patients. Again, the statutory sector has taken a greater share of the total responsibility for funding day centre services than in Ireland. Statutory funding to both streams of day services in the U.S. has been accomplished mainly by revenue sharing: the Federal Government matches funds raised by state or local governments, and funds are administered through a plethora of federal, state and local agencies and programmes. Within broad frameworks, states and local governments are left with a large degree of discretion over the development of particular services.³¹ Some services are purchased by contract from non-statutory agencies who bid against each other for contracts. Other agencies apply for grant money from several available sources. A combination of government and private medical insurance schemes cover part or all of the costs to users of day care programmes. It is difficult to compare Irish day centre programmes and services with either senior centre or day care programmes in the U.S., partly because services are organised differently and partly because the scale of operations is so big in large urban areas, for example. The most sophisticated programmes in the U.S. may have the benefit of huge budgets, expensive community facilities and highly skilled staff. At the other end of the scale are more modest operations similar to Irish and British day centres.

CHAPTER ONE

Notes

¹ See Mary Daly and Joyce O'Connor, *The World of the Elderly: the Rural Experience*, National Council for the Aged, Dublin, 1984, and A. O'Mahony, *The Elderly in the Community: Transport and Access to Services in Rural Areas*, National Council for the Aged, 1986.

² B. Power, *Old and Alone in Ireland*, Society of St. Vincent de Paul, Dublin, 1980.

- ³ Central Statistics Office, *Labour Force Survey 1985: First Results*, Stationery Office, Dublin, 1986.
- ⁴ *Ibid.*, p. 42, and J. Blackwell in National Council for the Aged, *Housing of the Elderly in Ireland*, 1985.
- ⁵ Bob Carroll, "Response of the Health Services to the Needs of the Elderly in the Community: Some Basic Principles", in *Future Directions in Health Policy*, Council for Social Welfare, Dublin, 1984, p. 143.
- ⁶ A. D. Tussing, "Poverty and the Development of the Health Services", in S. Kennedy (ed.), *One Million Poor?* Turoe Press, Dublin, 1981, pp. 217-232.
- ⁷ James Raftery, "Irish Health Expenditure: Policy Trends and Incentives", in *Future Directions in Health Policy*, p. 83.
- ⁸ National Planning Board, *Proposals for Plan 1984-87*, National Planning Board, Dublin, April 1984, p. 308.
- ⁹ Other factors include the payment to doctors on a fee-by-visit basis rather than on a capitation basis, the isolation of G.P.s and the lack of a nationalised, co-ordinated hospital programme. See also Tussing (1981), Raftery (1984) and Doherty (1984).
- ¹⁰ B. Desmond, Minister for Health, "Address to Conference", in *Future Directions in Health Policy*, Council for Social Welfare, Dublin, 1984, pp. 108-124.
- ¹¹ G. Bourke and A. Coughlan, *Dublin General Hospital and Geriatric Study*, Medical Research Council, Dublin 1966.
- ¹² D. McDevitt, T.D. Brett and M. E. O'Connor, "Care of the Aged", in *Admission to County Homes: A Study of the Aged in Three Homes and Three Communities in Ireland*, Medico-Social Research Board, Dublin, 1979.
- ¹³ A. Powell and F. Powell, "Too Fit for Hospital," *Community Care*, No. 331 (16 October 1980), pp. 19-21.
- ¹⁴ Inter-departmental Committee on the Care of the Aged, *Care of the Aged Report*, Stationery Office, Dublin, 1968.
- ¹⁵ National Planning Board, *op. cit.*
- ¹⁶ National Council for the Aged, *Community Services for the Elderly*, Report No. 3, National Council for the Aged, Dublin, 1983, p. 6.
- ¹⁷ Erving Goffman, *Asylums*, Penguin Books Ltd., Harmondsworth, 1974.
- ¹⁸ G. Jones, "The Decision to Admit" in Brearly *et al.*, *Admission to Residential Care*, Tavistock Publications, London, 1980.
- ¹⁹ R. M. Moroney, *The Family and the State: Considerations for Social Policy*, Longman, London, 1976, Chapter 3.
- ²⁰ Bob Carroll, *op. cit.*, p. 140.
- ²¹ Inter-departmental Committee on the Care of the Aged, *op. cit.*, pp. 68-69.
- ²² *Ibid.*, Chapter 1, pp. 25-28.
- ²³ Interview, Mrs. Iris Charles, Member, Dublin Council for the Aged, March 1985.
- ²⁴ Interview, Director of Community Care, Area 10, February 1985.
- ²⁵ Inter-departmental Committee on the Care of the Aged, *op. cit.*, p. 119.
- ²⁶ *Idem.*
- ²⁷ Much of the information in this section was obtained in interviews with a Senior Executive Officer, Community Care Programme Manager's Office, Eastern Health Board, January 1985.
- ²⁸ Department of Health, Circular No. 40, *Community Social Services: Care of the Aged*, 1968.

- ²⁹ Jan Carter, *Day Services for Adults: Somewhere to Go*. George Allen and Unwin, London, 1981.
- ³⁰ Several sources were used for this short section including: Kamerman and Kahn (1976); Nusberg in Hobman (1981); Tinker (1984); and Mace (1984).
- ³¹ D. Hobman, *The Impact of Ageing: Strategies for Care*, Croom Helm, London, 1981.

CHAPTER TWO

Description of Services — An Overview

Day Centre Definition

An operational definition of day centre services for the elderly has never been developed in any detail. There is, however, general agreement that, in order for a facility to be called a full day centre, it must meet certain, at least, implied criteria (although individual interpretations of criteria may vary). It is generally agreed that full day centres should be open for at least four to five hours a day for three to five days a week. Day centres should operate the year round to ensure continuity of care. Organised transport (for at least some clients) is usually considered to be necessary if centres are to be used by those clients who need them most.¹ Statements about the actual range of services that should be offered allow for individual variations according to local needs. Usually physiotherapy, occupational therapy, chiropody and a hot, midday meal are mentioned as minimum requirements.² Most Eastern Health Board officers said, in interview, that effective day centre service also depends upon the employment of at least one part-time paid staff person. For the purpose of this study, units referred to as day centres, in the main, will meet these board minimum requirements.

The following table attempts to categorise existing day centre services for the elderly by location, administrative jurisdiction and funding arrangements. Because of the way in which administrative responsibility for services is divided, (see Table 1) no one person or office is familiar (in detail) with the complete range of existing day centre services in the Eastern Health Board Region. Visits to every centre would be necessary to determine what exactly exists, but within the limits of this study, it was possible to broadly categorise facilities which are called day centres

TABLE 1
Day Centres in the Eastern Health Board Region 1984

Type and Location	Management	Administration Responsibility	Funding	Staffing†
1. Voluntary Services				
A. Grants of £9,000 or more	Voluntary Committee (Health Board representative)	Area Administrator Community Care Programme — Eastern Health Board	Section 65 grants + Fundraising + Charges to clients	Paid Supervisor, Part-time Cook, Driver, Volunteers.
B. Grants of less than £5,000*	Voluntary Committee (Health Board representative)	Area Administrator Community Care Programme — Eastern Health Board	Section 65 grants + Fundraising + Charges to clients	All volunteer
C. Day Centres in Social Service Centres	Voluntary Committee (often with backing of religious order or voluntary organisation)	Area Administrator Community Care Programme — Eastern Health Board	Section 65 grants + Fundraising + Charges to clients	Paid Supervisor, Part-time Cook, Driver, Volunteers. (Nurses, Social Workers, other support staff.)
D. Day Centres in Sheltered Housing Schemes	Voluntary Committee (some housing authority involvement)	Area Administrator Community Care Programme — Eastern Health Board	Section 65 grants + Fundraising + Charges to clients	Paid Supervisor, Part-time Cook, Volunteers
2. Statutory Services				
A. Day Care Centres (Eastern Health Board hospitals in rural settings)	Hospital Staff	Hospital Administrator Hospitals Programme — Eastern Health Board	Direct Budgets — £25-50,000	Nurse-Supervisor, Driver, (Attendant), (Volunteers).
B. Leopardstown Park Hospital	Independent hospital board. Day Care Centre Advisory Committee	Department of Health Hospital Secretary/ Manager	Direct Department of Health + £14,000 from Community Care Programme for transport	Assistant Matron, Assessment, O.T., Supervisor and Physiotherapist.
C. Naas Day Centre	Committee	Eastern Health Board Community Care	Community Care Programme Charges to clients	Nurse Supervisor, Paid Assistant, Health Board Drivers.

*Very few day centres received grants of between £6,000 and £9,000 in 1984. †Parentheses indicate 'only in some cases'.

by those who either fund or operate them. The following information about day centres was obtained from personal visits to day centres, interviews with Health Board officers, and, in some cases, correspondence with hospital administrators.

Day Centre Categories

1. Voluntary Grant-Aided Day Centres

Most day centres in the Eastern Health Board fall into this general category. Voluntary day centres are operated largely by untrained, unpaid staff (mainly female and sometimes elderly themselves) and managed by a voluntary board or committee. Grants are paid from the Community Care Programme, and accounts are submitted to area administrators. Reported attendance at voluntary day centres ranges from 20 to 50 per day, and individual clients may attend from one day a week to five days a week. Voluntary day centres may be further divided into the following sub-categories.

1A. Voluntary Day Centres in receipt of grants of £9,000 or more

These centres operate a comprehensive programme (see Table 3) five days a week, five or more hours a day. They organise transport for at least some clients and can cater for the needs of at least some dependent old people. Day centres in this category include: Sancta Maria Day Centre, Cabra and St. Fintan's Day Centre, Monkstown.

1B. Voluntary Day Centres in receipt of grants of £5,000 or less

There appears to be a "great divide" between centres receiving £9,000 or more and the rest. Many centres receive only £2,000-£3,000 a year, with very few in receipt of grants between £6,000 and £9,000 annually. The number of units in this category is largest, although the status of units receiving grants this small is ambiguous: they are called day centres by some and clubs by others. Typically they are operated entirely by unpaid volunteers, and services are usually less comprehensive than at other day centres, especially with respect to opening hours and transport. These centres are usually not able to stay open all day, every day, and client attendance may be infrequent. Transport, if available at all, is informally organised for the relatively few. Only in exceptional cases (Rathcoole, Sandymount and Whitehall, for example) where substantial funds are raised locally and volunteers can be recruited are the full range of services available to users in this category. In the majority of cases, small grants preclude full day centre service. Activities at these centres

will be necessarily aimed at the more mobile, independent users and a club orientation will prevail. Some of the centres in this category are listed under "Other Centres" in Table 2.

1C. Voluntary Day Centres in Social Service Centres

This category of day centre, although small in number, is unique in at least two ways. First, day centre staff may include nuns who have training in social work, nursing or related fields. Clients and their families may also have access to other support staff who work at the social service centre. Clients at other types of voluntary day centres typically do not have direct access to support services like these. Second, social service centres usually have the backing of either a religious order or a large voluntary organisation. This may make it easier for them to raise funds (from the community as well as from the Health Board — see later discussion on funding) and to recruit volunteers. Examples of day centres in social service centres are: Milltown Day Centre and Our Lady of Lourdes Day Centre, Sean McDermott Street.

1D. Voluntary Day Centres in Sheltered Housing Complexes

Although very few in number, day centres in sheltered housing complexes deserve attention because of their location, and because their development involved the co-operation of two separate statutory authorities. Otherwise they operate approximately on the same model as Type 1A. Two centres in this category in the Eastern Health Board are Beaufort Day Centre, Glashule and Lorcan O'Toole Centre, Crumlin.

2. Statutory Day Centres

Statutory day centres (or day care centres as they are called), straddle the theoretical boundary between day centres and day hospitals. They are included here because services and activities at statutory day centres appear to be very similar to those offered at other categories of day centres. However, because of certain other distinguishing features, it might be more accurate to define them as day hospitals in an early stage of development. Statutory day centres in all but one case are located in hospitals, they are usually funded directly through the Hospitals Programme of the Health Board, and they are administered by individual hospital administrators. Statutory day centre supervisors are usually trained nurses. Staff at statutory day centres work directly for the hospitals involved. (All but one are Eastern Health Board Hospitals.), while staff at voluntary day centres are paid indirectly from Section 65 grants, if they are paid at all. Statutory day centre budgets average

£35,000 annually which is two to three times larger than the average budgets of voluntary day centres. (See Case Study for example.) Statutory day centre users include residents and non-residents of the host hospital, and number 25-35 on average per day. There is evidence to suggest that attendance by individual users is less frequent than at day centres in category 1A (i.e. limited to once a week or less) except in cases where users live very near to the day care centre.

Two exceptions to this general description of statutory day centres are the day centres in Naas and in Leopardstown Park Hospital. Naas Day Centre is not located in a hospital: it is situated in rented premises in Naas town. It is funded from the Community Care Programme budget of the Health Board and in this way also differs from other statutory day centres. In most other respects however, it follows the same model. Leopardstown Park Hospital is a private hospital and funding to its day centre comes from the Department of Health rather than from the Health Board (as in the case of Eastern Health Board hospitals). The Health Board Community Care Programme contributes money for transport only. There are differences in staffing at this day centre which are noted in Table 1.

Statutory day centres in the Eastern Health Board Region include:

- District Hospital, Baltinglass
- Naas Day Centre, Naas
- St. Clare's Home, Ballymun
- Leopardstown Park Hospital
- St. Coleman's Hospital, Rathdrum
- St. Vincent's Hospital, Athy
- Wicklow District Hospital (opened in 1985).

Number and Distribution of Day Centres — Eastern Health Board Region

Attempts to ascertain current levels of day centre provision were hampered by the lack of an operational definition of the service noted above. There were discrepancies (within and between Community Care Areas) between the perceptions of those who authorise funding to services, fieldworkers, and those who actually provide services for the elderly, about the extent of the services available, the type and number of clients benefitting from services, and the staffing and financial arrangements governing centre operations. However, Table 2 and the map on Page 34

provide a rough idea of the number of day centres and the way in which they were distributed in the Eastern Health Board Region in 1984. The information was provided by Area Health Board representatives in interview and in many follow-up telephone calls.

The most serious difficulties emerged in attempts to distinguish between "proper" or full day centres and social clubs or facilities that were described as day centres but offered less than the minimum standard services listed later. The figures in Table 2 column 4 are necessarily ambiguous as a result.

Community Care Area	Address of H.Q.	Tel. No.
1	Our Lady's Clinic Patrick Street Dun Laoghaire	808403
2	Community Care Offices Vergemount Hall Dublin 6	688222
3	Carnegie Centre Lord Edward Street Dublin 2	792811
4	Health Centre Old County Road Dublin 12	752821
5	The Lodge Cherry Orchard Hospital Ballyfermot Dublin 10	208101
6	Community Care Offices Rathdown Road Dublin 7	303444
7	Health Centre North Clarence Street Dublin 1	743715
8	Health Centre Cromacastle Road Coolock Dublin 5	478141
Kildare	Poplar House Poplar Square Naas County Kildare	045 76001
Wicklow	Glenade Road Wicklow	0404 68400

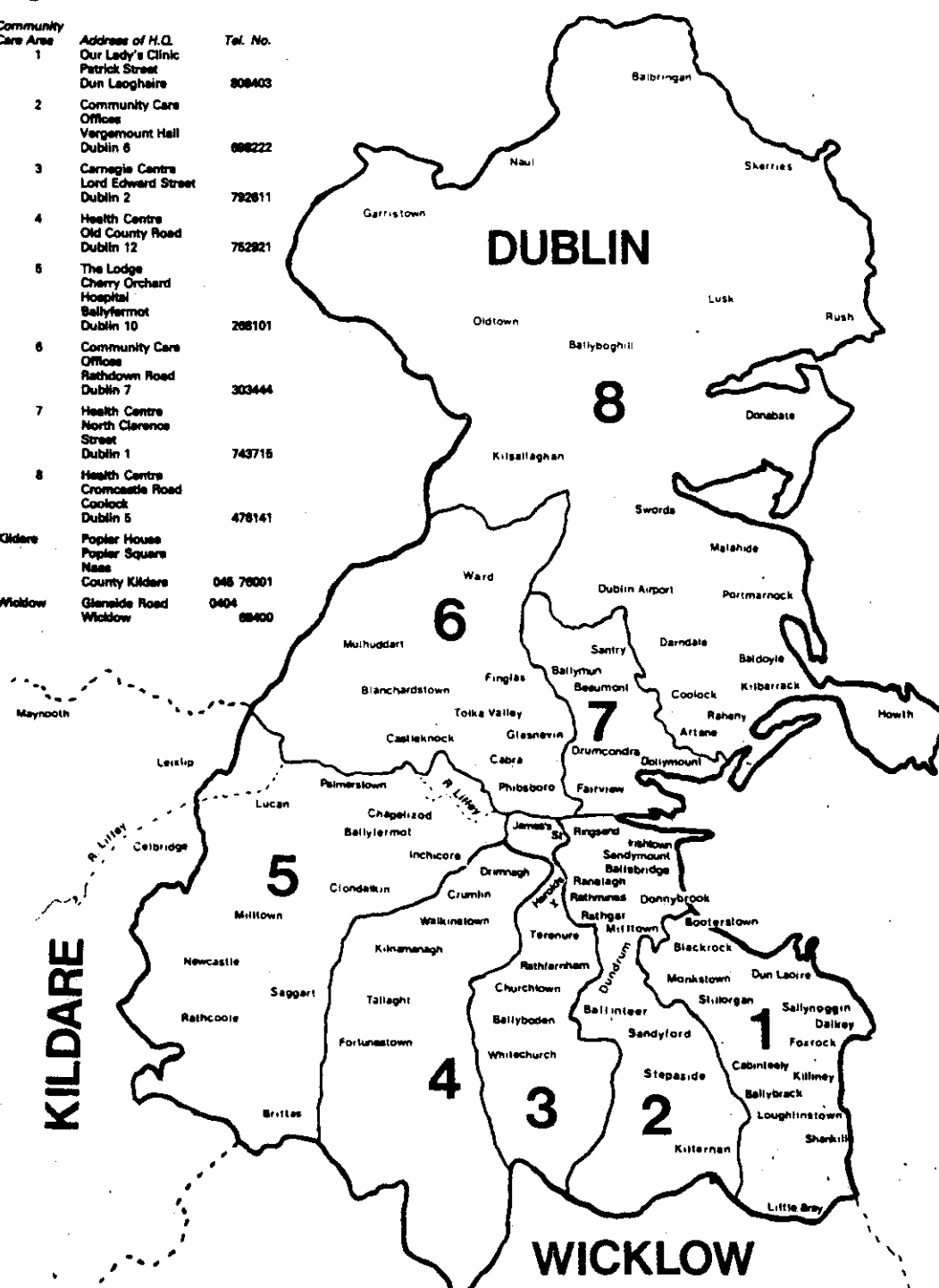


TABLE 2**Distribution of Day Centres Eastern Health Board Region (1984)**

Community Care Area	No. of Day Centres Funded	Budget Programme	Other Centres
One Dun Laoghaire	2	Community Care	1 opened in 1985
Two Dublin South East	6	Community Care	3 offering less than full service 1 funded by special arrangement

Leopardstown Park Hospital Day Centre		Department of Health Community Care	(Located in Area 2 but accepts clients from Area 1 and Area 2)
Three Dublin South Central	3	Community Care	4 offering less than full service
Four Dublin South West	2	Community Care	1 funded through grants to Tallaght Welfare Society 1 all voluntary
Five Dublin West	3	Community Care	4 offering less than full service
Six Dublin North West	2	Community Care	1 newly developed 1 formerly in receipt of funding
Seven Dublin North Central	4 1	Community Care Hospitals Programme	1 not specifically for elderly 1 all voluntary
Eight Dublin North	0	—	—
Nine County Kildare	2 1	Community Care Hospitals Programme	—
Ten County Wicklow	2	Hospitals Programme	1 opened in 1985

The figures in Table 2 show that the absolute numbers of day centres for the elderly are small, an average of less than three centres per Community Care Area (population approximately 100,000 per Area). Distribution is somewhat uneven: one Area (Area 8) has no day centres at all, while Area 2 has six day centres of various descriptions. Average daily attendance at the eight centres in the Health Board visited for this research was twenty-five: numbers reported for other day centres suggest that the total numbers of people benefitting from the service are small.

An Eastern Health Board report written in 1980³ suggested that a ratio of one day centre for every three parishes was desirable. The report estimated the need for the development of thirty-one new day centres.⁴ The situation has not altered dramatically since that report was written: no more than five or six completely new day centres have been established since that time. By the Health Board's own reckoning about twenty-five new day centres are still needed.

Day Centre Programmes

Following is an outline of specific activities and services found to be available to clients of day centres in the Eastern Health Board. Although each centre is unique in some respect, it was possible to identify a standard set of activities and services on offer at most day centres for the elderly. Other activities or services that are sometimes available are also outlined. A chart follows which matches services with types of day centres (as defined in the previous section). Centres in category 1B, while not always meeting the criteria for full day service, offer limited services and are included: (1) because they are called "day centres", and (2) because they have the potential for eventually evolving into day centres.

TABLE 3

Day Centre Services and Activities

Type of Service/Activity	Frequency
<i>A. Standard Services and Activities</i>	
<i>Services</i>	
Meals	Every day the centre is open.
Hot midday meal	
Cup of tea and bread	Morning and afternoon.
Occupational therapy	
Activities include rugmaking, sewing, knitting physical and mental exercises, games	Once/week, once/two weeks for one hour.
Chiropody	When requested. By session.
Hairdressing	Once/week. When requested.
Public Health Nurses	
Give baths to clients	Occasionally, depending upon interest of individual PHNs.
Organise activities	
Liaise with home	
Transport	To and from centre for some clients.
<i>Activities</i>	
Cards, bingo, newspapers, t.v., radio	Daily
Entertainers from outside	Occasionally
Christmas party, outing by bus	Once a year.
<i>B. Other Services and Activities</i>	
<i>Services</i>	
Pastoral Services	By arrangement with local clergy.
Social Work Services	
Counselling clients and their families. Assistance with forms and entitlements. Bereavement work	Limited mainly to social service centres.
Nursing care	
Changing dressings. Giving medications. Medical diagnosis	Limited mainly to day care centres with nurse-supervisors.
Physiotherapy	Only rarely offered.
Laundry service	Available to very few.
<i>Activities</i>	
Educational programmes	Occasionally available.
Work projects	
Used clothing shops	
Evening activities with transport	

TABLE 4

Activities and Services at Different Types of Day Centres

Type of Day Centre	Staff	Transport	Hours Open	Activities/Services
1. Voluntary Day Centres				
1A. Grant-Aided £9,000 or over	Untrained. Volunteers.	Own vehicle. Hired vehicles. Volunteer drivers. Transport for some.	10.30-4.30 approximately, 5 days a week.	Standard Pastoral services.
1B. Grants under £5,000	All volunteer.	Informally organised. Volunteer. Transport for the few.	Less than 5 days. Less than full days.	Activities aimed at the more independent, active, mobile elderly. May include some standard services. Club orientation.
1C. Social Service Centres	Trained and untrained staff. Volunteers.	Own vehicle. Hired vehicles. Transport for those who need it.	10.30-4.30 approximately, 5 days a week.	Standard and social work services. Home visiting, laundry, information services. Pastoral services.
1D. Centres in Sheltered Housing Schemes	May be trained. Volunteers.	No transport. Transport for the few.	10.30-4.30 approximately, 5 days a week.	Similar to 1A.
2. Statutory Day Centres	Trained nurse.	Hospital transport for all.	10.30-4.30 approximately, 5 days a week.	Standard and nursing care, (sometimes physiotherapy).

Day Centre Users

The majority of day centre users are female, and most are sixty-five years of age or older. Apart from age and sex, day centre users are by no means a homogeneous group. User interests and abilities appear to range widely. In terms of functional ability, at one extreme are the physically mobile, able and alert old people who come to day centres by choice because they enjoy it or because they feel that they, themselves, have something to offer. (There is sometimes a fine line between users and staff of day centres.) At the other extreme are the very dependent — the severely physically disabled or mentally confused. The mix of users is different from centre to centre.

The numbers of clients attending individual day centres varies from ten to fifty or sixty but as noted earlier, the average would be about twenty-five. Most centres have a larger number of clients on their books than attend regularly according to staff interviewed; some clients do not attend every day or even every week, so average daily attendance is lower than total client numbers suggest.

Referrals to Day Centres

Elderly people are referred to day centres if they have any problem that does not specifically require hospitalisation or direct medical care, e.g. loneliness, bereavement, family conflict. Most referrals to day centres come from public health nurses, but some home help organisers, occupational therapists, hospital social workers, general practitioners, geriatricians, family, friends and neighbours also make referrals. Self referrals are also not unusual.

Referrals to day centres are often made at some crisis point, i.e. after some type of breakdown has taken place — either the physical breakdown of the old person or a breakdown in caring arrangements. Often referrals take place when decisions are being made whether to send an elderly person home from hospital after an accident or illness. At least a small percentage of those who are referred do not show up at the day centre, according to day centre staff; they may be “lost” to the system until another crisis occurs and they again come to the attention of health care workers. It is left to referral agents or day centre staff to determine whether to pursue the potential clients.

Most of the elderly people who are referred to day centres (and who do choose to attend) are accepted without formal assessment having

taken place. Most day centre staff who were interviewed said that, if they could manage it at all, they would accept any client who was referred or who wished to come, including those who are in wheelchairs, who are incontinent or confused. (Statutory day centres may have better defined service target groups and select clients accordingly.) The number of clients with special needs who can be accommodated at any one centre is limited by considerations of staff numbers, physical facilities, transport and the needs of other clients, but not by unwillingness of staff for the most part.

Day Centre Premises

The physical premises of day centres (all categories) vary from dilapidated church halls or old schools to modern purpose-built facilities with handrails in specially built toilets, special bathing facilities and ramps for wheelchairs. More typical are centres in old premises that have been remodelled to some extent for use by the elderly. Obviously modern centres are more likely to conform to State health and safety standards, but all of the centres that were visited appeared to make every effort to maintain reasonable standards of cleanliness, comfort, attractiveness and safety.

The direct benefit to clients from sophisticated equipment or facilities may be less than appearances suggest. Some centres are well endowed with modern facilities, but in some cases these facilities are not being used for clients. For example, bathing facilities that have been built in several day centres in recent years are largely underutilised because no provision has been made for supplying the trained staff needed to use them. Washing machines, acquired by some day centres, may in fact be used exclusively for day centre linens and are not used *by* clients or *for* clients.

Superficially, the physical premises of day centres did not appear to influence the quality of services dramatically. Facilities obviously define the limits of what is possible, (e.g. without ramps, wheelchair users cannot be accommodated easily, without bathing facilities, no baths can be given), but services within the Eastern Health Board as described by Health Board and centre staff are much the same regardless of differences in physical facilities.

Premises do make a difference to providers: the cost of providing the services may be higher, or the difficulty of delivering services may be greater in premises that were not built (or adapted sufficiently) for use

as day centres. Heating costs are sometimes very high in old buildings. Distances between the kitchen and the dining room may be great or kitchens unsuited to cooking large quantities of food. Some buildings are very difficult to keep clean, and so staff must work harder than they might in more modern premises. Although clients may be just as well served ultimately, the burden on providers is greater where premises are unsuitable.

In only one Area was it suggested that elderly clients had stopped attending a day centre because the premises weren't "cosy" or attractive. In this case, the day centre had been forced to move from a building that was much better suited to providing day centre services. The only alternative premises that could be found consisted of a large, impersonal hall, which was draughty and cold in appearance. Attendance had dropped off noticeably since the move.

Voluntary Providers

Day centres are typically run by a small management committee or board who employ staff to develop programmes and provide services. Management committees may consist of a handful of committed individuals from the community who, with day centre staff, do the work of fundraising, organising and providing day centre activities. Although it may sometimes be the case, it cannot be taken for granted that day centres are operated by large organisations with generous supplies of volunteer recruits.

Health Board Representation on Committees

As indicated in Table 1 the Health Board is not necessarily represented on the committee of voluntary day centres, even those receiving large sums of money from the Health Board. Sometimes a public health nurse or an occupational therapist from the Health Board sits on a day centre committee because of personal interest. Occasionally representatives are deliberately placed on centre committees by directors of community care. Alternatively, fieldworkers may be asked to identify and recommend prospective committee members from the community. In at least one Community Care Area, Health Board representation was considered to be awkward because of a possible conflict of interest that could arise for the Health Board employee.⁵

Distribution of Eastern Health Board Funds between Community Care Areas

Table 5 shows the way in which day centre funds were distributed between Community Care Areas in the Eastern Health Board in 1984.

The funding figures included in the Table were supplied by Community Care Area administrators and hospital administrators. In one or two Community Care Areas, only the total amount allocated to day centres for the elderly was made available: this obviously makes it more difficult to determine the distribution of finance within these Areas.

The funding figures do not include assistance that may have been given to many day centres in the form of meals cooked at Meals on Wheels centres and financed through a separate budget. The value to day centres involved (i.e. those that do not cook meals at their own premises) is 55p per meal (= approximately £138 a year for a person attending five days a week for fifty weeks, which represents the most "expensive" extreme).⁶ Another form of assistance not reflected in the figures is transport: as noted earlier, in a few cases the Eastern Health Board may have either given or helped with the purchase of vehicles. In rarer instances (mainly in rural areas) Health Board vehicles and drivers are used to transport users to and from day centres for the elderly. Because transport may be the biggest single expense facing day centre providers (See Case Study budget, Table 11), assistance of this kind can be extremely important and of considerable value (relative to total annual budgets.)

The amount of Health Board money allocated to day centres in different Community Care Areas varies greatly as can be seen from Table 5. Although Area 3 has the average number of day centres (three), only £7,000 total was allocated to these centres in 1984 (average of £2,300 per centre). In Area 1, however, £18,000 was divided almost equally as it happens between only two day centres (average £9,000 per centre).

Even within Community Care Areas, there can be huge differences between the amounts received by individual voluntary day centre providers. In one extreme case, one day centre received over £20,000 more than the recipient of the next highest grant in the same area.⁷ In another Community Care Area, one centre attracted 65 per cent of the total allocation of funds to voluntary day centres while all the others shared the remainder: this pattern is not unusual in the Dublin vicinity.

TABLE 5
Eastern Health Board Region (1984)

Community Care Area	No. of Centres	Budget Programme	Amount
One Dun Laoghaire	2	Community Care	£18,000 (average £9,000/centre)
Two Dublin South East	6	Community Care	£24,000 (average £4,000/centre)

Leopardstown Park	1 (statutory)	Department of Health Community Care	unknown £14,000 (transport only)
Three Dublin South Central	3	Community Care	£7,000 (average £2,300)
Four Dublin South West	2	Community Care	£10,000 (average £5,000)
Five Dublin West	3	Community Care	£19,000 (average £6,300)
Six Dublin North West	2	Community Care	£25,820 (average £12,900)
Seven Dublin North Central	4	Community Care	£22,000 (average £5,500)
	1 (statutory)	Hospitals Programme	£34,000 annual budget
Eight Dublin North	0	—	—
Nine County Kildare	2 (1 statutory) (1 voluntary)	Community Care	£53,500 (average £27,000)
	1 (statutory)	Hospital Programme	£30,000 annual budget
Ten County Wicklow	2 (statutory)	Hospitals Programme	£75,000 combined annual budget

Funding to voluntary centres is much lower than funding to statutory day centres, mainly because labour costs are much lower (or nil) at voluntary day centres in the Republic. (In Northern Ireland, grant funding to voluntary day centres may be as high as funding to statutory day centres.)

Funding to Individual Voluntary Day Centres

Type/level of funding

Funding to voluntary providers is done at three levels: capital grants (a few hundred pounds) may be given as "seed money" to start a committee off towards service development: much larger capital grants of up to several thousand pounds are sometimes allocated to renovate or even build a day centre premises: and almost all voluntary day centres receive grants to cover a percentage of their running costs. Health Board assistance "in kind" may also be given in the form of rent-free accommodation, provision of utilities, transport, or the more usual, equipment or articles from Health Board Stores (e.g. crockery, cutlery, etc.).

Annual grants to help cover the running expenses of individual voluntary day centres range from a few hundred pounds to £25,000 for one centre in 1984, with average grants of about £5,700 per year in County Dublin. General Eastern Health Board guidelines have been developed to help Area managers determine the amounts of money to be allocated to voluntary providers, according to an officer in the Community Care Programme,⁸ although eight out of ten area administrators did not seem aware of their existence at the time they were interviewed. Most of those interviewed, however, said that they do apply a rough set of criteria when making decisions about funding day centres for the elderly. Most use a percentage formula: the majority would expect to pay no more than 50 per cent of anticipated running costs, while others would expect to pay about 60 per cent or 70 per cent. The voluntary provider would be expected to raise the balance. Most officers acknowledge that in exceptional cases, a much higher proportion of costs might have to be assumed by the Health Board in places where the need for services was high, but the potential for voluntary contributions (in terms of money, organisational expertise and staffing) was small.

According to day centre staff interviewed, grants to some voluntary day centres have stayed at the same level for the past few years. (See Case Study for example). Given that costs during the same period have risen steadily (including the cost of transport, heating fuels, food and other materials, not counting labour costs), the real value of Health

Board grants to some voluntary day centres has fallen. This has obviously created problems for service providers who wish to maintain the same level and standard of services to the same number (or growing numbers) of clients. Possible implications of "shrinking" grants for clients and service providers are considered in Chapter Six.

Health Board negotiations with voluntary day centre providers are usually conducted by area administrators who work out financial arrangements subject to the approval of the programme manager.

There are no formalised procedures for the funding of voluntary day centre operations or development of new day centres in the Eastern Health Board. There are no standardised grant application procedures and no contracts are drawn up regarding the respective rights and responsibilities of the Health Board *vis-à-vis* voluntary providers. There is a general reluctance to make definite commitments regarding actual amounts of money to be paid out by the Health Board.⁹ Letters may set out the limits of potential assistance, but if something goes wrong, neither side has legal recourse to compel the other side to act.¹⁰

Grants to voluntary day centres are usually calculated to cover the difference between a centre's income and expenditure for the previous year (presumably so long as the difference is not greater than 50 per cent of total running costs). Committees are asked to submit income and expenditure accounts (audited if grants total £5,000 or more in one year). Section 65 grant money is paid out in one lump sum or in quarterly payments. It is not unusual for a voluntary group to ask for additional grant money before the year is out due to rising costs or exceptional circumstances (e.g. a broken down van, vandalism, etc.). Health Board representatives said they would try to see that the voluntary body "stays out of trouble" financially, subject to the further approval of the programme manager.

No one interviewed in any Community Care Area had ever made the decision to withhold funding to a voluntary day centre because the quality of service was below standard. One case was mentioned, however, where grant money allocated to cover day centre running costs was used for other purposes by a voluntary group. Their grant request for the next year was being deferred until an "understanding" could be reached.

Development of New Services

Development Initiatives

Although directors of community care are authorised to look for gaps

in service provision in their Areas and to work accordingly towards the development of new services, including day services, the Health Board typically plays a reactive role in response to local development initiatives. It was suggested by Health Board representatives that, especially in times when money is tight, the Health Board is unlikely to go looking for new ways to spend money.

The demand for a new day centre is likely to originate from interested individuals in the community including public health nurses, G.P.s, the clergy, senior citizens clubs, old folks committees, etc. The point at which the Health Board becomes involved, in most cases, is when a potential service provider has been identified. Sometimes a voluntary group is providing a limited service to the elderly (e.g. dinners, outings, etc.). The Health Board may promote the idea of development of a day centre through the expansion of these already existing services. Or a group may come forward to offer to organise a completely new service.

Negotiations

Once a proposal has been introduced for the development of a new day centre, informal dialogue begins between the potential providers and the Health Board. There is no required minimum amount (or even proportion) of anticipated costs which must be raised before the Health Board will participate in development plans.

Negotiations between the Health Board and voluntary providers consist of personal visits, informal discussions and exchange of letters. The provider is advised about general levels of support that might be expected from the Health Board, in return for what types of input are expected from the voluntary group.

Possible sites for the new centre would be identified and discussed, and the lack of available premises could be a significant inhibiting factor at this point. Several directors noted that even where premises are not a critical problem, a percentage of potential providers would lose interest at this point in negotiations. Health Board representatives might follow up if they felt that there was a great need for a day centre in a particular area or if they felt that the voluntary group in question had the ability to mobilise resources sufficiently to provide a service. But generally the onus is on the voluntary organisation to proceed with plans.

If the voluntary organisation's interest is sustained throughout the early stages of dialogue with the Health Board, and if they show some organisational ability, work will begin towards service development. Verbal support, encouragement and assurances are given by the Health

Board that financial support will be forthcoming as services develop, although as suggested earlier, there are no formal procedures to cover such negotiations. Small sums of money and equipment may be offered along the way (from the earliest stages). Capital building grants may be offered in which case proposals would have to be worked out in greater detail. At the end of the first year, voluntary providers are asked to provide accounts of income and expenditure. Running cost shortfalls are covered by the Health Board where they are considered to be reasonable.

Community Care representatives who were interviewed said that only in a very few cases would they give an outright refusal to help fund voluntary organisations offering to develop community services for the elderly. Most said they had never had to do so. They gave two reasons why they might refuse funding: (1) if they felt that the voluntary group could not deliver what is promised, i.e. if their proposal was totally unworkable; or (2) if the new service is not needed, or duplicates one that was already being funded. In the latter case, one director of community care said that he would try to establish whether a new service was needed by asking the public health nurses to make a "headcount" of elderly people known to them who would use a centre if it were opened. Even in the former case, efforts would probably be made "to tighten up" the proposal and to help the group concerned get more firmly on its feet before negotiations came to a complete halt.

CHAPTER TWO

Notes

- ¹ Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow: Report of a Working Group*, 1982, pp. 104-105.
- ² Interviews with Directors of Community Care and other Health Board officers.
- ³ Eastern Health Board, *Care of the Aged Report* (unpublished), April 1980, Schedule of Proposals, p. 20.
- ⁴ *Idem*.
- ⁵ Interview January 1985 with Area Administrator.
- ⁶ Interview, Programme Manager's Office, January 1985.
- ⁷ The 1984 grant to this centre was deemed to be unusually large because of "special" circumstances. However, even in a "normal year" this centre received £12-13,000 more than the centre with the next highest grant.
- ⁸ Interview, Programme Manager's Office, January 1985. A request was made that the Guidelines not be published.
- ⁹ Interviews with Area Administrators, Spring 1985.
- ¹⁰ Suggested by the Director of Community Care who expressed concern about the lack of legal guarantees in the present system.

CHAPTER THREE

Case Study

Introduction

This chapter offers a close-up look at one voluntary day centre in the Eastern Health Board Region. Discussions first focus on the development of the centre, its physical facilities, the way in which it is financed, the day-to-day operations (including routines of staff and clients), and the services and activities which are available to clients. Staff and client perceptions of services are also considered. This section was developed after interviews with the day centre founders as well as with present staff and some clients.

Tables are included to outline client characteristics, referral routes, and staff as well as client perceptions about why clients were referred to the centre. A look at the outcomes of clients who previously attended the centre is followed by brief case histories of four people attending at the time the data were collected.

The last section looks at centre finances and includes an actual account of income and expenditure for 1984. Finally, the supervisor's concerns about future centre operations are considered.

History

The Dublin Day Centre* was started by the local home help organiser who saw a need to relieve the carers of some of her elderly clients — typically family members who were sometimes under very great stress themselves. She approached the Eastern Health Board Community Care headquarters: although initially warned that her plan to develop a centre would not work, she eventually received half of the estimated required

*The name of the day centre has been changed to protect the confidentiality of staff and clients.

funding (£2,500) and was told she must raise the rest. Health Board officials advised her to do what she could with the money and asked that accounts of her progress be submitted after six months. The organiser sought donations of money and materials from people and businesses in the community. "Contributions" from clients (i.e. charges to clients) and fundraising efforts raised the balance of what she needed to open and operate the day centre.

The centre was opened in a large house situated in what had been an old school complex. Staff consisted of a paid supervisor (whose wages amounted to £25 a week), a voluntary worker, including a nun. Accounts were kept by the home help organiser since, at that time, the centre was considered to come under that "umbrella". Meals were cooked on the premises.

There were eight original clients, all known already to the home help organiser. The number grew to twenty-five over time. A minibus was hired to transport almost all of the clients to and from the centre.

The original operating philosophy of the centre was that everybody should be engaged in some form of useful activity during the time they spent at the centre. Clients should believe that they were useful and needed there. "Work" activities were organised for everyone, often using donated craft materials. Charges were levied on clients from the start to raise revenue and to make clients feel that they were entitled to the service because they were paying for it.

The Health Board asked for representation on the centre's original committee: a Health Board community care senior social worker sat on the committee and the director of community care took an active interest in the centre as it developed. Other members included the home help organiser, the nun mentioned above, two interested volunteers (one who happened to be a social worker), and the driver.

In 1975 the house in which the centre was situated was sold by the owners. A move was made to another old house, a "community centre" owned by the County Council and rented out at a nominal rent. Meals had to be brought in from a meals on wheels centre because there were no cooking facilities.

Another move was made in 1980 to the present centre site, a one hundred year old house owned by the local community association. The house includes separate accommodation for a day nursery, the local branch of Alcoholics Anonymous, a senior citizens group and a youth club.

Current Operations

The Dublin Day Centre continues to offer a service to between sixteen and twenty elderly users and their families five days a week for 52 weeks of the year, except for bank holidays. The present supervisor stated the aims of the centre as follows: to prevent people from having to go into institutions; to give relief to families; to give clients necessary care during the day and return them home at night; to give companionship to those who live alone.

Staffing

The present staff includes a supervisor and three assistants. The supervisor (who has no formal professional training) is a housewife and mother with long experience as a volunteer. Her day starts at 9.30 a.m. when she is collected by the minibus, and ends at about 5.00 p.m. when she is one of the last to be dropped off on the second bus run. She describes her duties as including the following: dealing with referrals; liaising with clients' home or family; chasing up people who may be missing; supervising other staff; answering questions and special requests; assisting clients in getting on and off the bus; preparation of tea and snacks and the serving of lunch; cleaning up the premises and being generally responsible for the running of the centre.

A second staff member (over age seventy) collects "contributions" from clients, keeps the accounts and helps with clients. A third staff member (also over seventy) works directly with the clients (toileting, bringing them to the kitchen for lunch, serving lunch) etc. The fourth (a young married woman) helps in any or all of these duties: all say they "do whatever needs doing". One of the staff who is over seventy herself remarked that working at the centre helps her as much as it does the clients; she gets as much out of it as she gives.

Physical Facilities

The day centre consists of two main areas. One large, high ceilinged room with a fireplace is furnished with wooden arm chairs and small tables, and serves as the sitting room. The dining room/kitchen area is equipped with tables and chairs, a domestic four burner cooker, a sink, small fridge and cupboards for dishes and pots. Cups of tea, soups and some desserts are prepared here and main courses come from a nearby

meals on wheels centre (and are delivered to the centre by meals on wheels volunteers).

In 1985 new toilets and shower facilities were completed with AnCO money and labour. The work was organised by the landlord (i.e. the community centre). Previously, clients had to share toilet facilities with the day nursery across the corridor. AnCO workers also recently painted all the rooms (which now are smart and bright in appearance), and constructed a new ramp outside.

There is no central heating in the day centre: storage heaters, an electric heater, and the open fire help to counter the draughtiness of the building, but it is still quite cold at times.

A small black and white television in the sitting room is seldom watched. There is also a radio.

Transportation

A hired minibus and driver (with special PSV licence) carries most of the centre clients to and from the centre. The driver averages 55-60 miles a day in two trips. She waits the necessary time if someone is not ready, she investigates if anything seems amiss at clients' homes, she sometimes has to help dress clients and occasionally has to persuade them to come with her. One client comes by private car, and another by public transport.

No specific catchment area has ever been established for this centre.

Services

The Eastern Health Board occupational therapist comes to the day centre one afternoon a week for one hour. She conducts physical exercises and has been supervising several clients in the making of a rug which they hope to sell eventually. She is very popular with clients and several expressed regret that she would be leaving soon. (She is moving out of Dublin.)

There is no physiotherapy available at this day centre. A chiropodist comes once a month or more often if needed. She is hired by the centre on a sessional basis.

Public health nurses make referrals and have an occasional "look in". One nurse, described as an "itinerant nurse" (she has no defined district), gets clients up and plays games with them when she visits. The supervisor expressed disappointment that there is not greater and more regular contact with the public health nurses whom she feels have a lot to offer centre clients. It is hoped that with new shower facilities, some of the

nurses will come in to bathe clients and perhaps take a greater interest in the centre.

Hairdressing is done on Wednesdays or by appointment. The hairdresser (over 65 herself) also does home visits to clients when requested. Clients get their hair done at the centre for less than half the commercial cost.

Contact with social workers is limited to telephone conversations with hospital social workers who wish to refer clients. They are generally considered to be "good" in that they follow up on cases they refer and they provide background information about clients being referred. No Health Board social worker visits the centre.

Activities

A coach is rented for an annual summer outing when clients are taken out for a high tea. There is a Christmas party with Christmas dinner, entertainment and drink for those who are allowed.

Cards are played regularly, and magazines, newspapers and books are available at the centre. Mass is said occasionally, depending upon the schedules of the local priests.

The Committee

The committee over time has dwindled in numbers. The Health Board social worker (one of the original committee members) got married and left her job. Others either moved or lost interest. Presently there are only three members: the centre supervisor, a woman who raises money for the centre by knitting, and a man who is an active member of the St. Vincent de Paul (but who acts in an individual capacity and does not represent the St. Vincent de Paul organisation). Its main function, according to the supervisor, is fundraising. She noted that when she was hired, she was told that she would not have to concern herself with fundraising, i.e. that the committee would see to that. Things have developed differently and the supervisor is necessarily involved in any fundraising efforts that are carried out, because there is no one else to do it.

The director of community care or the area administrator try to come to committee meetings when they can. Meetings are held on a regular monthly basis. A housekeeping committee, consisting of centre staff,

meets periodically to discuss cases and day-to-day operations. The supervisor said she would welcome participation from Health Board representatives or outsiders to provide fresh ideas and more referrals.

Voluntary Input

There was never any voluntary organisation, as such, behind the Dublin Day Centre. It was started by one individual and grew from that. Although two individual volunteers sit on the present committee, as noted they do not represent support groups for the centre. There is a Senior Citizens Club which meets in the same building for social activities. The supervisor said that there have been some attempts to interest members in volunteering in the centre, but she feels that club members are "upset by our clients", i.e. because clients are relatively dependent. She cites bad experiences the centre has had with volunteers who, in general, are thought to be unreliable.

Occasionally the centre has advertised for volunteers, but they usually get people who are perceived to have problems themselves. (These are welcome to come, but it is felt that they contribute little in the way of help!) Early volunteer drivers disappeared when petrol prices increased sharply. There have been approaches to the youth group in the same building who have helped out with fundraising projects in the past.

The supervisor said that the type of voluntary input that is most needed is fundraising.

Clients

On 20 February 1985, there were sixteen clients at the Dublin Day Centre. There are six more (including three men and three women) on the list of those attending.

The following table shows a breakdown of clients by age and marital status.

TABLE 6

Marital Status and Age of Clients

No.	Marital Status	No.	Age Group
8	Widows with children	3	Aged 70-74 years
2	Widows without children	7	Aged 75-79 years
2	Never married	6	Aged 80 years or older
4	Married (including a husband and wife)		

The majority of clients interviewed said that they live on the non-contributory or the contributory Old Age Pension as their only source of income. Two clients live alone, and one lives in a local authority sheltered housing scheme flatlet. The rest live with their spouses or, in most cases, with a daughter or son.

The physical and mental condition of clients varied greatly, but few could be considered to be very agile or active. Two or three clients have had strokes. One man is blind. Arthritis affects several, one client to a serious extent. There were no wheelchair clients on the day the census was taken, but two were incontinent. Seven suffer from what was described as "dementia". Of these, four need special minding or management because they wander or could be a danger to themselves or other clients. One client has a history of nervous breakdowns with repeated hospitalisations.

TABLE 7

Who Refers Clients?

Referral Agent	No.
Public Health Nurses	5
Family Members	3
Home Help Organisers	2
Hospital Social Workers	2
GP	1
Community Welfare Officer	1
Volunteer	1
Community Care Social Worker	1

Client referrals come from several sources (listed above) with public health nurses referring the largest number of cases.

According to staff, the reasons for referral to the centre were many, and these are listed below. As might be expected, some clients were referred for more than one reason.

The supervisor stated that she could accommodate up to twenty-two clients per day if they were referred. She would take anyone believed by a referral agent to be in need of the service — or anyone else wishing to come to the day centre.

TABLE 8**Staff Explanations for Referrals**

Reason for Referral	No.
Relief for Family	9
Could not be left alone all day	3
Unable to cook for self	2
Bereavement reaction	1
Social isolation	1
Convalescence	1
Concern about nutrition	1
"Couldn't cope"	2

When clients were asked why they came to the centre they responded as follows:

TABLE 9**Clients' Reasons for Attending**

Reasons	No.
Gives me something to do	7
Enables me to get out of the house	4
Provides me with company	5
Gives me the will to live	2

All the clients interviewed expressed satisfaction with the centre and its activities and gratitude to the staff for the kind and caring attitude.

The only complaints from clients concerned a new client who is felt to have anti-social habits. The supervisor was already making attempts to isolate this client out of consideration for the others.

When asked how they spent their time at the centre, most said they chatted, read, dozed by the fire, drank tea and ate lunch.

Some said they do not participate in the occupational therapy activities either because of lack of interest or ability. Several people regularly play cards in the afternoon. Some of the women do knitting or crocheting of their own. A small number of the most confused clients do not interact with other clients at all: one or two people are minded by the other clients (as well as staff) because they wander or are disoriented.

The general level of activity at the Dublin Day Centre would seem to be quite low. But, as has been pointed out, the client group are, on average, very elderly and a large number have either limited physical mobility or mental concentration.

TABLE 10**Client Outcomes**

Number	Outcome
4	Died. (One person died at the day centre.)
3	Went into nursing homes. —Two were almost 90 years old —One was dying when she stopped attending.
1	Alcoholism problem. He just has not attended for awhile.
1	Went to live with a son after hospitalisation.

When the client list from July 1984 was compared with the current client list (February 1985) it was found that nine clients who used attend the day centre no longer attended. The table above shows what happened to these nine clients.

Client Case Histories

It may be helpful to include four brief case histories of Dublin Day Centre clients to give examples of the diverse situations of users.

- A. Mrs. S. had a stroke in her mid-sixties. She is a widow with no family, and she lives in a privately rented flat. When Mrs. S. was referred, she couldn't talk or do anything for herself. She was very depressed. Gradually over time, she has totally regained her speech, mobility and the will to live. Although she suffers from arthritis, Mrs. S. is lively and gregarious. She organises the card games at the centre and is generally one of the most active and outgoing people there. She says she would "go mad" if she could not come to the centre every day.
- B. Mrs. P. is a seventy-year-old widow. She sits at the centre with her hat on all day and tells everyone who approaches that she is going home shortly. She lives with one of her four children, a daughter who goes out to work. Mrs. P. needs to be persuaded to come to lunch or to participate in other activities but she is gentle and says she enjoys coming to the centre. She would wander if left alone.
- C. Mr. B. is a well-to-do retired man of seventy-six who suffered

a stroke three years ago. He comes to the centre one day a week because the public health nurse was worried about his wife who looks after him. Mr. B. states that the purpose of his attendance at the centre is to give the wife a needed break. The idea did not appeal to him at first, but he got used to it. He now enters into the spirit of things with great enthusiasm and is popular with staff and other clients.

- D. Mrs. D., aged seventy, was referred to the day centre three years ago to give relief to her daughter (and son-in-law) with whom she lives. Mrs. D. suffers from "confusion" and memory lapses: she cannot be trusted to be left alone because she has a tendency to wander, forgets to eat and has let strangers into the house. In interview, her daughter expressed extreme gratitude to the day centre staff for their kind care of her mother: she feels that her mother's health has improved since coming to the centre. Mrs. D. herself reports that she enjoys the people she meets there and says she would be doing "nothing" if she were not able to attend.

Centre Financing

The following table is a copy of Dublin Day Centre's Income and Expenditure Account for 1984. Of particular interest on the income side is the amount of money raised from charges to clients (listed under "Subscriptions") — £6,909 which represents almost 40 per cent of total centre income for 1984. Individual charges to clients now amount to £11 each per week: nearly all clients (or their families) pay the charges, although no one is refused service for not paying.

Donations and fundraising represent less than 5 per cent of the centre's total income. Fundraising activities last year included a sponsored walk, a pub evening, and a raffle. The supervisor (and her family) and other staff were directly involved in all fundraising projects, organising activities, selling tickets, etc.

The Eastern Health Board grant (which has remained the same for three years) covers slightly more than 50 per cent of the centre's running costs. Meals are contributed to the centre as a grant-in-kind.

On the expenditure side, transport expenses are the single largest item, followed by wages. The supervisor is paid £55 a week, and each of her assistants receive £25 a week. The total staff wages amount to

TABLE 11

Income and Expenditure Account for the year ended 31st December 1984

	IR£	IR£
INCOME		
Donations	657	
Subscriptions	6,909	
Proceeds from Fund Raising	809	
		8,375
Grants Received — Eastern Health Board		9,000
Bank Interest Received		7
		17,382
Less EXPENDITURE:		
Travelling	8,227	
Wages	7,152	
Light and Heat	255	
Food	798	
Rent	500	
Insurance	52	
Telephone	262	
Less Refund Received	93	
		169
Outing		90
Hairdressing and Chiropody	475	
Less receipts for Hairdressing	264	
		211
Accountancy Fees		200
Bank Interest and Charges		4
Sundries		133
		17,791
Excess of Expenditure over Income		409

just over £7,000 annually. Wages have also remained static for three years. Programme related expenditure, not including food, (but including outings, hairdressing and chiropody subsidies, and "Sundries") totalled £434 in 1984.

The Future

The supervisor reported two main concerns regarding future operations of the day centre. The first is continual worry about finances and the

difficulty of providing the type of service she would like to offer at present income levels. She feels frustrated at having to manage the day-to-day running of the centre (and care of individual clients) and also worry about fundraising at the same time.

The supervisor is also concerned about future staffing arrangements. Two of the care assistants are over seventy years of age, and it is uncertain how long they will be able to continue to work at the centre. If something happens to them, the supervisor is doubtful about the possibility of recruiting someone to work in their place (especially at the going wage level).

CHAPTER FOUR

Theoretical Perspectives

Community Care Objectives

Community care services, including day centres in the Eastern Health Board are broadly aimed at keeping elderly people out of residential institutions. Other alternatives to residential care include domiciliary services such as visiting nurses, home helps, and meals on wheels. Boarding out arrangements are another option.¹ The advantages offered by these community services include the following: they maintain or increase the independence of users; they allow for the harnessing of community goodwill and neighbourly resources; and they may be cheaper to provide than institutional care.² In recent years, focus has been on the economic arguments for choosing community services over residential services.³

Day Centre Objectives

According to policy statements,⁴ day centres are believed to have unique value among community services: they prevent loneliness and social isolation of the elderly (particularly those who live alone); they facilitate the provision of certain services to the elderly; and they give relief to carers of the elderly (usually family members who are often elderly themselves).

Individual health authorities and providers define other aims and objectives of day centre services as well.⁵ The provision of basic physical care and protection (i.e. feeding, toileting, and the provision of a safe, secure environment) figures prominently as a perceived day centre function. This sometimes means nursing care, when nurses are available, but more often it means minding or tending. Monitoring or surveillance of elderly clients who might somehow be "at risk" was mentioned as

another service objective, as was the dissemination of information about social welfare entitlements, aids or other services.

It is a critical weakness in the community care system as a whole that service objectives, including day centre objectives, have not been developed in sufficient detail to give meaningful direction to service operations and development. Day centre objectives have never been adequately defined in relation to the objectives of other services for the elderly. Priority among sometimes conflicting objectives has never been established. Finally, it will be argued that present service objectives are narrow and reflect ageist assumptions⁶ about day centre clients, which may underestimate clients' potential for positive change, and certainly limit the possibilities of using the service more constructively.

Day Centre Objectives in Relation to other Service Objectives

The relationship between day centre objectives and the objectives of other services for the elderly is not very clear. Interviews with Health Board officials and service providers suggest that there is confusion concerning the difference between the respective roles of social clubs, day centres and day hospitals in meeting the needs of the elderly. Indeed, under the present system, the referral of elderly people to particular services is more a function of their geographic proximity to users than of their particular ability to meet individual client needs.

According to policy documents⁷ the critical difference between day hospitals and day centres is that, in theory at least, day hospitals have a medical orientation and day centres have a social or welfare orientation. Day hospital objectives include assessment, treatment and rehabilitation: day centre objectives do not. Theoretically, elderly people in need of medical treatment (but not residential treatment) would be referred to day hospitals, while those whose needs are primarily social would be referred to day centres.

In practice, the distinction is not so obvious, apart from the difference in service setting. Day hospitals and day centres share certain objectives: both aim to keep people in the community; both work towards the prevention of social isolation; and both facilitate the provision of certain services to the elderly.⁸ The actual services provided by each may also be very similar. The National Council for the Aged note that some day centres provide hospital-type services like physiotherapy, occupational therapy, chiropody and bathing. They add that the hours of attendance

and transport arrangements at day centres may also be similar to day hospitals.⁹ Carter suggests that day hospital programmes in Britain may offer fewer medical, diagnostic and treatment services than is generally assumed¹⁰ because of lack of resources to do so. If the same were true in Ireland, the distinction between day hospitals and day centres would, in practice, become even more blurred.

The distinction between day centres and social clubs (active retirement associations, etc.) is similarly unclear: there is considerable overlap between the two and confusion about the difference between them under the present system.

It would appear that more thought needs to be given to the service objectives of social clubs for the elderly, day centres and day hospitals. The distinguishing features of each and their respective abilities to meet the needs of particular client groups needs to be clarified — as well as the way in which services might complement each other under a co-ordinated system of care. Resources could then be committed to developing programmes to meet the distinct objectives of each service, i.e. to providing the necessary medical and physical rehabilitation facilities to day hospital patients and to developing the social and other non-medical programmes at social clubs and day centres. The allocation of resources and the referral and admission of clients to services would then become more rational and more sensitive to the needs of all categories of elderly clients.

Priorities between different Day Centre Objectives

Most of the Health Board officers and day centre providers interviewed would acknowledge roughly the same day centre objectives, earlier described. However, they would not necessarily agree about the relative priority to be assigned to different objectives. In this there would appear to be little or no guidance from written policy statements. Individual providers or Area Health Board officials (if they take an active interest are left to determine the priority to be given to sometimes conflicting day centre objectives and to the needs of different target groups. Under the present system, providers who see it as their main objective to prevent the social isolation of those who live alone, for example, may give much less attention to meeting the needs of relations or neighbours who care for dependent elderly people in the community, and vice versa.

Relief to carers of the elderly was not immediately included by some respondents as an aim of day centre services at all. In the extreme, a

few supervisors consider relief to carers to be altogether secondary to the main objectives of the service. In one Community Care Area, the service is reserved for categories of "at risk" elderly only: elderly people with families who are involved (to any extent) in their care would not be considered to be "at risk" and therefore would not routinely receive priority as potential day centre clients.¹¹

Most voluntary day centres in the Eastern Health Board have open admission: clients are accepted as long as there is space (or transport) for them. At these centres, the ranking or service objectives may not be a big issue in so far as it does not prevent clients from having initial access to services (although it may influence the responsiveness of services to individual client needs). At statutory day centres, however, where clients are screened and decisions made about which clients to accept, priority of objectives becomes immediately important. Clients whose needs are given the highest priority will be given day centre places over those whose needs are considered to be less critical. Old people whose circumstances are similar may be given priority at some centres but will be denied access to services at others, depending upon staff definition and ranking of service objectives and target groups. To ensure equitable treatment of potential service users, admittance criteria should be clear and consistent within and between Community Care Areas. Clarification of day centre objectives and priorities may contribute to a more efficient service even if it means that some clients who are now "admitted" to day centres are in future screened out. Ultimately it will lead to a fairer and more rational distribution of scarce resources.

Narrow Objectives

The objectives most frequently mentioned by planners and providers of day centre services emphasise the maintenance of custodial aspects of care of the elderly.¹² The social benefits old people derive from mixing with peers at a day centre are widely acknowledged, but the minding, monitoring, basic physical care and protection elements of care still predominate in present day centre programmes.

While the present limited objectives are, by all accounts, being achieved quite successfully, there is evidence to suggest that day centres could be accomplishing much more with elderly clients. The social value of present programmes to clients could be greater with more thought and direction: other gains could also be made if the potential of both clients and the service itself were acknowledged. In the Eastern Health

Board, day centre services, are usually discussed as ends in themselves: service objectives imply a long-term "end of the road" solution to permanent, chronic conditions of old age. The possibility that day centres might be used to achieve short term objectives, either in relation to other services or in terms of individual client needs appears never to have been really explored.

Below is a discussion of day centre objectives which reflect a more optimistic view of elderly people's potential for positive change and a broader interpretation of what might be achieved by day centres with this client group.

1. **Short-term Assessment.** Day centres could be used in the short-term for the assessment of vulnerable elderly people, some of whom would be referred on to other services after the initial assessment period. Based on experiences in a Sheffield day centre for elderly confused clients,¹³ Mendal suggests that day centres can provide a lengthier period of observation than once-off examinations (or hospital stays which disorient patients and thus distort assessments). He notes that monitoring of day centre client behaviour could help to sharpen present diagnostic tools: problems of elderly people could be identified earlier and more accurately.¹⁴
2. **Education and Self-development.** Day centre clients in the United Kingdom¹⁵ and the United States¹⁶ are sometimes given the opportunity to acquire knowledge and learn new skills. One day centre in Washington, D.C. lists the following under "Educational Activities": classes in drama, Spanish, creative writing, cooking, history and physical fitness.¹⁷ In Northern Ireland, staff from at least one vocational training college teach courses to even quite elderly day centre clients as part of the regional adult education programme.¹⁸ Obviously such programmes may not be suitable for very dependent, confused clients, but for many users, benefits could be great.
3. **Preparation for Residential Care.** At least one day centre in England¹⁹ aims to prepare a percentage of its elderly clients for life in a residential institution, and this is a service objective which should also be considered. The day centre is seen as providing a gradual transition from independent living to institutionalisation, and day centre attendance is interpreted as a

first step towards relinquishing the freedom and independence of life in the community. Programmes are developed with this in mind. Research has shown that preparation for residential care can be important to a healthy transition for many elderly people.²⁰ Since many day centre users leave day care for residential care, it is appropriate that day centres should be used in this way.

4. **Rehabilitation.** Although the word is not mentioned in policy documents or statements of day centre objectives, rehabilitation is an implicit aim of day centre services. The services most often mentioned by Health Board officers as being necessary to full day centre service are physiotherapy and occupational therapy which are usually thought to be instrumental to the achievement of the physical rehabilitation of clients. While this is one important aspect of rehabilitation (and some day centres here do include it as an objective), many day centres elsewhere also aim to facilitate the mental or psychological rehabilitation of elderly people experiencing problems associated with depression and other forms of mental illness. Some centres in Northern Ireland form links with the psychiatric services:²¹ elderly out-patients are referred to day centres where programmes are developed (in close co-operation with medical personnel) to manage and rehabilitate them. The experience is that some clients improve to the point where they no longer need day centre services. Recent proposals to reorganise the psychiatric services in Ireland²² place emphasis on the importance of community oriented services (including day care) to the prevention and treatment of psychiatric illness in elderly people. If day centre objectives were interpreted more broadly, day services could complement specialist hospital services and play an important role in helping to maintain elderly people in the community in a co-ordinated system of psychiatric care.

Below is a specific set of day centre objectives developed by staff at a voluntary day centre for the elderly in Belfast.²³

1. Prevention of social deterioration or clinical deterioration.
2. Improve social skills and the ability to form relationships.
3. Relieve the family and neighbourhood.

4. Provide opportunities to pursue activities.
5. Provide friendly support.
6. Help the clients to lead as full and independent a life as possible.
7. Link the client to community resources.
8. Provide an opportunity for the client, where possible, to be included in the running of the centre. (It is important that these are "real" jobs with responsibility to achieve maximum potential.)
9. To assess how the client can use the day centre to meet his/her own individual needs.
10. Provide support over critical periods.
11. Help the client towards personal growth and achievement.
12. To ensure, at all times, that the personal dignity and worth of the client is protected.
13. To understand the role of the centre in the community and understand the importance of effective communication between the centre and health visitors, district nurses, social workers and other voluntary bodies, community, police, etc.
14. To provide a stimulative and indicative environment to help the client towards self-actualisation.

Service objectives provide direction to day centre activities and, since they reflect staff attitudes and expectations, they can make a dramatic difference to the way in which services are delivered. Objectives which focus on "looking after" elderly people may motivate staff to patronise clients and to concentrate on doing things for them. Objectives which assume that it is possible for elderly people to grow and develop may concentrate more on building up their confidence or skills so that they can then begin to take more responsibility for themselves. The day centre activities may look much the same superficially, but the outcome could be quite different. The acceptability of the service to clients could also be influenced.

Custodial Care

Present day centre programmes tend to emphasise the maintenance or custodial aspects of care of the elderly,²⁴ and this reflects the limitations of present day centre objectives, as discussed above.

The "custodial" approach to care is manifested in several ways. First,

day centre users are treated as passive recipients of services in very many cases. Clients are rarely involved in the organisation of activities or in the provision of services. Staff usually speak about doing something *for* clients or of giving something *to* them. A clear distinction is made between staff and users, even in cases where staff are unpaid and are elderly themselves. While many elderly clients may expect services to be delivered in this way, Whitaker and Garabino²⁵ argue for the importance of permitting even frail elderly people to engage in what they call "reciprocal exchanges". They note that if too much stress is placed on the one-way delivery of physical care to the elderly, the demand for that type of care may increase (i.e. dependency increases): lonely people especially will substitute it for reciprocal personal relationships. They urge practitioners to devise strategies of care that maximise elderly clients' own inner resources to help balance the exchange between them and care staff.

Second, day centre activities generally involve the segregation of elderly users (and providers) from other age groups, and this is another manifestation of "custodial care". Providers may believe that elderly people wish to remove themselves from the mainstream of life and be catered for in isolation. It may reflect the belief that elderly people have nothing to contribute to younger age groups — or have nothing to gain from experience with younger people. Or it may simply be that it is easier to manage elderly people in groups on their own. Although some day centres are located in buildings which also house facilities for other age groups, shared activities are rare, apart from the occasional concert or party given *by* the younger group *for* the elderly.

Third, centre activities and programmes are much the same for all categories of clients: the similarities are striking between centres. The programme described for the physically disabled at one centre, for example, does not differ from that offered to the physically fit or mentally confused clientele at other centres. Little allowance seems to be made for the particular needs of different client groups or of individual clients.

Centre programmes are geared mainly to women. While men are not expected to participate in the female pursuits that dominate the occupational therapy programme, (for example, knitting, sewing, rug-making) no special programmes are devised for them. Men are left to occupy themselves by reading newspapers or chatting with each other. Similarly women who are either uninterested or unable to participate in activities are also left largely to their own devices.

A More Positive Approach to Care of the Elderly

Contrast to the custodial model is found in the "horticultural" model of residential care which places emphasis on the growth of the individual in care.²⁶ Investment (in staff time and energy) is made in developing programmes designed to foster growth and positive change in individual clients. Staff expectations and attitudes are as important as physical facilities and finance to the development of programmes with a "horticultural" emphasis. There is evidence to suggest that this model could be applied to day care of the elderly with positive results in terms of improved functioning of individual clients and increased engagement of clients and staff in mutually satisfying activities.

In Northern Ireland, Faith Gibson²⁷ has developed simple tools that can be used to implement a "horticultural" approach with day centre users. Photographs, slides and objects from the "old days" are presented to encourage elderly people (in groups) to reminisce and relate their own experiences to what they are being shown. Even very withdrawn elderly people in psychiatric institutions have been stimulated by such experiences to communicate with others and share bits of their own personal history. Reminiscence techniques (also employed in Great Britain²⁸) cost little and could be used by staff with little or no special training.

In some cases a pet dog, cat or even fish²⁹ have been used to engage the interest of elderly people at day centres and residential institutions. Pets also give users the opportunity to assume responsibility in the centre (i.e. care of the pet).

In one day centre³⁰ knitting, a routine day centre activity, was invested with special purpose which generated great excitement and enthusiasm among clients. One client suggested that vests be knitted to send to Ethiopia. Clients were given freedom to choose and mix colours of wool, and goals were set concerning the number of vests to be completed by a certain date. This project fostered individual feelings of self-worth and capitalised upon the talents of the clients involved. The activity itself is not unusual, and it did not require a huge financial investment, since most of the wool was donated. The unusual thing about the project was its goal orientation: it was particularly satisfying for clients to know that they were doing something useful for others — to know that they too could contribute to the famine effort.

Another way to develop a more positive approach to day care for the elderly is to foster links between day centre clients and other community

groups. Younger age groups, including children, might be approached with a view to promoting communication and understanding between them and the day centre clients, to enrich the experience of each. Sandymount Day Centre, for example, has entertained groups of national school children who are encouraged by their teacher to chat with individual old people and to learn from them (about life in Ireland long ago, or about what school was like when the old people were children, etc.). The school children are then asked to write essays about old people who impressed them. These visits provide a learning experience for the children as well as an opportunity to enhance the self-respect of the elderly by engaging them in dialogue about themselves and putting value on their life experiences.

Elisabeth Kubler-Ross³¹ suggested the creation of what she called "E.T. Centres" where Elderly people and Toddlers are cared for together to their mutual benefit. The children benefit from being able to receive the individual attention of old people who would, themselves, gain from having the opportunity to carry out a useful role. A less drastic proposal (in terms of organisational implications) would be to foster links between individual children and individual day centre clients, using existing facilities. The centre in our case study (Chapter Three) is located across the corridor from a day nursery for pre-school children. It is possible that with imagination and direction, such a project could achieve success at this centre on a small scale. Foster grandparent schemes³² have been developed in the United States successfully along similar lines (although not necessarily from day centres).

Finally, contacts with other groups of elderly people (at lunchtime for example) could be encouraged with the aim of integrating dependent day centre users with more active elderly in the community (e.g. from Active Retirement groups or social clubs for senior citizens). Such links which have already been developed in some places on an informal basis, could stimulate interest and enthusiasm among both groups and make day centre clients less isolated from their peers in the community. Programmes could also be developed to put day centre clients into contact with Welfare Home residents. In at least one case in the Eastern Health Board Region, a Welfare Home is situated on the same grounds as a day centre, and yet there is no contact between their respective clients. Combined programmes could both enrich the experience of clients of each service and also promote co-ordination of services.

Superceding the development of group programmes, such as those outlined above, should be the development of individual goal-oriented

plans for each old person who attends a day centre on a regular basis. These plans do not have to be very sophisticated, but they should at minimum specify: the reason why the person was referred to the day centre; what benefits it is hoped will be derived from day centre services; suggestions about how best to meet client needs within the centre; and information about family members or other individuals who might be included in decisions being made regarding care of the client. Individual client plans will help to direct staff towards developing ways to effect positive change in individual clients. It will also help staff to relate centre programmes and activities to service objectives.

CHAPTER FOUR

Notes

- ¹ See R. Gilligan, *Home from Home?* Report on Boarding Out Schemes for Older People in Ireland. National Council for the Aged, Dublin, 1985.
- ² Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow*. Report of a Working Group, (unpublished), 1982, pp. 88-89.
- ³ National Planning Board, *Proposals for Plan, 1984-87*, National Planning Board, April 1984, p. 313.
- ⁴ Eastern Health Board, *Care of the Aged Report* (unpublished), 1980, and Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow: Report of a Working Group*, (unpublished), 1982.
- ⁵ Interviews with day centre staff and Health Board officers, Spring 1985.
- ⁶ Cherry Rowlings, *Social Work with Elderly People*, George Allen and Unwin, London, 1981, p. 22 describes ageism as "... prejudice ... against people on account of their age."
- ⁷ See Interdepartmental Committee on Care of the Aged, *Care of the Aged Report*, Stationery Office, Dublin, 1968, pp. 67-68, Eastern Health Board *Care of the Aged Report*, (unpublished), 1982, p. 104, and National Council for the Aged, *Day Hospital Care*, Report No. 1, National Council for the Aged, Dublin, 1982.
- ⁸ National Council for the Aged, *Day Hospital Care*, Report No. 1, National Council for the Aged, Dublin, April 1982, pp. 2-3.
- ⁹ *Ibid.*, p. 8.
- ¹⁰ Jan Carter, *Day Services for Adults: Somewhere to Go*, George Allen and Unwin, London, 1981, Chapter 8.
- ¹¹ Interview, Director of Community Care, Spring 1985.
- ¹² Steven H. Zarit, *Aging and Mental Disorders*, The Free Press, New York, 1980, p. 258.
- ¹³ J. Mendel, "Confusion Unconfounded", *Community Care*, No. 227 (August 16, 1979), pp. 19-20.
- ¹⁴ *Idem.*
- ¹⁵ Jan Carter, *op. cit.*, Chapter 13.
- ¹⁶ Sheila B. Kamermann and Alfred J. Kahn, *Social Services in the United States*, Temple U. Press, Philadelphia, 1976, Chapter 5, pp. 313-386.
- ¹⁷ *Ibid.*, p. 347.

- ¹⁸ Interview with Social Work Advisor to the Minister for Health, Northern Ireland, in Belfast, August 1985.
- ¹⁹ Jan Carter, *op. cit.*, pp. 267-273.
- ²⁰ P. Brearly *et. al.*, *Admission to Residential Care*, Tavistock Publications, London, 1980.
- ²¹ Interview with Director of Newington Day Centre, Belfast, August 1985.
- ²² Study Group on the Development of the Psychiatric Services, *The Psychiatric Services — Planning for the Future*, Stationery Office, Dublin, December 1984.
- ²³ Imelda Graham, "Staff Supervision in a Voluntary Setting", Paper submitted in partial fulfillment of the Certificate in Social Services Course requirements at the Ulster Polytechnic Institute (unpublished), Belfast, February 1983.
- ²⁴ Martin Davies, *The Essential Social Worker*, Heinemann, London, 1981, p. 86 and Peter Barclay, *Social Workers, Their Roles and Tasks*, National Institute of Social Work, Bedford Square Press, London, 1982, Chapter 4, discuss residential care models which are relevant to day care of the elderly.
- ²⁵ James K. Whitaker, James Garabino and Associates, *Social Support Networks*, Aldine Publishing Co., New York, 1980, Chapter 5.
- ²⁶ Davies, *op. cit.* and Barclay, *op. cit.*
- ²⁷ Faith Gibson, Lecture at Arthur Guinness & Son, Ltd., St. James's Gate, Dublin, July 1985.
- ²⁸ Cherry Rowlings, *op. cit.*, pp. 60-64.
- ²⁹ There is a fish tank at the Leopardstown Park Hospital Day Care Centre, and elderly clients take responsibility for feeding the fish and keeping the tank clean.
- ³⁰ Newington Day Centre, Belfast, Interview with Centre Supervisor, July 1985, Dublin.
- ³¹ Elisabeth Kubler-Ross, Lecture in Trinity College, Dublin, September 1984.
- ³² E. Matilda Goldberg and Naomi Connolly, *The Effectiveness of Social Care for the Elderly*, Heinemann Educational Books, Ltd., London, 1982, p. 173.

CHAPTER FIVE

Day Centre Staffing

In Ireland, services for the elderly have developed mainly in the voluntary sector. Voluntary organisations continue to provide the bulk of non-medical domiciliary and community care services to the elderly, including day centre services. There are several advantages to the employment of the voluntary sector for service provision: voluntary organisations are believed to provide a more flexible, personal service than is possible in the statutory sector; they are more local and may be more acceptable to users of services; they provide opportunities for people in the community to gain the personal satisfaction of giving of their time and talents; and, not insignificantly, the services provided by voluntary organisations typically cost less than State-provided services.¹

But there are also problems generally associated with reliance on the voluntary sector to meet the needs of any category of people,² and some of these surfaced in the course of this research on day centres for the elderly. First, table 5 showed that day centre services, developed mainly by the voluntary sector, are distributed unevenly across the Eastern Health Board, with obvious implications for clients and potential clients. Second, the research suggests that programme development has been seriously limited by the lack of trained expertise with the result that the needs of some individual clients may not be met. Finally, interviews with directors of community care and area administrators point to increasing difficulties associated with recruiting volunteers for day centre work. This is seen by many of those interviewed to be the single biggest problem to future day centre service development, but a diminishing volunteer workforce will also eventually affect the quantity and quality of services at existing voluntary day centres and so is critical to the continuation of services to old people in need of them.

The following discussion focusses on two staffing issues which are relevant to weaknesses in the present day centre system in the Eastern

Health Board: (1) the need for the employment of more trained personnel; and (2) the need for volunteer/voluntary staff training and development. The two are obviously interrelated.

Trained Personnel: Direct Work with Clients

One of the most often articulated aims of day centres is to facilitate the provision of certain services to the elderly, but the reality is that the trained staff necessary to the delivery of these services have never been allocated to Community Care in the Eastern Health Board. As a result, day centre clients are not receiving the services that many Health Board managers consider necessary to an adequate day centre service.

1. Physiotherapy

Physiotherapy is specifically mentioned in policy documents³ and Health Board officials' statements as a prerequisite to full day service, but it is almost never available to day centre clients. There are few, if any, physiotherapists directly employed by the Community Care Programme, and most centres lack the funds to employ outside physiotherapists or to buy the necessary equipment so that it can be offered.

2. Occupational Therapy

Occupational therapy is widely considered to be another requisite day centre service. While most centres are visited by an occupational therapist (employed by the Health Board), therapists are generally only able to give one or two hours of their time, every week or every two weeks, to groups of twenty or more people at a time. The value of such inputs is questionable. Where centre staff carry out occupational therapy exercises in the absence of the trained therapist, it may be of considerable value, but such follow-up may be very patchy.

3. Speech Therapy

Although there are few references made to it in discussions about day centre services, speech therapy is critical to the rehabilitation of some elderly stroke victims and, as such, should be available to those day centre clients who need it. However, there are very few speech therapists employed by the Eastern Health Board and their work is mainly confined to children.

4. Public Health Nurses

Although nursing care is not usually mentioned as being necessary to

the achievement of day centre objectives, public health nurses do refer clients to day centres and sometimes participate in day centre programmes. In some cases they bathe clients and provide basic physical care (changing bandages or dressings, giving medication, etc.); in others they may be involved in the organisation of centre activities. The impression given by centre staff is that public health nurses have a valuable contribution to make to day centres, but that present involvement is minimal and sporadic.

5. Social Work

Social work services are available only to very few day centre clients or their families. Although social work is rarely considered by Health Board officers interviewed to be essential to day centre services, social workers are involved in day centre service development and delivery in other countries, and the literature gives many examples of ways in which they might be employed. Social workers could first be used to do short-term crisis work with individual day centre clients. An Eastern Health Board Working Group observed that it is appropriate for social workers to work directly with individual elderly people who have been referred for "social problems".⁴ Goldberg and Connelly⁵ suggest that some elderly clients may periodically need short-term intensive casework or counselling, e.g. in times of crisis when even minor events can upset the precarious balance of factors upon which depends some elderly clients' health and well-being. Social workers could work to support families of individual day centre clients, many of whom are under great stress as a result of the demands made upon them in the care of their elderly relations. Short-term work with individual family carers (or even neighbours) and groupwork with a number of carers could help to prevent breakdowns in caring arrangements, could diminish the personal costs to individual carers and could possibly reduce the necessity for residential care.⁶ Social workers could also be employed as day centre supervisors as they sometimes are in Northern Ireland, the United States and Great Britain. Barclay considers that social work knowledge and skills in assessment and evaluation make social workers suitable managers of day or residential services.⁷

Trained Personnel: Indirect Work with Day Centre Staff

Apart from directly delivering the services discussed above, trained staff could also be employed to support the efforts of voluntary workers who

provide services to day centre clients. The National Social Service Board observes that most voluntary bodies need professional support to survive and develop. Support is needed at two levels: initially when objectives are being defined, structures established and services started; and on a continuing basis to monitor progress and assess new developments.⁸

At the first level, professionals could help to recruit, organise and train day centre volunteers, something in which no investment has been made up to now. Davies⁹ observes that volunteers can be valuable resources but that time and expertise are required if their needs and the needs of clients are to be met. The decline in the number of volunteers reported by Health Board managers and day centre staff suggest that more aggressive efforts are required to attract volunteers to day centre work and to keep them there.

In the early stages of service development, professionals could also help voluntary groups with information, funding and administration and could assist the Health Board in assessing the strengths and feasibility of voluntary initiatives.^{10,11} Professionally trained workers could help to give voluntary groups confidence and improve their ability to negotiate with funding agencies,¹² (including the Health Board and perhaps the housing authorities). At present, voluntary committees are often composed of people with little experience of "working the system": they may be cautious or afraid to take the risks involved in setting up a new service that will be dependent upon grant funds, or they may be poor at promoting their case to the statutory authorities.

At the second level, on a continuing basis, professional assistance to voluntary providers is equally important. Professionals could act as resource persons to keep groups up to date on social welfare/social service developments, funding opportunities and developments elsewhere in day care for the elderly. They could provide necessary continuity to voluntary groups that, by nature, are subject to periodic changes in membership, inflexibility in adapting to changing conditions, and personality conflicts between individual members (all cited by directors of community care as particular problems in the voluntary sector). Professional expertise could be applied to motivate volunteers and sustain their participation in groups thus helping to maintain a consistent service to clients over time.

There is a strong case to be made for the employment of professionals (e.g. social workers, community workers, nurses, occupational therapists, teachers, psychologists, etc.) to work directly with clients and to support day centre staff and voluntary day centre committees. The

continued participation of the voluntary sector in the development and delivery of day centre services and the quality of services to clients and their families could both be positively influenced by the introduction of trained staff into the system.

Volunteer/Voluntary Staff Development

In the absence of trained personnel to do the work described above both with clients and staff, most day centres in the Eastern Health Board are operated by untrained volunteers or staff earning very small wages paid from Health Board grants. These are the "unsung heroes" of the present system — middle-aged to elderly women who found "jobs" in day centres as a result of personal interest in the elderly and years of experience as volunteers in the community. In some cases they may be members of a club or larger sponsoring organisation, but often they operate as a separate small, dedicated core group.

The case study gives an idea of the level of wages being paid to workers in voluntary day centres.

The supervisor is paid £55 a week and her helpers each receive £25 a week (as of 1985). These wages are low in comparison with wages of other workers in similar jobs. For example, the wage scale for Eastern Health Board child care worker trainees was £7,858 to £8,578 in October 1985.¹³ AnCO trainees at the same time received a minimum of £29.75 per week.¹⁴ We do not know exactly how the wages of workers in other voluntary day centres compare to the case study workers, but most centres receive such small grants that it would be impossible to offer wages much more generous than those quoted. (Of course, many or most workers receive no wages at all for work at day centres for the elderly.)

As well as being unsupported financially, voluntary day centre staff receive little in the way of other types of support for their work. There are no courses available to help day centre workers acquire skills and knowledge about care of the elderly as there are for child care workers (to learn about children and child development), for example. There are no workshops or conferences or any other forum where day centre providers up to now are able to discuss problems of mutual interest or to compare notes on service developments which affect them or their clients. Nor is there any organisation to defend their rights or promote their interests.

Voluntary day centre staff are relatively isolated from other personnel

involved in the planning or delivery of community services to the elderly (except in cases where public health nurses have taken a particular interest in a centre and its clients). For the most part, there is no routine systematic way in which their views about services or individual clients can be shared with other workers, although their day to day work experience might make them knowledgeable about needs of the elderly in their area.

It is desirable that voluntary organisations and individual volunteers continue to participate in day centre provision, ideally in partnership with trained professionals, for reasons outlined at the beginning of this chapter. Given the current financial climate in which Health Boards must operate, it may be some time before trained personnel can be employed. Whether or not trained workers ever become available, it is necessary to consider ways in which voluntary providers can be better supported in the important work that they do to keep the system going.

There are several ways in which this could be accomplished. The development of minimum standard wage scales is one obvious way to support day centre staff. Training is another way. Training courses for day centre supervisors could be developed: to help relate individual centre activities to regional or national day centre objectives; to improve staff management skills; to develop programme planning skills; and to provide an opportunity to recognise the contributions and expertise of supervisors.¹⁵ Training courses could offer support and direction to an already good service. The quality of services, particularly sensitivity to individual client needs, would undoubtedly improve as staff acquired information and skills.

In-service courses for other day centre staff should also be considered. These could be offered outside the centre, and ultimately lead to some type of qualification. AnCO might be approached to assist in the development of a course for care attendants, for example. A small start — one day seminars or workshops organised by the Health Education Bureau, and conducted by outside consultants, might stimulate interest and be more acceptable to staff who feel that they do not want to take on an entire course. Meetings between staff at different day centres once or twice a year could provide opportunities for sharing or exchanging skills. Topics for discussion might include the ageing process, staff attitudes to the elderly, management strategies, groupwork skills, etc.

Less formal staff development within day centres could also be encouraged (but depends to some extent upon the supervisor already having had some training). One such programme developed in Belfast¹⁶ by a

voluntary day centre supervisor with social work training, included the following elements: (1) explanation of centre aims and objectives; (2) identification of individual staff development objectives (and ways to achieve them); (3) knowledge about the causes and effects of abnormal behaviour particularly in the elderly; (4) supervision and (5) evaluation. The experience of this supervisor is that her staff were enthusiastic about such training opportunities and derived great satisfaction from acquiring knowledge and skills in this way.

One other way in which day centre staff could be acknowledged and supported would be to give them the opportunity to contribute ideas and information about clients and services when decisions are being made about individual elderly people or when services are being developed or expanded. This may already be done informally in some instances, but a formal and structured approach (e.g. invitations to a regular monthly meeting, scheduled case conferences, etc.) would ensure that staff are automatically included in the decision-making process. Apart from improving services (and the co-ordination of services) over time, such inputs would enhance staff self-respect by giving official recognition to them as valued participants in the planning and delivery of services.

CHAPTER FIVE

Notes

- ¹ National Social Service Board. *The Development of Voluntary Social Services in Ireland: a discussion document*, NSSB, Dublin 1982.
- ² Sir John Wolfenden (Wolfenden Committee). *The Future of Voluntary Organisations*, Croom Helm, London, 1978. Ch. 12.
- ³ See Eastern Health Board, *Care of the Aged Report* (unpublished), April 1980 and *Geriatric Services in South Dublin, Wicklow and Kildare: Report of a Working Party*, (unpublished) 1982.
- ⁴ Eastern Health Board, *Geriatric Services in South Dublin, Wicklow and Kildare: Report of a Working Group*, (unpublished), 1982, p. 96.
- ⁵ E. Matilda Goldberg and N. Connelly, *The Effectiveness of Social Care for the Elderly*, Heinemann Educational Books, London 1984, Ch. 6. pp. 85-117.
- ⁶ See for example: Vanessa Wheatley, "Relative Stress", *Community Care*, no. 324, (28 August 1980), pp. 22-23, R. M. Moroney, *The Family and the State*, Longman, London 1976, and Eloise Rathbone-McCuan, "Geriatric Day Care: a Family Perspective", *The Gerontologist*, v. 16, no. 6, (December 1976), pp. 517-521.
- ⁷ Peter Barclay, *Social Workers, Their Roles and Tasks: Report of Working Party*, National Institute of Social Work, Bedford Square Press, London 1982, pp. 62-68.
- ⁸ National Social Service Board, *op. cit.*, p. 20.
- ⁹ Martin Davies, *Support Systems in Social Work*, Routledge and Kegan Paul, London 1977, pp. 70-72.
- ¹⁰ National Social Service Board, *op. cit.*, p. 20.

- ¹¹ See also John Lansley, "Caring for the Old: a Community Work Approach", *Social Work Today*, v. 4., no. 1 (5 April 1973), pp. 21-25.
- ¹² National Social Service Board, *op. cit.*, pp. 20-21.
- ¹³ Telephone call to Eastern Health Board, Personnel Office, 22 October 1985.
- ¹⁴ Telephone call to AnCO, Office of Research, Planning and Development, 22 October 1985.
- ¹⁵ Imelda Graham, "Staff Supervision in a Voluntary Setting", Paper submitted in partial fulfillment of the Certificate in Social Services Course requirements at the Ulster Polytechnic Institute, (unpublished), Belfast, February 1983.
- ¹⁶ *Ibid.*, pp. 23-24.

CHAPTER SIX

Funding Issues

The research into the financing of voluntary day centre services in the Eastern Health Board reveals at least four areas for discussion. The first has to do with the actual amounts of money that are being allocated to existing day centre services and the implications for providers and clients of the services. The second concerns the amount of money allocated for new day centre development, and the ways in which funding levels are determined. The third concerns the discretionary nature of Health Board funding to voluntary organisations generally. And the fourth concerns the charges that are levied to clients for day centre services. The issues involved in each of these areas are discussed below.

Levels of Funding to Day Centres for the Elderly

It would appear that a serious commitment to invest resources in day centre services for the elderly has never been made at Health Board level. This is a problem which supercedes most of the other problems in the present day centre "system" which surfaced in the course of this research. The average grant to voluntary day centres in Dublin (County) is about £5,720. (Wicklow has only statutory day centres, and in Kildare the proportion of funds spent on the one voluntary day centre is not known.) And yet it has been suggested that day centres in receipt of grants less than £9,000 a year cannot afford to offer a comprehensive day centre programme to elderly users. Staffing problems caused in part by insufficient funds have already been discussed. Day centre programme development and the availability of transport are also directly affected by current levels of funding.

It would have been very interesting to highlight day centre funding as a percentage of total community care expenditure in the Eastern Health Board. Unfortunately it is difficult to calculate community care spending

by Health Boards because Department of Health figures are mainly global figures and expenditure is divided into many different budgets under many different categories including Community Welfare Services, Allowances, Grants to Welfare Organisations, etc. However, it is our impression that total Eastern Health Board grants to voluntary day centres for the elderly constitute only a small fraction of total expenditure on grants to voluntary welfare organisations and a miniscule proportion of total community care expenditure, regardless of how this figure is computed.

1. Programme Development

The quantity and quality of day centre programmes is undoubtedly adversely affected by lack of adequate Health Board finance to services. Present unimaginative day centre activities reflect the lack of financial resources and trained staff as much (or more) as it reflects the limited expectations that some staff and Health Board managers have for services and service users. Without adequate funds, materials and equipment essential to programme development cannot be purchased. The Case Study illustrates the fact that even day centres that receive grants that are generous by Health Board standards are only barely able to cover the basic costs of transporting clients to the centre, feeding and keeping them warm and secure for the few hours a day at present funding levels. To do anything else requires more staff or money than most centres can afford. The development of programmes that are sensitive to the needs of individual elderly people, that distinguish between categories of clients and that are acceptable to clients who may most need them requires money and trained staff which to date have not been forthcoming.

2. Transport

Transport is a critical determinant of access to services, and without it many elderly people could not attend day centres at all. An Eastern Health Board Working Group recommends the careful selection of day centre sites to minimise transport problems but states that "... inevitably ... some persons will require transport facilities and if a reliable transport service is not available, it can weaken considerably the effectiveness of the centres."¹

We have seen that while most day centres in the Eastern Health Board do offer some form of transport to at least some elderly clients, centres in receipt of very small grants may offer no organised transport or may

arrange it for only the relatively few. This means that some elderly clients who are most vulnerable in terms of social isolation and loneliness are unable to attend the day centre in their area because they have no way to get there. It also means that some families caring for very dependent elderly relations get only infrequent relief from the often huge responsibilities associated with looking after someone who may be incontinent, confused or otherwise difficult. The more mobile, independent elderly people or those who have friends or relatives nearby with cars to help transport them will be at an advantage over those whose circumstances should make them a prime service target group (i.e. those who in fact may need the services more). Rural elderly people may be particularly disadvantaged in this respect. Many rural elderly are physically and socially isolated; they may also suffer bad housing conditions and have little access to other domiciliary services as well.² And yet the evidence suggests that rural elderly people have more limited access to day centre services than their urban counterparts because of the high costs of transporting them over long distances. According to interviews with day centre staff and correspondence with hospital administrators, day centre users who rely on centre transport in rural areas generally attend much less often than day centre users in Dublin who also require transport. O'Mahony suggests that strategies have never been developed to overcome service delivery problems of rural populations in Ireland; this may be one manifestation of a more general problem.³

Many urban elderly people may be similarly disadvantaged under the present system. If they are unable to walk by themselves or too frail to use public transport (if it is available) the distance to the nearest day centre doesn't matter: whether it is a few hundred yards or several miles, the old person will not be able to attend a day centre which does not provide transport unless he/she can organise it him/herself. Transportation costs are high, often the single biggest item in the budgets of centres that do provide it. (See Case Study for example.) But it will always be necessary to ensure that those clients who need services most will have access to them. Grants to day centre providers must be calculated to cover transport costs for clients who need it, at the very least.

The proposed overview of services for the elderly⁴ should include examination of transportation provision to day centre users to determine the equity of present arrangements, i.e. the influence of transport availability on user access to services as well as the adequacy of current

transport provision in relation to user needs. Costs of different types of transport need to be calculated and compared; consideration should also be given to developing catchment areas and rationalising present transport arrangements.

Plans for future day centre development should include estimates of the need of potential clients for transport. If it is determined that it is too expensive to bring clients to day centres, the possibility of developing mobile day centres (as in Scotland)⁵ should be considered. Mobile centres could operate from caravans in a similar fashion to mobile banks and book mobiles that currently travel in rural Ireland from small town to small town offering services to members of local communities on a once/twice a week basis. Alternatively, they could be set up in local premises once weekly by staff who move from place to place.

Funding for Development of New Services⁶

The development of all new health care services will be inhibited to some extent when funds are short. The ever increasing costs of existing services will be met first, leaving little room for the extension or development of services. Services like day centres for the elderly, for which the Health Board have no statutory responsibility, may be more vulnerable in this respect than other types of services for other client groups. The Minister for Health, while giving verbal support to the development of community care services, has also repeatedly declared his intention to actually reduce Government spending in the health services. Against this background, support for new services becomes even more unlikely.

Several Area Health Board representatives (in interview), suggested another problem in relation to the funding of new day centres, that is, the need for a separate development budget within which funds can be earmarked specifically for development of new community services for the elderly. Under the present system, funds must be juggled from a general capital fund, and as health boards come under increasing pressure to spend less, it will become harder and harder to find development funds. The lack of earmarked funds makes it very difficult to plan or implement plans for development at area or regional level. Requests for funding of new services are handled on an *ad hoc* basis which diminishes the possibility that rational allocation of funds will take place over the whole system.

In the absence of earmarked development funds, directors of community care are put into competition with each other for scarce general

funds. Development may depend less on estimates of need or on unevenness of existing service distribution than on individual director's abilities to make a strong case for additional funds. As noted above, the impression given is that funds for day centres could always be found if providers could be identified. But first, directors must give priority to the development of services for the elderly, and second, they must be able to argue more effectively for funds than their colleagues who are also looking for money for other projects. Service development will be inhibited to the extent that it depends upon those two factors.

The Discretionary Nature of Day Centre Funding

The Health Board is, at present, under no statutory obligation to provide or even support community services for the elderly. Services, including day centres, are funded at the discretion of local health authorities whose views about their own role (and that of the Health Board) vary considerably. Health Board representatives accept limited responsibility for helping to finance day centre services, but beyond that there is little consensus. We have seen that there are few formalised guidelines or procedures governing the allocation of funds to voluntary service providers. We have also seen that the system up to now has resulted in the uneven distribution of funds within the Health Board as well as the uneven distribution of services themselves, with obvious inequities resulting between providers and between service users. Some of the factors which currently influence the level of support received by individual day centre providers are discussed below.

1. The first factor involves the way in which individual officers interpret what they believe to be Health Board rules and regulations. In the absence of clearly defined and documented funding guidelines and procedures, it is left to individuals to determine what the rules are and how they should be applied.

For example, one administrator expressed unease about the implication of what was interpreted to be a Health Board rule, i.e. that the Health Board would only cover the difference between expenditure and income of a voluntary provider in a given year (assuming costs remained approximately the same). A case was described in which an organisation had been able to raise unexpectedly large sums of money towards day centre operations. It was explained to them that the more money they raised, the less they could expect to receive from the Health Board. It

was felt that, in a case like that, the system (as interpreted here) incorporated disincentives to fundraising by voluntary providers.

In another community care area, however, a committee which is highly thought of (at least partly because of its "colossal" fundraising ability) was rewarded for its fundraising efforts by being given three additional grants (above and beyond the agreed upon annual grant) in one year. The final grant was for double the amount requested by the committee: £3,000 was requested and £6,000 was granted "to keep them on their feet". Although in general, "good" voluntary committees (i.e. those who raise a lot of their own funds) would tend to get increased levels of support wherever possible, the above cases illustrate the way in which officials can come to radically different interpretations of authority guidelines. As a result, individual providers in similar circumstances may be treated quite differently.

2. When they come looking for Health Board funds, the different philosophies of individual directors of community care or area administrators regarding aid to voluntary organisations in general is another factor that may influence funding variations between areas. Some directors interviewed start from the premise that if committees are "just handed funds" they will not have the necessary level of dedication and commitment to their work. Unless they struggle a bit for funds, voluntary groups will not appreciate the money that is given (and the implication is that they will waste funds). At the other extreme are directors and administrators whose emphasis is on supporting voluntary providers to the largest possible extent and who are prepared to do whatever they can to get money for day centres. Requests for grants to officers holding these opposite perspectives are likely to be handled differently.

3. A third factor influencing levels of funding involves the quite different ideas or expectations held by Health Board officers about what is required (in terms of money and staffing) to operate a day centre service. Some directors and administrators expect that volunteers alone will be available and competent to staff day centres. Requests for grants that provided for staff wages would be frowned upon. But in other areas it would be assumed that a comprehensive day centre service could not be provided without salaried staff — professionals in some cases. Grants will vary according to expectations. The lack of clearly defined service objectives or standards helps to foster inconsistencies within the system.

4. There is evidence to suggest that personality factors may also help to explain differences in grant allocations. The onus is largely on the provider to catch the attention of the Health Board and promote its own interests (or that of the centre). In the absence of regular feedback mechanisms, clear funding guidelines and consistent monitoring procedures, voluntary committee members who project themselves as being efficient and enthusiastic will be looked upon with more favour than those who do not. Great "characters" will be tolerated in their idiosyncracies and given leeway that others are not. Personalities that get on particularly well with the area administrator will naturally receive a better reception when requests are made.

5. Finally, interviews with Health Board representatives suggested that one category of potential providers may be more favoured than others, namely religious. Several community care officials professed a bias towards nuns as day centre providers. "You'd feel better knowing money was in the hands of the nuns, who are more committed and dedicated to the work", said one director and other officers said they would consider a day centre proposition "safe" if they knew that nuns were involved. This puts the clients of centres run by nuns at a relative advantage over those in concerns run by lay people for reasons that have nothing to do with their need for services.

The lack of formalised funding procedures was not seen to be a problem by Health Board representatives. They repeatedly stressed the need for the Health Board to keep a "low profile" with regard to voluntary providers. It is thought that voluntary committees do not like contracts and would be suspicious of too many formalities. In any case, as one administrator put it, "We just don't do things that way in the Health Board."

Informal discussions and personal visits by Health Board representatives supplemented by a statement of financial accounts from providers, are considered the appropriate way of vetting funding proposals and keeping tabs on the way in which Health Board funds are spent.

Although there is undoubtedly a balance to be struck between keeping a low profile and interfering in the affairs of voluntary organisations, there is evidence to suggest that voluntary providers would welcome modifications in the present funding system. Day centre providers complained in interview about continuous uncertainty about the amounts of

money the Health Board would pay and long delays in payment of grant funds already committed. One committee member had received a cheque from the Health Board the day she was interviewed (February 1985) to cover expenses going back to 1983. Financial accounts of these expenditures had been submitted the previous July as requested. This was not unusual in her experience, and others gave similar reports of always having to operate in arrears.

Present funding procedures cause problems for voluntary groups already operating day centres in the Eastern Health Board, and some providers are clearly unhappy with the discretionary nature of the present funding system.

The Wolfenden Report on *The Future of Voluntary Organisations* suggests that the vagaries surrounding the issue of statutory funding to voluntary providers are not a uniquely Irish problem. Wolfenden advocates⁷ the use of carefully developed standardised procedures for making and considering grant applications from voluntary providers, based on clearly defined criteria.⁸ Voluntary organisations polled in the United Kingdom for that study expressed the view that more explicit terms for granting financial aid were badly needed. Many voluntary day centre providers in the Eastern Health Board would agree.

In the Irish context, McDaid calls for more precise funding guidelines at national level and suggests that "... the existing system of funding voluntary bodies is capable of too much irrationality to be left alone".⁹ Both Wolfenden and McDaid recommend the establishment of an intermediary body to oversee the distribution of statutory funds to voluntary providers (advisory committees at regional or community care area level) with participation of the voluntary groups as well as the statutory agencies involved. Such a body could facilitate communication between voluntary providers, between providers and sponsoring agencies and could also create a forum for clients to present their views about services. An intermediary body could also help to monitor services with a view to maintaining service standards as well as better coordination of services within regions. This would ultimately lead to a fairer system of rationing resources, and would improve service quality and distribution over time.

There is no evidence to suggest that once a centre is in operation, unhappiness with the funding system has ever caused providers to go so far as to cease operations altogether. Once day centres start operating a full service, the goodwill of staff, the needs of clients and the Health Board's desire to "see them right" appears to be sufficient to keep

centres in business. As one administrator put it, voluntary providers do not like it, but they get used to the system.

But at the initial stages of negotiations with potential providers, the lack of formal funding procedures *does* present problems which could be discouraging individuals or groups from following through on plans to offer a new service. Potential providers are rarely given indications of what exact levels of support can be expected from the Health Board. Exact figures are avoided at all stages in negotiations. Groups are told that the Health Board will make up the difference between operating costs and income "within reason", but exact limits are rarely spelled out and almost never committed to paper.¹⁰ At the stage of early development, potential voluntary providers are faced with many uncertainties — about possible sources of outside income, about the number of volunteers they will be able to recruit, and about the number of clients that will eventually turn up to use the services. The lack of definite commitments by the Health Board added to the other uncertainties surrounding the development of a new day centre means that voluntary groups must take a calculated risk or make "an act of faith" (both phrases were used by Health Board officers) before proceeding with plans to offer a new service. Health Board funding to day centres is retroactive to a large degree (i.e. providers are reimbursed for money already spent). The knowledge that a centre may have to operate "in the red" for an uncertain period (before Health Board funding comes through) is quite likely to scare off some potential providers.

Voluntary groups have been known to back down early on in negotiations with the Health Board over service development: at least one group actually gave back money which had been given by the Health Board to help develop a new centre.¹¹ Unfortunately, records have not been kept to determine how many other offers have been withdrawn and for what reasons, but financial uncertainty is undoubtedly one factor. Voluntary providers with a large organisation behind them (very few in the Eastern Health Board), or those whose faith is particularly strong may not be deterred by the financial risks involved in setting up a new day centre, but those who are not used to the system might be more easily frightened away. The Health Board argument that the latter groups would probably not have been able to organise sufficiently to provide a service anyway would be acceptable if it could be assumed that, in a given place, other more capable groups would come forward to provide the service. Unfortunately, this is not always the case.

Charges for Day Centre Services

There was no overall policy being implemented regarding charges to elderly day centre users in the Eastern Health Board at the time of this research. It had been left to individual providers to determine whether they should charge for services or not and how much to charge. Up to 1985 no specific guidelines had been officially established to determine charges for services at voluntary day centres (although a Health Board officer said that it was planned to ask voluntary providers to charge "realistic" fees for services in the near future).¹² Charges range from 25p per day (at some statutory day centres) to over £2 a day, although a few centres may not charge clients at all. (Charges are usually levied separately for hairdressing).¹³

Day centre staff said that in some cases, charges are waived if elderly clients either cannot or will not pay, but usually some attempt is made to collect fees from them or their families and in most cases these attempts are successful.

Centres that now charge for services generally give two reasons for doing so. First, it is believed that clients' self-respect is enhanced by giving them the status of "paying customers" rather than recipients of charity. The assumption is that services will be more acceptable to clients if they have to pay for them, however small the amount. The second reason given for levying charges for day centre services concerns the desire to raise revenue to meet rising service costs.

Taking the first reason, there is no evidence to suggest whether elevating elderly day centre users to paying customer status increases their self-respect. Nor can it be demonstrated that the absence of charges makes services less acceptable than fee-paying services. Day centre users, in most cases, do not have a choice between centres that charge and those that do not: users attend the centre closest to where they live (because of transport considerations as much as anything), and there are almost no neighbourhoods served by more than one day centre. It has not been shown that day centre clients prefer a fee-paying service over a free service. Nor has it ever been demonstrated that the introduction of charges would result in an increased uptake of services.

There is evidence, however, to suggest the opposite — that the introduction of charges or increases in charges may discourage elderly people from attending day centres at all. Many fieldworkers and supervisors perceive that it is sometimes difficult to persuade elderly people (who they believe most need them) to use day centre services. One

barrier to the uptake of social services by old people has been found to be their inability or unwillingness to pay for them.¹⁴ Parker notes that instead of making services more acceptable to social service clients, charges could, in fact, influence them to reject services. This could ultimately lead to a redistribution of service benefits from needy to less needy clients.¹⁵ A closer examination would need to be made of service uptake patterns and reasons for them — at centres that do charge, at those that do not, where charges have been raised, and where charges vary between centres — before it could be demonstrated that charges for services make them more acceptable to elderly users as many providers believe they do.

It may be equally difficult to justify charges to elderly service users as a revenue raising tactic. From the Health Board point of view, if imposing or raising charges for services to “realistic levels” is seen as an alternative to increasing Health Board grants to day centres, then the “savings” to the Exchequer from doing so must be considered. At day centres currently charging 25p per day, the total revenue earned in one year from charges to clients is approximately £1,250 ($= 25p \times 5 \text{ days} \times 50 \text{ weeks} \times 20 \text{ clients}$). At other centres where average revenue of £2,000-£3,000 may be realised from charges of 50p per day, for example, the amount of money raised is still only a miniscule proportion of the total budget for community health services for one year.¹⁶ Even if it were decided to raise all charges to £1.00 a day, the relative “gains” to the Health Board would be symbolic at best.

Against this very small benefit to the Exchequer must be weighed the implications for voluntary providers and users. From the perspective of individual providers, charging for services (or increasing charges) may be seen to be one way to make up deficits created by service costs that are increasing at a time when Health Board grants may be decreasing in real value. (Some area officials fear that grants may actually be cut in nominal terms in the future.)¹⁷ The other options open to providers would be: to “water down” services to the same number of clients (i.e. thereby reducing or maintaining costs); to deny users access to services so that client numbers decrease (again reducing costs); or to raise money from private sources. The latter option would allow day centre providers to continue to offer the same standard of services to the same number of clients, but voluntary groups’ relative ability to fundraise obviously varies (and that is acknowledged widely within the Health Board).

Charges to clients at centres that are able to raise the necessary funds in other ways (or those who are successful in their application for larger

Health Board grants) will remain low. But in cases where money cannot be raised, the burden of financing an increasingly costly service will fall more and more on clients who will be asked to pay higher and higher charges. (The burden will be shared by staff who will have to forego wages or wage increases.) The centre in our Case Study is one such example of the latter phenomenon. Clients at this centre pay charges that are eight times greater than those paid by clients at other centres offering roughly the same service.

The variation from area to area and the different ways in which day centres are funded inevitably result in inequities between users in the same or similar financial circumstances. The level of current charges is entirely a function of where clients happen to live. Charges have nothing to do with clients' relative need of services or ability to pay or on the quality of services received. As voluntary providers are asked to bear a larger proportion of total service costs, charging inequities may be expected to get larger.

There may be some justification for charging elderly users for day centre services on the grounds that they can afford it and should not be getting something for nothing. Present charges are not high compared to parallel services like childminding where fees average £30 a week, for example.¹⁸ Most day centre staff interviewed believe that users' Old Age Pensions or other sources of income should be sufficient to cover present charges. Further research would be required to determine if this is so, but it would seem that clients who are being transported to day centers, spend the entire day in a warm and sheltered environment, eat a hot dinner and receive certain non-medical services are getting good value for money. The charges to those clients requiring special minding or management are no higher than for other less dependent clients, and are low in comparison to other fee-paying options available to their families (including "granny sitters" and private nursing homes).

But as suggested above, charges however small, may deter a certain percentage of potential clients from ever attending day centres, or may result in the redistribution of service benefits from the needy to the less needy. If it is a social policy objective to encourage elderly people to use community services (instead of other expensive and often inappropriate institutional services), then charging practices may be found to be inconsistent with stated policy aims. Furthermore, present charging practices are resulting in inequities between clients at different centres.

If it is decided that the benefits of charging for services are greater than the "costs" and are thereby justified, then to be fair, charges should

be imposed equally on all clients in the same category, regardless of where they happen to live. A standard charge to all clients would be fairer than the present system. Clients should not be asked to pay according to the voluntary provider's relative ability to raise money and recruit volunteer staff. It would be fairer to day centre users to increase financial support to individual day centres by a few thousand pounds than to cover deficits by imposing or increasing charges on only some users in the system.

CHAPTER SIX

Notes

- ¹ Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow: Report of a Working Group*, (unpublished), 1982, pp. 104-105.
- ² Ann O'Mahony, "The Provision of the Community Care and Other Health Services in Rural Areas: A Case of Regional Inequality?" in *Future Directions in Health Policy*, Council for Social Welfare, Dublin 1984, pp. 226-244, and *The Elderly in the Community: Transport and Access to Services in Rural Areas*, National Council for the Aged, Dublin, 1986.
- ³ *Ibid.*, pp. 242-243.
- ⁴ The then Minister for Health, Mr. Desmond set up a Working Party to study services for the elderly in Ireland.
- ⁵ E. Matilda Goldberg and Naomi Connelly, *The Effectiveness of Social Care of the Elderly*, Heinemann Educational Books Ltd., London, 1982, p. 125. See also the discussion on mobile day hospitals in Dept. of Health, *Institutional Geriatric Care in Eastern Health Board Areas*, (unpublished), Dublin, undated, Appendix 4.
- ⁶ Much of the information for this section and the following sections was obtained in interview with directors of community care and/or area administrators in community care areas, Spring 1985.
- ⁷ Sir John Wolfenden, Wolfenden Committee, *The Future of Voluntary Organisations*, Croom Helm, London 1978, pp. 88-94.
- ⁸ *Ibid.*, p. 88.
- ⁹ P. McDaid, "Grants-Autonomy and Accountability", presented at an Institute for Public Administration Conference on Voluntary Effort, 29 September 1982, Dublin, p. 2.
- ¹⁰ Interviews with Area Administrators, Spring 1985.
- ¹¹ Interview with Director of Community Care, March 1985.
- ¹² Interview, Programme Manager's Office, Community Care Headquarters, January 1985.
- ¹³ Interview with day centre staff.
- ¹⁴ Erdman Palmore (ed.), *International Handbook on Ageing*, The Macmillan Press Ltd., London 1980, pp. 434-454.
- ¹⁵ R. A. Parker, "Policies, Presumptions and Prospects in Charging for the Social Services," in *Pricing the Social Services*, by Ken Judge (ed.), The Macmillan Press Ltd., London, 1980, pp. 24-45.
- ¹⁶ A letter from a Department of Health representative, 25 February 1985, gives £20,634 million as the total expenditure on Community Welfare in the Eastern Health Board in 1983.
- ¹⁷ Interviews, Spring 1985.
- ¹⁸ Telephone conversation with member Irish Playgroups Association, September 1985.

CHAPTER SEVEN

Future Development

The previous two chapters have discussed weaknesses in the present system that point to the need for changes in the way services are defined and delivered as well as in the way they are financed. The future development of day centre services will depend to some extent upon progress made in these areas.

There are other factors, however, which are critical to future service development and they include: the way in which the need for new services is determined; the availability of suitable premises; and most important of all, community care officers' perceptions of the development role of the Health Board *vis-à-vis* that of voluntary organisations. The following chapter discusses the way in which each of these factors currently inhibits service development and suggests implications for the future. Alternative development models are offered, including Beaufort Day Centre which is described in some detail.

The chapter ends with a discussion of the need for better monitoring and evaluation of services which should be an integral part of service planning and development. A role for the Department of Health in this area is suggested.

Demand as an Indicator of Need

At present, services for the elderly are developed in response to local demand for them, for the most part. If demand for a day centre is not articulated at local level, then it may be assumed, under the present system that either there is no need for it or that there are not sufficient numbers of elderly people to justify service provision.

Demand alone is not a sufficient indicator of need,¹ and in the case of the elderly, it may be a particularly unreliable barometer of need.

First, the elderly demand less of community health and welfare services

than other adult groups. They express overwhelming satisfaction with existing services (see Daly and O'Connor's study of rural elderly in Ireland, 1984² for example), and are slow to make additional demands on services. Second, there is no strong Irish lobby group (like Age Concern in the United Kingdom) to represent the interests of the elderly and press for service development. The National Council for the Aged (the most obvious potential lobby organisation) confines itself to the support of basic research because its resources are extremely limited; an advocacy role could develop in future, but up to now finances have precluded it.

Finally, the needs of the elderly are less likely to attract public attention than the needs of other groups, especially children. McCarthy, in a discussion about social justice notes that the needs of some groups (including the elderly)

. . . may be less dramatic than others and may, therefore, occupy a lower place in the consciousness of policy-makers and the community as a whole.³

He argues that health care needs of groups who are unable to promote their own self-interest should be given priority if social justice is to be achieved.⁴

Carroll⁵ suggests that the needs of the elderly have not adequately been acknowledged. He recommends that the thorough and systematic surveying of the elderly be done at community level on a regular basis and suggests that screening programmes should be aimed at identifying the five most vulnerable groups of elderly (already outlined in Chapter One). An Eastern Health Board Working Group⁶ similarly recommends the development of professional screening procedures like those already used by the Health Board for screening of infants and pre-school children. They recommend that the director of community care be made responsible for compiling comprehensive lists of elderly in each area from two sources; General Medical Service lists of medical card holders supplemented by lists supplied by public health nurses of elderly in their districts.⁷

At least one director of community care has attempted to compile such a list. He secured lists of people eligible for medical cards in his Community Care Area. But the computer lists which he received were not broken down into health centre districts, and to date he has had neither the time nor the manpower needed to organise the information

into useful form. Another director of community care approached the problem differently. He requested a list of Old Age Pensioners from the Department of Social Welfare with a view towards using it to identify vulnerable elderly in his area. He was refused the list on grounds of confidentiality of records.

More aggressive efforts are needed to accurately identify those elderly people (and their families) who could benefit from day centre services. Systems should be developed at Department of Health level which could then be applied to local level.

Scarcity of Premises

Another factor currently inhibiting day centre development is the increased difficulty of finding suitable premises. Since the early spurt of growth in the number of new day centres in the late 1960s and early 1970s, the number of community premises available to voluntary providers has decreased: at the same time, safety and health standards have improved to the point where some of the premises previously used would no longer be considered suitable. The cost of even adapting premises for use as day centres for the elderly has increased dramatically, and the building of new centres is considered to be prohibitively costly in a climate of financial restraint. The location of day centres in sheltered housing complexes or in long-term residential institutions may help to solve the problem of premises in future. Alternative development models are discussed later in this chapter.

Interpretations of the Development Role of the Health Board

Many area Health Board representatives interviewed⁸ describe what they see as the role in the development and delivery of community services for the elderly in very narrow terms. Some believe that it is not their responsibility at all, and suggest that the little they do now to support voluntary groups that provide services is above and beyond what is required of them. They point to the lack of statutory mandate for such services to underline the fact that, strictly speaking, they are not obliged to assist in day centre development or even to support it. Some Area Administrators see it merely as a kind gesture on the part of the Health Board to give day centres "the little bit of help to allow them to get on with things". Services to the elderly are perceived by some Health Board managers to be entirely peripheral to their main business which is to

see that the Health Board's statutory obligations are fulfilled (difficult enough when funds are short).

In general, local Health Board officers are content to wait for voluntary development initiatives to present themselves and consider it appropriate that voluntary groups should take the "lion's share" of responsibility for planning, staffing and delivering services to elderly day centre clients.

In one Community Care Area the director, in interview, explained the difficulties he had experienced with one voluntary committee that had been unable to find a day centre supervisor to run a new, expanded service. The development of a new service was being held up because of (what he believed to be) this committee's stubborn refusal to take responsibility for staffing the new centre. The committee in question told the director that they felt the Health Board should find a supervisor, but because he did not see this as the Health Board's role, he had refused to become involved. Service development was being inhibited in the meantime. Other examples were offered by Health Board representatives in other Community Care Areas of volunteer committees that are perceived to be similarly obstreperous or "difficult", and such committees are being blamed, in some cases, for standing in the way of service expansion or development. This is seen to be especially critical in cases where voluntary committees are already offering limited services which the Health Board say they would like to see further developed (i.e. into full day centres).

The research suggests that the Health Board's failure to accept a larger share of responsibility for services is inhibiting new day centre development as much or more than any lack of co-operation on the part of voluntary providers. Voluntary groups are doing the best they can under increasingly adverse conditions, (i.e. rising costs, diminishing numbers of volunteers, difficulties in locating premises, and health board grants which are not increased to meet rising service costs but they are grossly undersupported in their efforts to develop good services for clients.

Many Health Board representatives embrace a development model that has become increasingly unrealistic. It can no longer be expected that services for the elderly will materialise spontaneously and at little or no cost to the State. The very slow growth in the number of voluntary day centres in the past several years suggests that, if the often articulated commitment to the provision of community services for the elderly is to be realised, the Health Board is going to have to take increasing responsibility for service development. If the shift to community care is

to be anything more than rhetoric, health board roles will need to be reinterpreted and current policies and procedures analysed in terms of their effectiveness in promoting service development. New development alternatives will have to be explored and experimented with (at Department of Health level) to determine future directions of day centre development.

An Alternative Development Model

A good example of one such development alternative is Beaufort Day Centre⁹ which opened in Glashule (Area One) in 1985. It deserves special attention because of the way in which it developed and the possibilities it opens up for the future development of day centres. Located in a new sheltered housing scheme for the elderly, Beaufort's development involved the direct co-operation and joint financial commitment of two statutory authorities — Dun Laoghaire Corporation and the Eastern Health Board — at all stages of development.

The Local Authority provided space for the centre, and built it. The Health Board was responsible for the capital costs of building, equipping, furnishing and maintaining the centre, as well as the operation costs. A considerable amount of Health Board money was committed including capital grants of over £100,000 towards the cost of building and outfitting the purpose-built centre, and £14,000 per year in Section 65 grant money (and other grant monies) towards the cost of employing a part-time cook, a centre supervisor and other running costs. The Corporation agreed to build and furnish a warden's flat and the Health Board provided the wardens (who also contribute to the running of the day centre). Completed day centre premises (all on the ground floor) include a specially designed kitchen, a dining room *cum* activity room, toilets to accommodate wheelchair users and other frail elderly, shower facilities, an "examination room" (for use by a chiropodist for example), and a laundry. The Health Board took responsibility for identifying management committee members representing both the statutory and voluntary sectors in the area and was involved in the hiring of centre staff.

Apart from being an exceptionally attractive and well designed day centre, Beaufort is unusual in two ways. First, the very high degree of co-operation and joint financial commitment of the two statutory authorities involved would seem to be unprecedented in the Eastern Health Board. There are other examples of day centres that were

developed with the help of grant money from more than one statutory agency (Our Lady of Lourdes in Sean McDermott Street, and Sandymount Day Centre are two examples),¹⁰ but in these cases, the voluntary provider raised considerable funds themselves and maintained overall responsibility for development. The respective funding agencies (the Eastern Health Board and Dublin Corporation in both cases) acted more or less independently of one another. Lorcan O'Toole Centre in Crumlin (the only other day centre located in a local authority sheltered housing scheme) offers another example of inter-agency co-operation. But the Health Board in this instance assumed much less responsibility at each development stage and made no financial commitment to the project apart from grant aid towards operating costs and some assistance "in kind" (cutlery, delf, etc.).¹¹

The second unusual feature of Beaufort Day Centre's development is the extent to which the director of community care took responsibility for initiating development and following through on all aspects of planning facilities and service provision. It was observed earlier that many Health Board representatives do not believe that they have a development role to play at all in relation to services for the elderly. Others see their role in development in only very limited ways. The impression given in interview is that few directors would have taken personal responsibility for organising the selection of a management committee, much less for the actual staffing of a voluntary day centre. The director of community care in this case exhibited a high degree of interest and commitment to the development of this new day centre. He interpreted his role more broadly than many of his colleagues would, and this enabled him to play a much more active part in day centre development than would normally be the case.

Beaufort Day Centre is an attractive development model from several perspectives.

First, Beaufort proves that inter-agency joint developments can succeed. It illustrates what is possible and demonstrates that, technically speaking, there is nothing to prevent similar developments from taking place elsewhere. It opens up possibilities for meeting the needs of the elderly in new ways.

Second, this development may offer economic advantages over other options. The cost to the State of developing this new day centre (£100,000 +) is certainly lower than the cost of building a new purpose-built centre of the same standard "from scratch". It

may also be less expensive than adding day centre facilities or making modifications to older buildings constructed for other purposes. In the Beaufort case, particular economies were achieved by Health Board participation in planning from the earliest stages. The initial investment in Beaufort may appear high in relation to what has been spent on other centres, but the relative suitability and safety of a purpose-built centre is likely to contribute to a more attractive and effective service to users. If the resultant service is of a high standard then it may be considered to be more cost effective than alternatives involving a smaller initial investment.

A third reason for highlighting the Beaufort case is because it illustrates one way in which to maximise the use of resources already committed to services for the elderly. At present, the Health Board and the local authorities are each investing in separate programmes aimed at achieving similar objectives with the same client group, the elderly in the community. Joint day centre development provides an opportunity to combine complementary resources from each agency to provide a service that may be more effective and cost less money in the long run than if services were developed separately.

The local authorities routinely built common rooms (or community rooms) with fully equipped kitchens in many sheltered housing schemes for the elderly. (Dublin Corporation has 38 common rooms with only one currently in use as a full day centre. The others are reported to be largely underutilised.¹²) The justifications for building common rooms are: to provide places for elderly residents to congregate; to prevent social isolation; to improve the quality of life for elderly residents; and to facilitate the provision of services and activities (especially a meal service).¹³ These coincide with many of the stated aims of day centre services which are supported by the Health Board.

A skeleton day centre service is already being provided to residents of many sheltered housing schemes. Hot midday meals cooked and served by voluntary providers and funded from the Health Board meals on wheels budget are often available, and some of the afternoon activities planned for residents of sheltered housing schemes are similar to day centre activities. In some cases, it would not take much to "flesh out" the present common room programmes to develop them into comprehensive day centre services. Lack of money and personnel are cited as the main factors inhibiting the further development of common room services. At the same time, voluntary day centre development is being

inhibited by the lack of suitable premises and the high cost of building. The development of day centres in local authority sheltered housing schemes is an obvious way in which to combine resources and thus rationalise services.

Other Development Alternatives

1. If it is impossible to identify a voluntary day centre provider even after premises have been secured in a sheltered housing complex, the Health Board could decide to provide staff and fund the operation of a new centre directly, especially if a high degree of need for a new service has been established. (The Health Board is already directly providing day centre services at Naas Day Centre and in day care centres described in Chapter 2).
2. Bureaucratic divisions, personality conflicts, competition and rivalry between the Health Board and the housing authorities may be persistent enough to preclude joint development, in individual cases, or feasibility studies may show that joint development may not always be practical or desirable.

But other possibilities remain. Co-operative or co-ordinated projects with agencies other than the housing authorities are one alternative. AnCO trainees might be enlisted to apply their skills to the conversion or building of day centre premises on a project basis, for example.

The development of multipurpose facilities in which day centres could be situated is another possibility that has been suggested from within the Health Board.¹⁴ Services for the elderly have been developed in this way in many places in the United States.¹⁵ Existing long-term residential institutions, including welfare homes and non-acute care hospitals could be used to house day centres for residents and non-residents and day centre facilities could be included in the plans for entirely new units.

A commitment to develop services for the elderly is needed. Alternative development models should be considered, and time-limited, costed plans developed. Present planning efforts are primitive and contribute to the irrational development and distribution of services.

Monitoring and Evaluation of Services

The general consensus among Health Board officials is that day centre services are good and valuable. Most users who were asked responded similarly. The general impression of services is positive overall, but it is impossible to determine the relative quality of services between centres or between community care areas.

Several Health Board representatives interviewed saw it as their role to ensure that day centre service coverage is uniform and consistent, and they felt that in general they were carrying out this role satisfactorily. But there is little evidence to suggest that systematic and consistent monitoring or evaluation of services is possible in the present system. The lack of operational service definition and objectives have already been mentioned as factors making evaluation of services difficult. There are other factors which also inhibit the comprehensive assessment of service quality from taking place. They are outlined below.

Division of Administrative Responsibility

Statutory responsibility for day centres in the Eastern Health Board Region is divided between two Eastern Health Board programmes and the Department of Health. This means that no one person or office at present is in a position to oversee all day centre operations within the Eastern Health Board Region. Within Health Board programmes, responsibility is further divided and, although the respective Programme Managers' offices have ultimate responsibility for giving support to services, information and records are mainly kept at local level (by area administrators or individual hospital administrators).

Evaluation of services on a regional basis is made difficult by the current division of responsibility: development planning is similarly impeded. The designation of a person or office to oversee non-institutional services for the elderly at health board level would improve present monitoring, evaluation and planning.

Record Keeping and Lack of Feedback Mechanisms

At present, the evaluation of day centre services is largely based on financial accounts and personal impressions created during infrequent visits to day centres by Health Board officials. In general, Health Board officials showed only a sketchy knowledge about existing day centre

services in their community care area.¹⁶ Fieldworkers' perceptions of services were sometimes very different from those of Health Board management.

There is no systematic way for day centre staff to report back to area community care officers about individual clients or the operation of day centres. Record keeping is patchy, inconsistent and in some cases unreliable. As suggested above, the Health Board does not routinely request written reports of day centre activities, clients policies or plans — only financial accounts. Some staff may, in fact, offer considerable information about themselves to the Health Board in order to attract funds, but such promotional efforts should not be confused with monitoring or evaluation of services.

Kildare (Area 9) provides one exception to above generalisations. The superintendent of public health nursing has been designated to oversee day centre operations in the area. She keeps records and compiles reports which are submitted to the director of community care. The standardised and systematic collection of information about services and service users would seem to be requisite to a more effective system of monitoring and evaluating day care services for the elderly, including day centres. The development of information systems for this purpose could perhaps best be carried out at Department of Health level, rather than by individual health boards. Information collected at local level then could be used by the Department and the health boards to evaluate service effectiveness and to compare services between day centres in different community care areas and between health boards. Improved information-gathering procedures will also help to make service providers more accountable to the health boards which fund them (in the same way that the health boards are being asked to become more accountable to the Department of Health).

Need for Development of Criteria by which to Evaluate Services

There is no evidence that a clear set of criteria is now being used to evaluate services for the elderly in the Irish context. However, criteria have been developed which could be employed for this purpose. Challis¹⁷ suggests seven dimensions upon which community services to individual elderly clients have been assessed in Kent. They include: nurturance (basic comfort and security provided); compensation for disability (i.e. degree to which mobility is improved); morale, social integration or

reduction of isolation; family relationships (ability to meet the need of families for assistance); and community development (ability of the service to enable potential assistance to be "released").

In Ireland, Gilligan¹⁸ suggests four criteria that should be used to assess the quality and viability of long term care arrangements for old people. They include consideration of the old person's physical needs, psychological needs, the levels of dependency in the person over time and the feasibility of the mode of care ". . . in terms of administration, financial and manpower considerations and in terms of achieving a consistent and acceptable quality of care".¹⁹

Froland *et al*²⁰ offer criteria for evaluating the relative cost effectiveness of services as well as for assessing delivery of services. These criteria were developed to assess the outcome of programmes involving partnerships between statutory agencies and informal helpers and so may be of particular relevance in the case of voluntary day centres. Froland's criteria include: accessibility (availability, acceptability of services to clients); use of informal resources; degree of reduction of hospital or institutional care; efficiency (cost per client, range of services offered with existing staff resources); and degree of participation by community residents.²¹ These criteria might be easier to quantify and thus may be more appealing to budget conscious managers than criteria that focus on psychological human needs, for example.

The development of criteria (again, most appropriately, at Department of Health level) with reference to specific service objectives will help sponsoring agencies and service providers to focus better on what it is that services are supposed to be doing for elderly clients and evaluate how well they are doing it.

CHAPTER SEVEN

Notes

¹ See for example, Jonathan Bradshaw, "The Concept of Social Need", *New Society*, v. 19, no. 496 (30 March 1972), pp. 640-643, for a discussion of the other indicators of need to be considered in developing social policies.

² Mary Daly and Joyce O'Connor, *The World of the Elderly: The Rural Experience*, National Council for the Aged, Dublin 1984.

³ Diarmuid McCarthy, "Principles for the Allocation of Resources in Health Care", in *Future Directions in Health Policy*, Council for Social Welfare, Dublin, 1984, p. 33.

⁴ *Idem*.

⁵ B. Carroll, "Response of the Health Services to the Needs of the Elderly in the Community," in *Future Directions in Health Policy*, Council for Social Welfare, Dublin 1984, pp. 127-147.

- ⁶ Eastern Health Board, *Geriatric Services in South Dublin, Kildare and Wicklow: Report of a Working Group*, (unpublished), 1982, pp. 90-91.
- ⁷ *Idem.*
- ⁸ Interviews with directors of community care and area administrators, Spring 1985.
- ⁹ The following brief case study was developed from interviews with the director of community care, Area 1 and discussions with day centre staff and other Health Board representatives in Area 1.
- ¹⁰ Interview with a representative from Dublin Corporation Community and Environment Department, 8 February 1985.
- ¹¹ Interview and telephone conversation with the director of community care and area administrator from Area 4, January-February 1985.
- ¹² Interview with representative Dublin Corporation, *op. cit.*
- ¹³ *Idem.*
- ¹⁴ Department of Health and Eastern Health Board, *Institutional Geriatric Care in Eastern Health Board Areas*, (unpublished), Dublin, (undated).
- ¹⁵ See Rick T. Zawadski and Marie-Louise Ansak, "Consolidating Community Based Long-Term Care", *The Gerontologist*, v. 23, no. 4 (August 1983), pp. 364-369, for a discussion of one such centre developed in San Francisco to deliver health and social services to elderly people in the community.
- ¹⁶ Interview with Health Board officers, Spring 1985.
- ¹⁷ D. J. Challis, "The Measurement of Outcome in Social Care of the Elderly", *Journal of Social Policy*, v. 10, no. 2 1981, pp. 179-208.
- ¹⁸ Robbie Gilligan, *Home From Home? Report on Boarding Out Schemes for Older People in Ireland*, National Council for the Aged, 1985, pp. 44-45.
- ¹⁹ *Ibid.*, p. 45.
- ²⁰ Charles Froland *et al.*, *Helping Networks and Human Services*, v. 128, Sage Library of Social Research, Sage Publications, Beverly Hills and London, 1981, pp. 95-96.
- ²¹ *Idem.*

CHAPTER EIGHT

Conclusions

Day centre services are not sufficient alone to solve the problems of long term care of the elderly, nor will they ever replace residential care. They should be considered as one of the many services which comprise a continuum of care options available to elderly people and their families. As such, day centres are sometimes critical to maintaining elderly people in the community. At relatively low cost they may offer a lifeline to many old people who live alone (often by choice), and who are not able to look after their own physical needs on a daily basis. Day centres may help to prevent family caring arrangements from breaking down by offering relief from the sometimes constant demands made by frail elderly relations, and the value of this should not be underestimated as our elderly population gets older and their needs increase with age. For some clients, day centres offer some place to go and something to do — escape from an otherwise lonely and tedious existence. Many independent and mobile elderly also derive benefits from the opportunities to socialise and join in activities (and to do volunteer work) that day centres offer. Voluntary day centres, especially, deliver personal care in an informal setting free from the stigma of “welfare services”.

But the evidence suggests that day centre services have not achieved anything near their full potential up to now. The theoretical assumptions upon which service development and delivery are guided are vague and sometimes inconsistent, and this has had a profound effect on all aspects of the day centre system. Day centres have sprung up in an *ad hoc* fashion, largely at the initiative of local voluntary groups. Arrangements between the Health Board and local service providers have been idiosyncratic and are governed more by individual personalities than by formalised guidelines or systematic procedures. Day centre services remain at minimum level, coverage is uneven and inequities between service users continue in terms of the quantity and quality of services

available to them, their access to services, and the fees they are charged for services.

Day centre objectives have never been developed adequately to give positive direction to service planners. Day centres have been defined more by what they are *not* (i.e. day hospitals) than by what they can or do achieve. Little attention has been given to the non-medical aspects which are supposed to be the unique, distinguishing feature of day centre services. Ageist assumptions have coloured the way in which client needs have been defined and have influenced the way that programmes have been developed and services delivered. Present services meet the basic physical needs of elderly people but their other needs (including psychological, occupational and educational) are rarely addressed with any sensitivity. The care "model" that has evolved is a limited one which treats elderly people as a homogeneous group of dependent people who need little other than physical minding. Evidence from outside the Republic suggests that day centres could be used to achieve more ambitious goals including: short-term assessment; rehabilitation; education; and preparation for residential care — none of which are currently considered to be day centre objectives here.

A related issue is the still prevailing notion among some Health Board managers that anyone with their "heart in the right place" can meet the needs of elderly people. Up to now, untrained volunteers have been expected to develop and deliver day centre services with little support or acknowledgement from the Health Board. This has contributed to the service limitations described above and may also be a factor in the increasing difficulties associated with the recruitment of volunteers for day centre work. Staff support and development would improve day centre service quality and would also help to ensure the continued participation of volunteers in care of the elderly.

Funding levels to day centres for the elderly have been pitifully low in most cases: even day centres which (by Health Board standards) are considered to be well endowed are often unable to do much more than offer the "bare bones" of a service which heavily emphasises physical minding. Underinvestment in day centre services has meant: (1) that some clients who most need services are denied access to them because there is no way to transport them and (2) professional services considered to be requisite to the achievement of even present modest day centre aims are not available to clients. Grants need to be raised to reflect rising service costs and the diminished availability of voluntary resources which is worrying many Health Board managers. Funding should cover

transport costs for those who need it and should allow for the employment of salaried (and preferably trained) staff.

Current funding practices add a great deal of uncertainty to the business of day centre operations which has also been detrimental to service effectiveness over time. Funding criteria need to be developed and documented, and funding procedures need to be better standardised between community care areas. The issue of charges to clients needs special consideration since there is evidence to suggest that some elderly clients are being asked to shoulder the burden of rising service costs while others are not. The most vulnerable clients may be most affected by increased service charges. The outcome may be that those who most need services may be either unwilling or unable to use them if charges are raised.

Funding to already existing day centres is problematic, but current Health Board funding practices are even more of an inhibiting factor to new service development. Voluntary day centre providers have to overcome increasing odds to get a new day centre service started. Low funding levels limit development possibilities to a considerable extent: the lack of formalised funding procedures makes development absolutely risky for potential providers.

It is desirable to maintain the involvement of voluntary groups in day centre development and delivery but thought needs to be given to finding ways to better promote and support voluntary initiatives so that local groups can continue to participate in service provision. It is no longer enough to give voluntary groups "the little bit of help" to see that they "stay out of trouble" with their finances. More aggressive efforts are needed to clarify the respective responsibilities of voluntary providers and the Health Board, and to facilitate collaboration between them. New models which dictate a much larger role for the Health Board are needed to respond to the increasing difficulties associated with new service development. The Health Board and the Department of Health will have to accept greater responsibility for planning and financing day centre development if it is to happen at all, and if client needs are to be met equitably and adequately. In some cases where voluntary providers cannot be identified, responsibility will also have to be taken by the Health Board for directly providing services.

A final weakness in the present day centre system concerns the lack of accurate and objective information available about day centres, day centre providers and the elderly clients who (need) use day centre services which makes the planning, development and evaluation of

services irrational and inefficient. The research suggests that, again, there is a role for the Department of Health to play in developing systems to collect and process the information necessary to the accurate assessment of client needs and to the evaluation of day centres' ability to meet them. Public expenditure on day centre services does not make sense unless mechanisms exist to determine if these services are successful in achieving stated policy objectives.

Appendices

APPENDIX 1

METHODOLOGY

The research for this study involved an extensive review of the Irish and British literature and, to a lesser extent, the American literature on day centre services for the elderly, as well as on other relevant issues in health and social policy areas. The social work literature on work with the elderly was also covered in great detail in the course of the research, though is not dealt with directly in this report.

Contact was made with a large number of planners and providers of services for old people. Directors of community care and/or section officers from nine of the ten Eastern Board Community Care Areas were interviewed in person. (Area Eight has no full day centre services and contact with this area was made exclusively by telephone.) Appendix 2 gives a list of questions that directors of community care were asked to answer. In most cases, the list of questions was sent before interviews took place so that facts and figures could be assembled in time. Follow-up telephone calls were sometimes necessary to fill in gaps in the data.

Information about statutory day centres came from correspondence with hospital administrators responsible for day centres located in Eastern Health Board hospitals. Appendix 3 lists the questions that were sent to them.

Seven day centres in the Eastern Health Board Region were visited in the course of the research. The author worked as a volunteer in one of these centres for 12 months between 1980-81. She acquired further information about one other as a social work student on placement in the centre in 1982. Two day centres in Belfast (one statutory and one voluntary) were also visited for comparative purposes in August 1985. All of the day centres visited are listed in Appendix 4.

Many other people working in the health and social services co-operated in the collection of data for this report. The agencies or offices represented are listed finally in Appendix 5.

In spite of the best efforts of the author and a very high level of co-operation from those being interviewed, some inaccuracies and omissions are inevitable. Obviously personal recollections and impressions are never wholly reliable. Wherever possible, comparisons were made between the personal accounts supplied by a number of individuals and it is hoped that, in this way, general accuracy has been ensured.

APPENDIX 2

QUESTIONS SENT TO DIRECTORS OF COMMUNITY CARE REGARDING DAY CENTRE SERVICES IN THEIR AREA

1. To your knowledge, when were the first day centres for the elderly set up in your area and by whom?
2. The 1968 Circular 40/68 gave health boards the authority to give grants without getting sanction from the Department of Health. Did this change the picture much with regard to the granting of money to voluntary bodies to provide day services for the elderly?
3. What were the original aims of day care services for the elderly? (e.g. to improve the nutrition of elderly clients, to prevent loneliness, to provide social life, rehabilitation, etc.) Have these aims changed emphasis over the years? Is the client group (of elderly users of the service) the same as originally intended?
4. What is the scope of day care services for the elderly in your area?

Number of centres?

Open all day, five days a week; open a few days a week for limited hours?

Operated by which voluntary bodies?

Health Board input:

Grant money only

Buildings, other facilities

Transport

Staff

Representation on voluntary committees or boards.

Types of services offered:

Physiotherapy

O.T.

Crafts, other activities

Discussion groups

Chiroprody
Laundry
Hairdressing
Transport

Cups of tea, biscuits
Full, hot meals
Social work services
Pastoral services
Other

5. Typically, from where does the initiative come to create new day centres? (Voluntary bodies; concerned individuals — parish priest, local committees; elderly people themselves or their families; the director of community care; other.)
6.
 - a. If a group or individual comes forward to offer a day care centre service, what procedures follow?
 - b. To whom must they apply? Are there forms to be filled in?
 - c. Are written contracts or guarantees given to the effect that the Health Board will fund the proposed centre?
 - d. Are many groups refused funding? On what types of grounds?
 - e. Would centres typically have been in existence before funds are requested from the Health Board?
 - f. Is funding done on an *annual* basis? What must an organisation do to ensure that its funding will continue? Who makes the decision to continue/raise/lower/discontinue funding to a day centre?
7. In your area, how much money is being given to voluntary bodies for the running of day care services for the elderly?
8. What is your view of the relationship between the health boards and the voluntary bodies that are funded (or not) to provide services for the elderly? What are their respective responsibilities towards each other? Are there problems in the present system that you would like to see corrected?

APPENDIX 3

QUESTIONS ABOUT THE OPERATION OF STATUTORY DAY CENTRES IN EASTERN HEALTH BOARD HOSPITALS – SENT TO THE HOSPITAL ADMINISTRATORS INVOLVED

1. Does the centre cater for residents and non-residents of the hospital?
2. How many clients come to the centre each day? How many non-residents? On average, how often do they come (once a week, twice a week, more often)?
3. Is the supervisor a nurse?
4. Who else is on the staff of the centre?
5. What services/activities are offered at the centre?
6. What would be the approximate annual budget for the operation of the centre? (Total figures.)
7. Is transportation available to bring clients to the centre? How is it handled?
8. Are clients asked to pay a charge for meals or other services at the centre? How much?
9. What would be regarded as the main objectives of the service?
10. Anything else you would like to comment on regarding the service?

APPENDIX 4

DAY CENTRES VISITED

Beaufort Day Centre, Beaufort Sheltered Housing, Glasthule.

Irish Red Cross Day Centre, Sandymount.

Leopardstown Day Centre, Leopardstown Hospital.

Milltown Social Service Centre, Milltown.

Naas Day Care Centre for the Elderly, Naas.

St. Fintan's Day Centre, Monkstown.

Sancta Maria Day Centre, Cabra.

Newington Day Centre, Belfast (voluntary).

City Ways Day Centre, Sandy Row, Belfast (statutory).

APPENDIX 5

INDIVIDUALS/AGENCIES WHOSE REPRESENTATIVES WERE INTERVIEWED FOR THIS STUDY

1. Department of Health: Planning/Research Unit, Medical Services Division.
2. Department of Health: Social Work Advisers.
3. Department of Health and Social Services, Northern Ireland: Social Worker Adviser.
4. Dublin Corporation: Housing Welfare Department.
5. Eastern Health Board, Community Care Headquarters: Programme Managers Office.
6. Eastern Health Board Social Workers.
7. Home Help Organiser.
8. Hospital Consultant Geriatrician.
9. National Council for the Aged.
10. National Economic and Social Council.
11. National Planning Board.
12. National Social Service Board.

APPENDIX 6

DAY CARE SERVICES FOR THE ELDERLY THROUGHOUT THE COUNTRY

1. INTRODUCTION

The following discussion on Day Care Services for the Elderly is based on information supplied* to the National Council for the Aged by the seven Regional Health Boards, other than the Eastern Health Board. The information available is much more detailed in respect of some areas than others and, consequently, it is not possible, in this appendix, to provide a totally comprehensive picture of the nature and extent of day care services for the elderly throughout the country. The discussion is based on the information available to the Council in July 1987.

There is substantial variation and range in the type of day care services for the elderly provided throughout the country. It would appear that in many instances a clear distinction is not made between clubs, day centres and day hospitals. Indeed, considerable difficulty was experienced by some health board personnel and voluntary agency personnel in determining which services came into the category of Day Centres. This, obviously, raises a question in respect of the definition of the term 'Day Centre'. Day care services for the elderly are best viewed along a continuum, at one end of which is the club type of social centre, functioning two or three afternoons a week. At the other end of the continuum are the purpose-built day centres providing a broader range of personal services and catering for a relatively high level of social and physical need and, occasionally, a relatively high level of dependency. The majority of day care services can be located at the middle of the continuum, providing meals, bathing, laundry services, occasional chiropody, hairdressing, nursing when required, arts/crafts, games/entertainment, occasional religious services, and occasional outings and parties. Occupational therapy is provided in only a small number

*Available on request from the National Council for the Aged.

of day centres and physiotherapy to an even lesser extent. While a few day centres report having talks and discussion groups as part of their programmes, educational programmes and activities are not generally catered for. There appears to be little scope for interaction between day centre users and other members/groups in the community, although one centre reports having regular visits from pupils in the local school. Day centres for the elderly seem to be primarily directed towards the maintenance and development of social contacts by people among their own age-group with a view towards combatting loneliness and avoiding social isolation.

The general picture of day centre users which emerges is of a group of ambulant, mentally alert people, predominantly female and aged between 65 and 85 years. A relatively small percentage suffer from some mental or physical incapacity. Most elderly people who attend day centres were stated to do so in order to combat loneliness and/or to avoid social isolation. A proportion of users were stated to have referred themselves to the day centre services.

In some instances health boards are very much involved in the development, operation and funding of day centres; in others the main impetus comes from the voluntary sector supported by Section 65 grants from the relevant health board. In the latter instance the public health nurse usually plays a key role in referring elderly persons to the day centre. In some instances the health board community worker plays a significant role in stimulating the development of day centre services by voluntary agencies.

The state of repair/decor of day centre premises was in almost all instances stated to be either good, very good or excellent.

2. SERVICES IN EACH REGIONAL HEALTH BOARD

Midland Health Board

Day centres for the elderly are mainly run directly by the Health Board and are fully staffed and funded. The day centres are usually located adjacent to welfare homes or hospitals and are purpose built or adapted. In all instances, but one, the day centres are operated under the auspices of the Community Care Programme. Such day centres are located in Tullamore; Clara; Birr; Portlaoise; Abbeyleix; Athlone; Mullingar. There is also a day facility operated in conjunction with St. Joseph's Geriatric Hospital, Longford. Special transport is provided in all instances. The premises of Portlaoise Day Centre are owned by Port-

laoise Social Services Council and rented to the Health Board at a nominal rent. Voluntary bodies operate laundry services in conjunction with the above day centres. There is usually a charge to day centre users. The usual services provided in these day centres are meals, bathing, nursing, hairdressing, chiropody, crafts, occupational therapy, games/entertainment, laundry. In two instances a physiotherapy service is provided.

In addition to the day centres provided directly by the Health Board, three day centres are provided on a part-time basis by voluntary social services councils in Ballymore, Moate and Rahugh. These centres receive grant-aid under Section 65 of the Health Act 1953.

Discussions are currently under way with a view to providing day centres for the elderly in Mountmellick and Rathdowney.

Mid-Western Health Board

Day centres for the elderly are operated by voluntary organisations subsidised by grants under Section 65 of the Health Act 1953. Currently there are no day centres for the elderly run directly by the Health Board.

Day centres are located in the following areas: Ennis; Killaloe; Kilrush; Shannon; Vizes Court, Limerick. Three of the centres are run solely by volunteers and operate on a 2-3 day a week basis. The other two operate 5 days a week, one with a full-time staff member and the other with a part-time staff member. Transport is provided in one day centre by a vehicle owned by the day centre and in three of the others a voluntary private car pool is in existence. The services provided include meals, nursing, laundry, games/entertainment, crafts. An annual holiday for users is organised by four of the centres. A chiropody service is available monthly in one of the centres.

In the case of the day centre at Vizes Court, Limerick, which is located in a sheltered housing complex, Limerick Corporation contribute to the running costs.

Discussions are currently in progress in respect of the development of day centres for the elderly at Nenagh and Ballylanders.

North-Eastern Health Board

The North-Eastern Health Board operates day centres for the elderly at:

St. Mary's Hospital, Castleblaney, Co. Monaghan.

St. Felim's Hospital, Cavan.
St. Joseph's Hospital, Trim, Co. Meath.
St. Oliver Plunkett Hospital, Dundalk, Co. Louth.
Ozanam Holiday Home, Mornington, Co. Meath.
Loreto Convent, Navan, Co. Meath.

Day centres for the elderly are operated by voluntary organisations at:

Fair Street, Drogheda, Co. Louth.
Church Street, Ardee, Co. Louth.
Emyvale, Co. Monaghan.
Clontibret, Co. Monaghan.

North-Western Health Board

Day centre services for the elderly are generally operated by voluntary agencies with support from the Health Board both in terms of funding and personnel. There are four day centres managed directly by the Health Board. Most day centres have some paid staff, at least on a part-time basis. Some day centres are run solely by volunteers however. Special transport is usually provided — either by a Health Board vehicle, a vehicle hired by the day centre or by means of a voluntary private car pool. In a few instances no special transport is provided. Many of the day centres are purpose-built or adapted. The normal services provided in day centres are bathing, meals, laundry, nursing, arts/crafts, games/entertainment and chiropody. Occupational therapy is provided in two day centres and occasional discussion groups are part of the programme in three centres.

The following is a list of the day centres for the elderly in each of the counties of the North-Western Health Board area:

Leitrim	Carrick-on-Shannon
	Manorhamilton
	Dromahaire
	Mohill
	Kiltycloher
	Drumshanbo
	Ballinamore

Discussions are currently in progress in respect of the provision of a day centre in Carrigallen.

Donegal	Carndonagh
	Moville
	Arranmore Island
	Letterkenny
	Ballyshannon

It is planned to open a day centre in Annagry in August 1987. Discussions are under way in respect of the provision of day centres in Ardara and Donegal Town.

Sligo	Sligo Town
	Enniscrone
	Easkey/Dromore West
	Skreen/Dromard
	Riverstown
	Geevagh/Highwood
	Tubbercurry
	Cliffoney

Ballymote, Tubbercurry, Collooney have been identified as areas requiring further provision of day services.

South-Eastern Health Board

Day care services are provided both directly by the Health Board and by voluntary organisations with grant-aid from the Health Board. Day care services provided directly by the Health Board are usually associated with a hospital or home and may come more into the category of day hospitals rather than day centres. Such day care services are located in Thomastown, New Ross, Enniscorthy and Cashel. There is also a day care facility associated with St. Fiacc's House, Graigcullen. The main services provided in these day care units are: meals, laundry, bathing, chiropody, hairdressing, checking of medication and in two centres physiotherapy is provided. Transport is usually provided either by a Health Board vehicle or through voluntary drivers.

A purpose-built day centre has recently (1987) been opened in Carrick-on-Suir and discussions are in progress in respect of day units in Carlow, Tipperary, Dungarvan and Castlecomer.

There is a very active day centre run on a voluntary basis in Waterford City with support from the Health Board.

There are day care facilities operated in conjunction with community homes for the elderly under the auspices of Kilkenny Social Service

Council in Kilkenny, Freshford, Kilmoganny, Callan, Kilmacow and Ballyragget. In addition there are a number of social clubs for older people run under the auspices of the Kilkenny Social Services Council. Social day centres also operate in Wexford Town and Fethard-on-Sea.

Southern Health Board

Day care services are generally provided by voluntary organisations supported by grant-aid from the Health Board under Section 65 of the Health Act 1953. The Health Board community workers also play an important role in stimulating and supporting the development of day care services.

The following are the areas where day care services are provided:

Kerry	Dingle
	Tralee
	Sneem
	Kenmare
	Killarney
	Killorglin
	Kilgarran
	Caherciveen
	Annascaul
	Ballyferriter
	Listowel
	Lixnaw

Cork	Charleville
	Clonakilty
	Skibbereen

There are also a range of day care services and facilities throughout the city of Cork and its suburbs all run by voluntary agencies with the support of Health Board community workers.

There are plans for the development of a centre in Bantry.

In some instances transport is provided either through a special vehicle or through an organised voluntary private car pool, but in many cases such transport is not provided. Day centre staff are employed in most of the day centres on a part-time basis through the Home Help Service and through the Social Employment Scheme. There are, however, a number of centres dependent solely on volunteers.

The main services provided are meals, laundry, chiropody, nursing, bathing, outings, craftwork and entertainment and games are also organised.

Western Health Board

Day centres for the elderly are operated

- (i) Directly by the Health Board under the Special Hospital Care Programme and funded totally by the Board, apart from a small charge to users.
- (ii) By voluntary organisations under the auspices of the Community Care Programme and grant-aided under Section 65 of the Health Act 1953.

Day centres under the Special Hospital Care Programme are located in homes for the aged except for one which is purpose-built and located in the grounds of the district hospital, Swinford and which caters for an average of 45 persons per day. The following is the list of day centres operated under the Special Hospital Care Programme:

County Galway St. Francis Home, Newcastle, Galway.

St. Martins (adjoining St. Brendan's Home), Loughrea, Co. Galway.

Aras Mhic Dara, Carraroe, Co. Galway.

Aras Mhuire, Tuam, Co. Galway.

County Mayo Aras Deirbhle Home, Belmullet, Co. Mayo.

St. Augustine Home for Aged, Ballina, Co. Mayo.

McBride Home, Westport, Co. Mayo.

Sacred Heart Home, Castlebar, Co. Mayo.

D'Alton Home, Claremorris, Co. Mayo.

District Hospital, Swinford, Co. Mayo.

County Plunkett Home, Boyle, Co. Roscommon.

Roscommon Aras Mathar Pol, Castlerea, Co. Roscommon.

Sacred Heart Home, Roscommon.

These centres operate normally 4-5 days a week. The services provided are meals, laundry, bathing, chiropody, hairdressing, nursing, arts/crafts, occupational therapy, games/entertainment. Physiotherapy is provided in six of the centres and five have occasional discussion groups.

The following day centres are operated by voluntary agencies in

the Western Health Board area: Achill; Ballinasloe; Boyle; Castlebar; Clonbur; Galway; Glenamaddy; Knock.

3. SELECTED ISSUES RELATING TO THE PROVISION OF DAY CARE SERVICES

It is evident that day care services play an important role in the lives of many elderly persons, helping to combat loneliness and social isolation and, in some instances, providing essential personal services. It is less clear, however, where and how day care services fit into the overall context of caring for the elderly in the community. The nature and the extent of day care services varies greatly between health boards and, indeed, within health boards. This is particularly evident in the case of both the planning and the funding of day care services.

The following are a number of key issues which arise and require to be addressed in respect of day care provision for elderly persons.

1. The statutory sector and the voluntary sector working together would appear to offer the ideal dynamic for the effective development of day care services. However, if this dynamic is to achieve its full potential there is a need for greater clarification by health boards of the respective roles of the statutory sector and the voluntary sector in the planning, development and running of the day care services. There is a need for more effective co-ordination between the sectors than is the case at present.
2. There would appear to be a lack of awareness in some instances of the enormous potential of day care services within the overall context of community care of elderly persons and a lack of any overall plan for the development of such services.
3. Voluntary organisations, particularly in more sparsely populated areas, frequently do not have the personnel or resources to run an effective day care service without substantial support from the health boards. Even with support from the health boards there may be a great difficulty in some areas in recruiting volunteers and motivating local communities.
4. The development of day care services by health boards is being greatly hampered by the current severe budgetary restrictions. These restrictions affect both the capital cost of providing and

furnishing premises and the ongoing costs of staffing and running the service.

5. Transport is widely recognised as one of the key elements in the running of a successful day care service. In some instances, particularly in the case of day care services provided by voluntary agencies, the provision of an adequate transport service is becoming increasingly difficult.
6. In some areas there is a difficulty in motivating elderly persons to attend day centres. This may relate to the type and quality of the service provided and/or to the availability of suitable transport.
7. Given that the majority of users of day care services are mentally alert and mobile, it would appear that there are possibilities for a much more creative use of the time spent in day centres, e.g. the development of the non-medical aspects of day care programmes, particularly educational programmes.
8. Religious congregations and their personnel play a significant and crucial role in the management and staffing of day care services in various parts of the country. The possible non-availability of such personnel in the future would have major implications for the provision of day care services. This is an issue which health boards will need to address.

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