Cost-effective study of mental handicap services: analysis report: volume 2.

Analysis Report

Volume II

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Contents

CHAPTER 1

INTRODUCTION

1.1 Background

This study was commenced, at the request of the Department of Health, in November, 1986.

The primary purpose of the study was to examine the cost effectiveness of various services for people with mental handicap. A secondary, but important purpose was to complement another study being conducted for the Department of Health by a committee of selected experts on Mental Handicap. It is expected that this Review Group will present its findings at the end of 1987.

By examining the care of the mentally handicapped from two perspectives, using very different skills and expertise, it was hoped that ultimately a broader picture would be obtained which would better facilitate policy making in the area of mental handicap.

1.2 Terms of Reference

After discussions with the Department of Health on 21st November 1986, the following terms of reference were agreed:

> "To compare the cost-effectiveness of alternative levels of care for different groups of mentally handicapped
>
> and
>
> To make recommendations based on this analysis."

1.3 Methodology

The methodology followed comprised two distinct blocks of work:

(i) Background reading of available reports and surveys dealing with the services for the mentally handicapped and analysis of statistical and census data.

(ii) Field research, including visits to Special Residential Centres, Day Care Facilities, Hostels, Psychiatric Hospitals and Community facilities. The purpose of these visits was to examine at first hand the types of services being provided and to determine how resources were being used.

A number of visits were also made to various Governmental agencies -notably the Western and North Western Health Boards, and various Sections of the Department of Health. The main purpose of these visits was to obtain statistical data relating to the number of patients, degree of handicap and expenditure within the various services.

This report has been produced in two volumes.

Volume I - "The Mental Handicap Services in Ireland" is intended as a guide to the types of services currently being provided.

Volume II - "A Cost - Effectiveness Study of the Mental Handicap Services" is a critical evaluation of the effectiveness of those services.

CHAPTER 2

CARING FOR PEOPLE WITH MENTAL HANDICAP - WHAT DOES IT COST?

2.1 Overall Cost

The Department of Health's most recent figures (1986 Outturn) give a total estimated cost for running the Mental Handicap Services as £127 million which is made up as follows:

	Million
Non-Statutory Agencies Funding	£67.8
Health Board Agencies Funding	£15.4
Psychiatric Hospitals (Proportion of)	£28.7
D.P.M.A. and other allowances (Proprotion of)	£15.2
TOTAL	£127.1

2.2 A comparison of costs

The major issue of contention in relation to the costs of care facilities is whether community facilities are cheaper or dearer than special residential centres. The following table summarises how the most expensive community service - 7 day staffed hostels for adults - compares with the traditional institutional models.

Average Cost of Mental Handicap Facilities by Degree of Handicap - 1985 Figures

Annual Cost per Person

Degree of Handicap	Hostels - Incl. D.P.M.A. and Day Care Costs	Mental Handicap Centres	Psychiatric Hospitals
Mild	£4,600	£8,300	£12,500
Moderate	£9,200	£10,500	£12,500
Severe	£17,800	£16,500	£19,000

The following are a number of points which should be made about this data.

* The costs set out in this table are average costs based on actual expenditure in 1985 of 34 seven-day hostels, 16 residential centres and 6 psychiatric hospitals. A detailed breakdown of the costs relating to individual centres is provided in the Appendix 1 of this report.

  * Psychiatric Hospital Costs

  As stated above these costs are based on the average cost of 6 psychiatric hospitals. However, the range of costs in individual locations varied considerably and these average cost figures should not therefore be used for calculating savings in individual cases.

  Costs for people with mild or moderate handicap in psychiatric hospitals are identical to those of ordinary psychiatric patients, in virtually every case. In the 6 hospitals visited the staffing ratio in wards catering for people with mild/moderate mental handicap were precisely the same as those in the general psychiatric wards. In many cases the two types of clients were not segregated but were kept in mixed wards, and costs would therefore be identical. Costs for people with severe mental handicap were calculated on the basis of costs for 3 wards where such patients were segregated and such costs could be readily identified.

* Costs for people with profound mental handicap are not shown in the above table because they could not be isolated accurately - there were no hostels or residential centres in the survey group catering primarily for people with profound handicap. However, on the basis of the staffing ratios necessary for people with profound handicap it is estimated that costs would be as follows:

People with Profound Handicap - Estimated Costs

	£
Hostels and Day Care	26,000
Mental Handicap Centres	24,000
Psychiatric Hospitals	20,000

Hostels

* Cost of hostels shown above are deliberately overstated by virtue of the fact that only seven-day adult hostel costs were considerable. Costs for five day hostels show that they are usually 45% - 50% cheaper than the seven day facilities.

Costs for administration, medical and support staffs have been included in Hostel costs.

For the purposes of this analysis, hostels are defined as ordinary residential housing, not purpose built, for people with mental or physical handicaps.

2.3 Variations in Costs - An Explanation

2.3.1 Hostels v Residential Centres

In undertaking the survey the initial expectations were that hostel costs (including day care and D.P.M.A.) would be dearer than residential centre costs. This was because it was expected that the staffing ratios of hostels would be higher and it was also expected that some economies of scale would operate in the larger institutions.

What was found, in fact, was that although the nursing/client ratio is often higher in a hostel than in a residential centre, the staffing/client ratio is dramatically lower. This is because residential centres employ large numbers of cleaning, catering, maintenance and administration staff. In the hostel, on the other hand the clients do their own cleaning and most catering while much of the administration will be done by the houseparent.

As can be seen from the following table, there are sometimes more people employed in residential centres than are actually cared for by them.

1986 Staff/Client Numbers

Mental Handicap Residential Centres

Staffing

Centre	Nursing and Allied	Admin	Catering and Housekeeping	Medical Dental Para-medical	Maintenance & other	Staffing Total	No. of Clients
Stewarts	303	25	83	14	24	449	342
John Paul II	47	10	12	8	17	94	136
Cheeverstown	74	8	17	8	7	113	75
Moore Abbey	104	12	25	10	22	173	198
Beaufort	69	8	22	6	11	116	111
St Mary's, Delvin	54	5	11	4	7	81	115
Kells Road	89	5	20	3	12	129	171
Roscrea	43	2	25	1	4	75	111
Upton	20	3	8	nil	5	36	55
Cregg House	154	7	32	4	6	203	216
Carriglea	35	5	10	1	13	64	107
					Total	1,622	1631

The overall staff/client ratio in these residential centres is almost 1:1.

In hostels on the other hand, the staff/client ratio, including day care, will usually be about 1:2. Hostels generally represent a far more cost effective use of personnel.

Curiously, although the burden of responsibility and work load is often heavier in a hostel, the evidence suggests that staff in hostels are often happier than their counterparts in large residential centres. Many of the agencies running both types of facilities have found that absenteeism in the traditional institution is often a serious problem whereas absenteeism in hostels is virtually non-existent. Conversely, some centres have found that some of their staff are reluctant to leave the institutional setting as it appears that that they become every bit as dependent on the 'protected' institutional environment as the client they look after.

2.3.2 Different Costs for Similar Centres

There is enormous variation in the costs of centres catering for similar clients.

The following table shows the annual costs per person of a number of centres which cater primarily for the severely handicapped.

Centre	% of clients with Severe/Profound Handicap	Annual Cost Per Client
Stewarts	73%	22,180
John Paul II Centre	98%	18,515
St Mary's, Delvin	53%	14,625
Beaufort	71%	13,385
St Partick's, Kilkenny	64%	8,929

The reasons for these large variations in cost can be attributed to a number of factors.

a) Many centres are more expensive because they provide higher nursing or support staff ratios, more comprehensive services and better quality care. Others may be inexpensive because they provide lower levels of care services.

b) A small minority are more expensive because of administrative inefficiencies.

c) The client mix of centres varies considerably. Some have high levels of disturbed clients and therefore require higher staffing levels. Others cater for young children who are comparatively less expensive to maintain than adults.

However, the main reason why there is a dramatic difference in the per capita expenditure levels of different centres is the more obvious one.

They all get very different allocations and spend in line with those allocations.

As is common practice in public sector budgeting, resources are allocated by the Department of Health or Health Boards on the basis of

(1) Previous year's outturn
(2) Approvals to improve or expand services
(3) Availability of finance generally.

In the area of mental handicap, allocations are not based directly on the numbers of clients being cared for or on the levels of handicap of those clients. While it is obvious that such criteria should be used this has not been done due to the absence of information on what it <u>should</u> cost to care for people with varying levels of handicap.

In the course of visits to many hostels, residential centres, workshops etc. it became very clear that there are large inequities in the manner in which resources are allocated. Some facilities suffer from chronic deficiencies of resources; most have just about adequate funds; a minority receive an allocation well in excess of what would be merited by the type of clients catered for and the types of services provided. As a result, a minority of centres spend large sums of money on wasteful and unnecessary items. Examples of such spending are:

(1) Inordinate numbers of administrative, maintenance, gardening and catering staff. etc.
(2) High energy costs (Heating of empty premises).
(3) Exhorbitant maintenance costs - often on new buildings.

It is estimated that these inefficiencies cost the mental handicap services approximately £3 million per annum out of a total expenditure of £127 million. This £3 million per annum could purchase new housing and day care premises for 1,000 people within 5 years.

To redress this situation a later chapter suggests what it should cost to provide services for people with different levels of handicap and it is recommended that on a phased basis the inequities in resource allocation should be reduced considerably, using these guidelines. It is also

recommended that the Department of Health and Health Boards should make public the allocations given to individual mental handicap agencies.

While it will never be possible to achieve perfect equity in resource allocation, there is no doubt that it is possible to reduce the present level of inequities.

Where inequities do exist they should reflect the fact that many agencies provide better value for money than others. Here I would like to emphasise that the majority of agencies are providing a value-for-money service. The problems relate to a small, but very costly minority.

Since most agencies are funded by the Department of Health, the primary responsibility for ensuring equity will reside with them. To this end, the re-structuring of the Department currently taking place should greatly facilitate this. Traditionally, resource allocations have been seen within the department as a numerical exercise which was exclusively the function of the Finance unit. The Mental Handicap Section which has detailed knowledge of the level and quality of service provision and real needs of individual agencies have had a minimal input into the allocation of resources.

The re-organisation now taking place is directed towards the following changes:

"(i) The Service units must be seen as the primary focus of the Department;

(ii) The function of the ....Finance.... Unit will so far as possible be in the broad policy determining area in support of the service units".

- Department of Health Circular 2/87.

The logical application of this process would be for

(1) The Mental Handicap Section to determine the allocations to individual agencies.

(2) The Finance Unit to monitor expenditure to ensure that agencies adhere to allocations, under each expenditure sub-head.

Such a re-location of responsibilities is essential if allocations are to be based on a detailed knowledge of the real needs of agencies.

CHAPTER 3

THE EFFECTIVENESS OF MENTAL HANDICAP FACILITIES

3.1 Assessing Effectiveness

When assessing the relative effectiveness of a mental handicap facility, we are simply asking the question "By how much does the client benefit by being cared for here as opposed to somewhere else?"

Unfortunately, although the question is simple, the answer is obscure because the effect of the care setting on individual clients is difficult to determine and even more difficult to prove.

Despite the absence of any large body of empirical research, we can however highlight some of the obvious differences between different care settings.

3.2 The Mentally Handicapped in Psychiatric Care

The Psychiatric Hospital is often an inappropriate setting even for those with psychiatric illness. This is the fundamental conclusion of the Working Party on the Psychiatric Services as contained in their report "Planning for the Future." In that document it was noted that the size of these large institutions militates against the type of individual care that is required for successful treatment of psychiatric illness. The Report therefore recommends a shift in the pattern of care from an institutional to a community setting.

The psychiatric institutions which have been found to be unsuitable for the treatment of psychiatric patients are even less suitable for those with mental handicap. It has long been recognised by those involved in the management of psychiatric hospitals that of all their patients, "the mentally handicapped are least resilient to the socially disabling effects of life in an institutional setting" (1). The disabling effects of the institution manifest themselves in a number of ways:

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(1) "Study of Rehabilitation and Care Needs of Long-Stay Patients" - produced by the staff of St. Brigid's Psychiatric Hospital, Ballinasloe, Page 10.

3.2.1. Institutional Mannerisms

The instinct to imitate each other is part of the basic human condition. It is especially strong in the formative years before we learn to make independent decisions for ourselves. It is precisely this imitative instinct which teaches us to walk and talk through copying those around us in early childhood. For the mentally handicapped, many of whom do not develop psychologically beyond this early childhood stage, these imitative instincts can remain particularly strong. In the institutional setting where there are large numbers of clients with mental handicap and psychiatric disorders congregated together, with limited regular contact with "normal" adults, there is a great tendency for the mentally handicapped to take on the mannerisms of those around them. An obvious manifestation of this imitative behaviour is the fact that over 50% of the mentally handicapped in psychiatric institutions have been diagnosed as having a psychiatric condition in addition to their mental handicap (2). It is worth noting that the prevalence of psychiatric conditions increases among older or long-term patients which could suggest that the longer the term of stay in a psychiatric hospital, the greater the propensity to develop a psychiatric condition.(3) This belief is supported by research work into the phenomenon of 'institutionalisation'.(4)

This psychiatric condition can vary from mild ritualistic behaviour (rocking or clapping hands) to more disruptive or destructive behaviour such as spitting, kicking, destruction of property and clothing etc. While not all such behaviour is "learned behaviour", it is generally agreed among psychologists that a high proportion of it is. Even that which is not "learned" is often a product of the stressful institutional environment.

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(2) Census of Mental Handicap 1981 - Page 55

(3) Census of Mental Handicap 1981 - Page 55, 56

(4) See "Relationship between Chronological age, length of institutionalisation and measured intellectual functioning among moderately mentally retarded adults" - Russell, Dillon and Bryant - Journal of Mental Deficiency Research, Vol 30; 4

Within the psychiatric institutions the diagnosis of a psychiatric condition is often used as an argument for keeping people with mental handicap in psychiatric care. Conversely, the presence of such a condition is also a strong argument for taking the client out of psychiatric care. Just as particular mannerisms have been learned in psychiatric hospitals they can be "un-learned" in another environment.

3.2.2 Social Skills

In the psychiatric hospitals only a minority of the mentally handicapped have appreciable social skills. Over 80% of them are unable to dress, wash, eat and communicate to a standard that would enable them to live in the community (5).

This is primarily because most of them have received little or no training in this regard. Professionals in the mental handicap area generally believe that if the patients in psychiatric hospitals were transferred to the more intensive social skills training within mental handicap centres at least 60% would develop such skills. On the basis of my experiences in visiting psychiatric and mental handicap facilities I would have no reservations about supporting this view.

None of the psychiatric hospitals visited in the course of this survey had an adequate social skills/activation programme for more than a minority of their mentally handicapped clients. The vast majority of the mentally handicapped in psychiatric hospitals are provided with custodial care only. Typically, they are kept in large groups of 20-40 in locked wards supervised by 1 psychiatric nurse for every 10 clients.

The normal day is a monotony of inactivity punctuated only by mealtimes. For each client, all personal decision making is removed. Everything from the time of dressing, eating and sleeping to the choice of menus is dictated by the institution around them. Although the limited number of more progressive hospitals are advancing beyond this type of care, it is still the case that even they contain significant numbers of mentally handicapped who are receiving totally inadequate training/activation.

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(5) This figure is based on details provided by the Psychiatric Hospitals visited in the course of this survey

In all of the psychiatric hospitals visited self-care was obviously at a low level. Clothing was typically ill-fitting and very shabby (often torn) and personal grooming was obviously neglected by many.
It was observed that table manners were generally very poor, largely because there was insufficient "front-line" staff available to provide the type of individual attention necessary for adequate training.

3.3 Special Residential Centres for Mental Handicap

3.3.1 Institutional Mannerisms

Whereas 52% of those mentally handicapped in psychiatric care have an observable psychiatric condition, only 15% of those in S.R.C.'s have such a condition (6). This can be attributed to various factors:

(1) They are not in a psychiatric environment where such behaviour will be learned.

(2) They have more regular contact with "normal" adults through

  (a) Contact with family (Generally more regular than is the case with psychiatric clients (7).

  (b) More regular community contact via Open Days, visits to parks, zoo, beaches, etc.

  (c) Higher "front-line" staffing ratios. 1 staff per 5 clients is normal for around-the-clock care, with much higher ratios for the severely/profoundly handicapped.

(3) Many residential centres actively seek to eliminate negative behaviour mannerisms through behavioural modification therapy.

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(6) See Census of Mental Handicap - Page 72

(7) See Census of Mental Handicap - Page 54

3.3.2 Social Skills

Accurate statistics on social skills proficiencies are not available generally. Psychologists and other professionals involved with mental handicap believe that in residential settings with a similar mix of clients to those in psychiatric care (approximately 25% mild, 40% moderate, 30% severe, 5% profound [8]) a far higher proportion will have sufficient social skills levels to enable them to live in the community. A rough estimate, based on personal observations is that of those in S.R.C.'s, approximately 40%-50% have appreciable social skills, whereas in psychiatric care the proportion is less than 20%.

The psychiatric nurse is typically trained to believe that his/her role is to act as custodians of their 'patients,' to see that no harm comes to them. The mental handicap nurse or care worker, is trained to believe that his/her role is to stimulate the residual learning ability of their 'clients' and so make them as self-sufficient as possible. This difference in training and attitude is very significant because it leads to an enormous difference in the quality of life for clients in specialised mental handicap centres as opposed to psychiatric hospitals.

A typical daily activation programme for a mental handicap centre is included in Appendix 2 of this report. This day-long list of activities designed to train and stimulate people with mental handicap contrasts starkly with the depressing monotany of inactivity in most psychiatric hospitals.

As stated earlier the only way to accurately assess the effectiveness of different types of care is to compare the performance of large numbers of clients over time. In the absence of such data, an alternative way of comparing psychiatric and mental handicap institutions is to examine the performance of any clients who have been moved out of a psychiatric setting into a special residential centre. The recent experience in this regard (although somewhat limited in terms of numbers) has clearly and consistently shown a marked improvement in such clients after they had been transferred to specialised mental handicap care.

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(8) Based on Census of Mental Handicap Data

3.4 Hostels

3.4.1 Institutional Mannerisms

This phenomenon is virtually non-existent in hostels for 2 reasons:-

(a) Of their nature, hostels are generally used as a means of accommodating the less handicapped client. They cannot therefore be directly compared with residential settings.

(b) In the hostel setting the client has a high level of contact with non-handicapped people and even if the imitative instincts remain strong they usually imitate the more socially acceptable behaviour around them, rather than the negative, unacceptable mannerisms that proliferate in institutions.

3.4.2 Social Skills

Because hostel clients are pre-selected on the basis of their social skill levels, it goes without saying that almost all of them have appreciable social skills. For this reason they are not directly comparable to residential centre clients.

However, this being acknowledged, it is the case that by virtue of being in a hostel setting clients have the opportunity to develop such skills to a much greater extent than is feasible in the residential centre, for the following reasons:

(a) Because the hostel setting is community based, hostel clients can, and do, join any of the many social clubs and associations which are available to them. In the course of this study, clients of hostels visited were members of local clubs and associations catering for such diverse interests as tennis, badminton, basketball, snooker, swimming, girl guides, meals-on-wheels etc. Unfortunately, it must be acknowledge that this type of community integration does not always occur. In large urban areas integration seems to be more difficult to achieve.

(b) Apart from social activities, hostel clients have ready access to facilities not available to those in institutions - shops, libraries, pubs, discos, buses, restaurants, public telephones, parks, etc. All of these can serve as a useful training ground in aiding the enhancement of the mentally handicapped persons social skills. This is aside from the obvious improvement in the quality of life which can be achieved by availability of these facilities.

(c) In the hostel itself, the client no longer has the catering, maintenance and domestic staff supports which are available in the institution. The client therefore gets a much more intensive self-care programme in the hostel than is supplied in an institution.

It is particularly worth noting that many agencies running hostels have found that over time they could recognise very significant improvements in individual client's performance levels - through general observation, through psychological testing and through medical testing. The reasons for much of this improvement are not yet fully understood but it seems to be primarily due to the change of environment from the de-personalised anonymity of the institutional setting to a more natural familial environment in the hostels which is more in tune with the basic human needs.

3.5 Effective Care - Some Closing Comments

3.5.1 When this project was originally undertaken it was assumed that people with mental handicap should be assigned to residential or community care on the basis of the severity of their mental handicap. This assumption seems intuitively reasonable and is widely supported within the mental handicap services. However, it is considered that this original assumption is flawed.

A persons mental handicap level does not determine the appropriate care setting for that individual. It is the degree of secondary handicap which is of prime importance when considering what care setting is best:

a) Clients without secondary handicaps will require community based services.

b) Clients with severe secondary handicaps (non-ambulant, epileptic, disturbed etc.) will generally require residential services.

Those clients falling between these two categories will require community or residential care, depending on the severity of their secondary handicaps. Because a person's level of mental handicap, as defined by the W.H.O. is an unreliable indicator of that persons actual level of performance, professionals in the mental handicap area are making increasing use of assessments which look at overall levels of dependence, rather than mental handicap.

3.5.2 Although the potential benefits of hostels over residential centres and residential centres over psychiatric hospitals are clear, these benefits will only accrue if such facilities are adequately staffed and properly managed. A client will always be better off in a well run residential centre rather than a badly run hostel. Similarly, clients in well run psychiatric units (e.g. the community hostel programmes, St. Lomans, Mullingar and St. Sennan's, Enniscorthy) are better cared for than they would be in any poorly managed or understaffed residential centre.

In managing the mental handicap services, clients should not be transferred to a different environment simply as a cost cutting exercise. Experience in Britain suggests that this approach tends to lead to placement of clients in under-staffed hostels with minimal support from professionals such as social workers, psychologists, therapists etc. However, savings can be made even when the emphasis is on transferring clients to a better quality care setting.

CHAPTER 4

Caring for people with Mental Handicap - What Should it Cost?

4.1 The Service we Provide

In Chapter 2 we saw that the cost of running the mental handicap service in Ireland (including psychiatric care) is approximately £127 million. At present, many of the people cared for out of that £127 million are in inappropriate care settings. The purpose of this chapter is to suggest what the mental handicap service would cost if those people were in the correct care settings.

The table on page 19 shows where people with varying levels of mental handicap are currently located.

Location of People with Mental Handicap

(Department of Health Figures 1985)

Level of Handicap	*Psychiatric Hospitals	Residential Care in S.R.C		Day Care in S.R.C.		Specialised Day Care Units		Hostels		Total
		Adults	Children	Adults	Children	Adults	Children	Adults	Children	
Mild	578	430	203	205	13	774	101	236	49	2,589
Moderate	737	1,806	355	417	125	1,101	239	318	37	5,135
Severe	560	1,481	257	181	68	294	305	109	12	3,267
Profound	156	421	146	9	20	25	85	12	Nil	874
Total	2,031	4,138	961	812	226	2,194	730	675	98	11,865

*Note: A breakdown between adults and children in psychiatric hospitals is not available. However it can safely be assumed that almost all of these are adults.

4.2 The Changes Needed

The mental handicap services in Ireland require major re-structuring if they are to provide a more effective service to the clients. This re-structuring will require two major elements;

(a) the transfer of people with mental handicap from psychiatric to mental handicap services.

(b) The transfer of suitable clients in the mental handicap services from an institutional to a community setting.

4.2.1. Transfer from Psychiatric Care:

Of the 2,031 people with mental handicap who are currently in psychiatric care, it is estimated that approximately 800 clients are suitable for transfer to community hostels (500 with mild handicap, 300 with moderate handicap). A further 800 clients would require care in mental handicap residential centres. It is unlikely that the remaining clients (approx 400) would be suitable for transfer to mental handicap facilities because of advanced age or acute psychiatric disorders.

4.2.2. Transfer from Mental Handicap Centres.

It is estimated that there are approximately 1,900 people with mental handicap inappropriately placed in institutional care (600 with mild handicap, 1,300 with moderate handicap). These should be transferred to community based services.

4.3 Estimating the Cost of Running a Re-Structured Service

If we adjust the figures in the table on page 19 shifting these inappropriately placed people to the appropriate setting, we can then estimate what this 'ideal' mental handicap service would cost to run: The table on page 21 shows how these people might best be placed while the following table on page 22 suggests what this service should cost at 1986 prices.

Location of People with Mental Handicap in more appropriate settings

Level of Handicap	*Psychiatric Hospitals	Residential Care in S.R.C		Day Care in S.R.C.		Specialised Day Care Units		Hostels		Total
		Adults	Children	Adults	Children	Adults	Children	Adults	Children	
Mild	Nil	50	50	200	20	800	100	1,173	196	2,589
Moderate	100	1,500	140	500	120	1,200	240	1,079	256	5,135
Severe	200	1,875	260	200	70	300	302	50	10	3,267
Profound	100	484	150	10	20	25	85	Nil	Nil	874
Total	400	3,909	600	910	230	2,325	727	2,302	462	11,865

*Note: A breakdown between adults and children in psychiatric hospitals is not available. However it can safely be assumed that almost all of these are adults.

Projected expenditure on Mental Handicap if clients were in more appropriate setting 1986 Costs

Level of Handicap	Psychiatric Hospitals	Residential Care in S.R.C.		*Day Care in S.R.C.		*Specialised Day Care Units		* Hostels (incl Day Care)		Estimated Cost
		Adult	Children	Adult	Children	Adult	Children	Adult	Children	
Mild	Nil	50	50	200	20	800	100	1,173	196	(2,589 people)
Likely Ave Cost	-	8,500	8,000	7,300	5,600	4,700	2,800	6,200	7,800	
Likely tot Cost	-	425,000	400,000	1,460,000	112,000	3,760,000	280,000	7,272,600	1,528,800	15,238,400
Moderate	100	1,500	140	500	120	1,200	240	1,079	256	(5,135 people)
Likely Ave Cost	12,500	10,500	10,000	8,500	6,800	5,700	3,800	9,200	7,800	
Likely tot Cost	1,250,000	15,750,000	1,400,000	4,250,000	816,000	6,840,000	912,000	9,926,800	1,996,800	43,141,600
Severe	200	1,875	260	200	70	300	302	50	10	(3,267 people)
Likely Ave Cost	19,000	16,500	16,000	12,100	10,400	8,200	6,800	18,000	17,300	
Likely tot Cost	3,800,000	30,937,500	4,160,000	2,420,000	728,000	2,460,000	2,053,600	900,000	173,000	47,632,100
Profound	100	484	150	10	20	25	85	Nil	Nil	(874 people)
Likely Ave Cost	20,000	24,000	23,000	16,600	14,600	12,500	10,800	-	-	
Likely tot Cost	2,000,000	11,616,000	3,450,000	166,600	292,000	312,500	918,000	-	-	18,755,100

Total Cost of Service £125 million

* These costs are inclusive of D.P.M.A. and R.M.A. payments

The costings used in the preceding table are estimates based on the actual expenditure of mental handicap centres visited.

These projections suggest that if clients with mental handicap in inappropriate care settings were transferred to more effective care settings, the overall cost of running the service for these 11,865 people in 1986 could be reduced marginally from £127 million to £125 million. However, this conclusion is based on a number of critical assumptions.

It is assumed that if clients were transferred out of psychiatric hospitals or residential centres real and substantial expenditure reductions will be achieved and money would not be diverted to other uses or retained in an inefficient agency. It is also assumed that capital to fund an expansion of hostels and day centres would be made available.

A further point which must be made is that this projection does not allow for expanding the service to provide for those people with mental handicap who are currently on waiting lists for services.

Finally, it should be borne in mind that demand for services may change due to changes in demographic trends or other factors.

4.4 Even bearing these reservations in mind two important conclusions can be drawn from this chapter:

1. A mental handicap service where people are all placed in an appropriate setting would be no more expensive than the ineffective service being operated at present.

2. If people are not transferred to more effective care settings, existing inefficiencies will persist.

CHAPTER 5

A Strategy for Change

5.1 The Need for Change

As we have seen, the mental handicap services in Ireland require major re-structuring if they are to provide a more cost-effective service to the clients. Such a shift would require two major elements:

(1) The transfer of people with mental handicap from the psychiatric services to community services or special residential care

(2) The transfer of suitable clients in the mental handicap services from an institutional to a community setting.

In the present economic situation, it is likely that additional funding to finance such changes will be minimal.

Obviously, future plans must take cognisance of this factor and it is an inescapable conclusion that future development and enhancement of services must rely to a fair degree on better management of existing resources.

The following are a number of strategy options for achieving this end.

5.2 Transfer from Psychiatric Care

As has already been shown, there are just over 2,000 people with mental handicap in psychiatric care. These break down as follows:

Level of Handicap	No.*
Mild	578
Moderate	737
Severe	560
Profound	156
TOTAL	2,031

* December 1985 figures

As has also been shown, there are financial savings to be made by transferring many of these to more effective but less expensive care settings. For people with mild/moderate levels of handicap, psychiatric care costs an average of £12,500 per annum. By transferring these people to community care, running costs (including D.P.M.A., administration etc.) can be reduced to £4,600 for mildly handicapped and £9,200 for moderately handicapped clients. Reductions to such levels will only be achieved after a lag period while intensive training/rehabilitation takes place. In some psychiatric hospitals this rehabilitation is already in train (St. Loman's, Mullingar, St. Sennan's Enniscorthy). Unfortunately, most other psychiatric hospitals have made sparse efforts to care for the needs of their mentally handicapped clients.

It is expected that the successful rehabilitation of mild/moderate clients will initially be quite expensive - about £7,500 per person for <u>all</u> clients in the first year as all will require fully staffed hostels during the initial training period. It is only as the more mildly handicapped clients become sufficiently competent for semi-independent living that the lower long-term costs will be achieved.

5.2.1 Transfer of Funds

A. Mild/Moderate Handicap

Appendix 1 to this Report provides a breakdown of the costs of six psychiatric hospitals with relatively high proportions of mentally handicapped patients. These figures show that of the average per capita costs in each hospital those costs which are variable with each mildly/moderately handicapped patient (nursing, food, clothing, bedding etc.) account for 60% of the overall costs. The remaining 40% is accounted for by relatively fixed costs such as heating, lighting, maintenance and administration. These fixed costs can only be reduced if entire wards/hospitals are closed.

These figures show that where a psychiatric hospital transfers patients to another agency its costs will be reduced by up to 60% of the average per capita cost. It is strongly recommended that this saving should transfer <u>with</u> the individual client in order to fund the more effective care in the community/special residential settings. In the case of mild/moderate clients, this 60% will usually amount to about £7,500 - sufficient to fund the running cost of day care and hostel facilities.

The data on average costs per capita also suggests that where sufficient numbers of clients are transferred to enable entire wards to be closed down additional savings on maintenance, heating and lighting etc. will enable at least 75% of the average costs to transfer (approximately £9,500 per patient). Where entire psychiatric facilities close down, the entire cost per capita should transfer (approximately £13,000).

B. Severe/Profound Handicap

The person with severe or profound handicap costs significantly more for the psychiatric hospital to maintain. The data gathered on three psychiatric wards where severe/profound clients exclusively were catered for suggests that where any of these clients transfer, the entire average cost per capita should transfer.

The guidelines for transfer of savings suggested by this study closely match the results of similar research elsewhere. In Britain, the Health Economics Centre of the University of York concluded in a comprehensive report in this area:

"Savings in the early stages of the rundown of a hospital are typically around 56-60% of average cost, rising as the dependency of patients discharged rises "(1).

This report did not consider any costs as being 'fixed' beyond a 2 year period.

It is believed that the approach taken here will be resisted by some psychiatric hospital administrators. It is likely that they will argue that this approach is unrealistic because the only way open to them to reduce these 'variable' costs is to make nursing staff redundant when people with mental handicap are moved out.

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1. See "The Decline in Patient Numbers in Mental Handicap Hospitals" How the Cost Savings should be calculated" Charles Normand & Pat Taylor.. University of York Centre for Health Economics.

There are, in fact, two ways for psychiatric hospitals to reduce their costs and transfer funds:

(1) Allow vacancies to remain unfilled

(2) Transfer suitable staff with the patients and allow the cost of these staff be met by the mental handicap agency to whom funds are transferred.

5.2.2. Transfer of Personnel

Within the mental handicap services there is a considerable degree of scepticism about whether psychiatric nurses could provide a good mental handicap service. On the basis of my own observations I would suggest that this scepticism is ill-founded.

In the more progressive psychiatric hospitals staff working with the mentally handicapped have been pre-selected on the basis of their aptitude and willingness to work in this area. In St. Loman's, Mullingar, staff have been re-trained (with the aid of St. Peter's Mental Handicap Centre, Castlepollard) to equip them better to care exclusively for people with mental handicaps.

Having seen the work being done in Mullingar, I am firmly convinced that many psychiatric nurses could make the transfer to specialised mental handicap services and would be a considerable asset within those services. For such a transfer to be effective, there would be two essential components:

(1) Candidates would have to be selected on suitability through competitive interviews.

(2) Successful candidates would require a period of both formal and on-the-job training in mental handicap nursing.

5.2.3 Capital Costs of New Facilities

Of the 2,000+ in psychiatric care, it seems likely that about 800 could be accommodated in community hostels/day care centres (500 mildly handicapped, 300 moderately handicapped) while a further 800 would require placement in residential care.

At present, capital costs would be approximately £7,000 per hostel place and £7,500 per place in a day centre. Because it is envisaged that those transferring to residential care would fill existing vacancies (left by people in residential care transferring to community based services), it is not anticipated that capital for new residential centres will be required. Facilities for these 1,600 clients now in psychiatric care would therefore cost £11.6 million - a sizeable amount of capital by any standards.

However, capital costs could be reduced dramatically by:

(1) Using local authority housing instead of purchasing from the private sector.
(2) Renting accommodation for hostels and day centres. (Due to declining pupil ratios many primary schools are beginning to accumulate empty' classroom spaces which could be rented out as day centres).
(3) Using former psychiatric or residential premises as day centres.

By such means the capital costs could be reduced to less than £5 million - a sum which would be required over an extended period of time.

It is quite possible therefore that the transfer of these 1600 clients could be achieved at a capital cost of less than £1 million per annum over 5 years.

Assuming these people could be transferred to the more effective specialised mental handicap care, the cost of running the service for them could ultimately be reduced from £20 million at present to less than £17 million (including D.P.M.A.) - a saving of over £3 million <u>every year</u>.

5.3 Transfer from Residential Care

The transfer of psychiatric patients will obviously proceed only if space can be made for about 800 clients in residential care. This can only occur in tandem with the transfer of the 1900 inappropriately placed clients in residential care (600 mildly handicapped, 1300 moderately handicapped).

At present, the service to these clients costs approximately £19 million. In the community setting the more effective service will cost approximately £16 million a further saving of £3 million every year. However, to effect the transfer, significant capital could be required.

Capital to purchase housing and day centres for these clients could amount to £27.6 million. Again, if other options are used (local authority housing and rented premises), the capital requirement could be as low as £10 million over an extended period of time - say, £2 million per annum over five years.

When clients are being transferred from residential to community facilities, resources should transfer in precisely the same manner as has been suggested for clients in psychiatric care. Again, this may be resisted by the administrators of some residential facilities.

8.4 Sources of Funds.

8.4.1 Reducing Wastage.

One potential source of funds is to harness some of the resources which are being wasted in the minority of inefficient agencies (statutory and non-statutory). This would require stringent control of some agencies' spending on items such as maintenance, administration and energy costs, allied to a redundancy programme where inordinate numbers of maintenance, catering and administrative staff are employed.

On the basis of an examination of the accounts of many agencies it is estimated that of the £83 million spent by all agencies, approximately £3 million could be recovered and used more effectively. However, to achieve this better utilisation of resources would require a tougher approach by the Department of Health and Health Boards than has to date been shown.

Ultimately it will be necessary to impose a proper resource management strategy on the few agencies operating without such a strategy. This may require severe limiting of spending authorisations and notifying banks that credit to certain organisations will not be guaranteed. These measures would be necessary to force such agencies to stay within their allocation, something which has not been achieved in the past.

Even with such measures, the re-distribution of resources will take some time. In the first year up to £1 million could be saved purely by restricting expenditure on unnecessary non-pay items. However, additional savings will require cuts in salary costs - which will require redundancies (non-nursing

posts) or the non-filling of vacancies. Redundancies, of their nature, do not result in real savings until at least 2 years after their introduction. It is, therefore, likely that it will be three to five years before savings of the order of more than £3 million pounds per annum are achieved.

Having achieved these savings, they should ideally be converted to capital for the purchase of community facilities to enable the transfer of people with mild/moderate handicap to take place.

If such transfer to capital purposes is not possible, then the very least which should be done is that savings should be re-distributed to agencies whose need is greatest and who are not, at present, getting their fair slice of the cake.

5.4.2 Transfer of Capital

One further possible source of capital for community services is to re-direct any capital funding in the pipeline for residential services. Essentially, this would mean that no additional capital would be made available for expansion of residential services.

Undoubtedly, such a suggestion would be resisted by any residential centre seeking finance for additional places. With this in mind, I would make the point that residential vacancies can be created in <u>two</u> ways:

(1) By building new facilities

(2) By moving existing clients out to a community setting.

Recent experience (e.g. Cheeverstown and Swinford) shows that the capital cost of building new facilities exceeds £30,000 per person.

The capital cost of purchasing a day care and hostel facility can be achieved for less than £15,000 per person.

Moving suitable existing clients out of residential facilities to more appropriate community facilities is, therefore, a far more cost-effective method for creating additional <u>residential</u> vacancies.

5.4.3. Additional Capital Funding

The final source of capital is the traditional one. The Department of Health should seek additional capital funding from the Department of Finance. This capital would be required over a period of 5 years (approximately £3 million per annum). The injection of capital should be allied to a small (about £1 million) reduction in the combined running costs for mental handicap and psychiatric services from the commencement of the first year increasing in subsequent years. Over the 5 year period, the additional capital provided should be more than equalled by a reduction in the running costs of the mental handicap and psychiatric services.

Essentially, the Department of Health would have to give an absolute commitment to ultimately fund this additional capital by reducing the running costs of these services.

This approach advocates a type of strategic planning which is unusual in government accounting.

5.5 Achieving Change

If the re-structuring of our mental handicap services cannot be achieved by making better use of existing resources, then it can only be achieved with an injection of capital of up to £35 million and an increase in revenue costs of over £30 million each year. This is what the shift to appropriate care settings will cost if these are regarded as additional, rather than alternative services. Obviously, we must accept that such funds will not be forthcoming, considering the current economic situation in this country.

Moreover, if lack of finance is used as an excuse to sit and do nothing, then the existing inefficiencies will persist, to the obvious detriment of the people who depend on this service.

While the strategies suggested here may look deceptively simple on paper, they will not be achieved without a great deal of resistance from within many of the agencies involved (including government agencies). While many difficulties may be solved through conciliation, the achievement of a better mental handicap service may require very strong direction by the Department of Health and Health Boards, causing administrative headaches within those offices and much anguish within the mental handicap and psychiatric agencies.

CHAPTER 6

Conclusions and Recommendations

1. There is strong evidence that the traditional institutional model of services provides an often ineffective care setting for many people with mental handicap. Those with high levels of dependency may always require such services but for clients with low levels of dependency community based services provide a more effective and less expensive alternative.

2. The resources currently provided for mental handicap are sufficient to provide a better service. There are at present over 3,000 people with mental handicap in inappropriate institutional care. It is recommended that between 1,000 and 1,500 people with mild and moderate levels of handicap be transferred from institutional to community services. A further 1,600 of those with mental handicap who are currently in psychiatric hospitals should be transferred to more appropriate residential and community services.

3. In most cases, such transfers will entail the movement of people to a less expensive care setting. These major changes do not represent additional services but require a transition to alternative services. They can therefore largely be achieved by making better use of existing resources. However, some additional capital will be required for new hostels and day centres but the amounts required will be small (approximately £3 million per annum) and can be recouped relatively quickly through reduced running costs for the psychiatric and mental handicap services.

4. There is a great deal of inequity in the level of resources allocated to different mental handicap agencies. These inequities should be considerably reduced. Funding to mental handicap agencies should be related to the number of clients catered for and the level of handicap of those clients. The allocations to individual agencies should be made public.

5. The mental handicap service in Ireland is generally well run by highly motivated personnel. Obvious wastage of resources is uncommon and good management is the norm.

   However, in a very small number of agencies, significant sums of money are being wasted on items which do not benefit people with mental handicap.

   It is estimated that these inefficiencies cost the mental handicap services approximately £3 million per annum, out of a total expenditure of £127 million.

6. As was pointed out in Volume I, D.P.M.A payments are being withheld from clients in hostels in some health boards area. This is counter productive as it can lead to people with low dependency levels being kept in inappropriate and more expensive institutional care.

   Regulations on D.P.M.A. payments should be re-defined to remove these inequities.

7. Notwithstanding the fact that there is a waiting list for residential services in many areas, capital investment in new residential places should be severely limited.

   The most cost-effective way to expand services is to transfer inappropriately placed low-dependency clients out of residential care, leaving vacancies for people who have a greater need for such services.

APPENDICES

APPENDIX I

Mental Handicap Residential Centres - 1985 Costings

Centre & Average	*Adjusted Nos	Dep Index $	Variable Costs: Pay & SI 71%	Medical 1%	Food 7%	Furniture, Bedding + Cloth. 2%	Total Variable Costs	Fixed Costs: Maintenance 5%	Heat & Light 6%	Cleaning 1%	Admin + Other 7%	Total	Cost Per Client
		%	£	£	£	£	£	£	£	£	£	£	£
Mild													
St Theresa's	60	0	335,000	2,000	43,000	2,000	382,000	31,000	28,000	4,000	38,000	483,000	8,050
Glenmaroon	66	0	376,000	1,000	57,000	10,000	444,000	27,000	44,000	6,000	53,000	574,000	8,697
Moderate													
Moore Abbey*	177	14	1,628,000	36,000	137,000	49,000	1,850,000	134,000	153,000	25,000	202,000	2,364,000	13,355
Lisnagry*	174	23	1,333,000	19,000	136,000	23,000	1,511,000	29,000	114,000	23,000	100,000	1,777,000	10,213
Mary Immaculate	91	30	752,000	7,000	64,000	39,000	862,000	79,000	68,000	8,000	75,000	1,092,000	12,000
St Patrick's Upton	55	49	370,000	4,000	49,000	6,000	429,000	6,000	58,000	3,000	47,000	543,000	9,873
Clonsilla	274	33	1,535,000	29,000	250,000	64,000	1,878,000	47,000	125,000	47,000	116,000	2,213,000	8,077
St Vincent's Navan Rd*	353	47	2,848,000	47,000	324,000	17,000	3,236,000	71,000	199,000	30,000	231,000	3,767,000	10,671
Cregg House*	216	37	1,828,000	22,000	170,000	8,000	2,028,000	34,000	175,000	22,000	96,000	2,355,000	10,903
St Anne's Roscrea	111	48	673,000	6,000	60,000	15,000	754,000	47,000	84,000	11,000	47,000	943,000	8,495
Bros. Ch. - Belmont*	93	46	704,000	17,000	77,000	34,000	832,000	74,000	74,000	25,000	187,000	1,192,000	12,817
Severe													
St Mary's Delvin	96	53	968,000	19,000	74,000	25,000	1,086,000	96,000	115,000	12,000	95,000	1,404,000	14,625
Stewarts*	295	72	4,520,000	59,000	371,000	96,000	5,046,000	537,000	310,000	64,000	586,000	6,543,000	22,180
St Patricks Kells Rd	170	64	1,135,000	18,000	92,000	18,000	1,263,000	63,000	119,000	8,000	65,000	1,518,000	8,929
Beaufort	109	71	1,115,000	18,000	106,000	18,000	1,257,000	38,000	96,000	17,000	51,000	1,459,000	13,385
John Paul II*	68	98	935,000	10,000	61,000	16,000	1,022,000	40,000	77,000	19,000	101,000	1,259,000	18,515

* For the purpose of this exercise any people who are attending centres during the day only, are costed at .6 of the cost of persons in full residential care.

$ The index shown above gives the % of clients who have severe or profound mental handicaps.

ADULTS DAY CARE CENTRES & WORKSHOPS

AGENCY	LOCATION	NO	HANDICAP	PAY & S.I. £	FOOD £	HEAT & LIGHT £	FURNITURE & EQUIPMENT £	TEACHING AIDS £	TRANSPORT £	CLEANING & LAUNDRY £	PHONE £	ADMIN & SUPPORTS £	OTHER £	SUB TOTAL £	SALES £	TOTAL £	COST PER CLIENT £
Bros Charity	Castlerea	37	Moderate	78,229	4,121	1,893	438	2,930	14,878	472	833	27,079	5,285	136,158	- 5,797	130,361	3,523
"	Gort	37	"	79,196	12,531	3,199	422	2,493	8,262	8,429	1,070	27,079	12,594	147,271	-11,222	136,049	3,677
"	Costelloe	24	"	70,387	4,860	3,162	440	2,038	6,927	420	967	27,079	5,472	121,752	+ 1,310	123,062	5,128
"	Ballinasloe	17	"	44,835	3,622	1,572	352	1,529	3,119	380	572	13,855	1,488	71,324	- 287	71,037	4,179
"	Clarinmore	42	"	69,057	10,699	5,431	-	973	2,548	560	1,064	27,079	17,336	134,747	-19,457	115,290	2,745
Galway Assoc	Galway T.C.	53	"	77,428	7,466	3,934	4,773	753	24,336	N/A	1,095	34,256	11,897	165,938	-13,803	152,135	2,870
"	St Joseph's T.C.	40	"	77,746	7,345	4,878	2,192	1,035	22,454	N/A	1,186	34,256	4,855	155,947	- 705	155,242	3,881
St Michaels House	Charles St	82	"	113,721	2,468	7,179	1,894	1,038	13,612	N/A	3,204	72,160	976	216,252	-22,932	193,320	2,357
"	Glasnevin	80	"	148,716	1,665	6,049	765	391	13,280	N/A	2,058	70,400	6,891	250,215	- 9,543	240,672	3,008
"	Goatstown	40	"	95,752	1,501	7,016	532	-	6,640	N/A	825	35,200	2,415	149,881	- 23,182	126,699	3,167
"	Templeogue	70	"	146,457	3,178	10,373	1,668	1,200	11,620	N/A	4,200	61,600	14,637	254,933	- 55,651	199,282	2,847
N.W. Parents & Friends	R.S.W. Sligo	72	"	189,393	7,917	8,182	410,878	NIL	35,483	NIL	4,910	See Pay	32,189	688,952	-513,115	175,837	2,442
St. John of God's	Islandbridge	270	Mod/Severe	851,392	61,789	48,461	12,909	N/A	67,353	9,577	N/A	"Pay"	101,511	1,152,992	-32,132	1,120,860	4,151
"	Dunmore Hse	150	Mod/Severe	433,247	18,391	24,220	4,916	N/A	36,031	6,448	N/A	"Pay"	73,511	596,764	- 7,899	588,865	3,926
St Michael's House	Ballymun	72	Mod/Severe	175,303	268	7,412	1,787	1,439	16,643	N/A	2,036	63,360	13,007	281,255	NIL	281,255	3,906

7 DAY ADULT HOSTELS - 1985 COSTS - MODERATE HANDICAP

AGENCY	Location	NO	HANDICAP	PAY & S.I. £	RENT & RATES £	HEAT & LIGHT £	FOOD £	PHONE £	CLOTHING + bedding £	FURNITURE £	CLEANNG £	DAY CARE + Support £	D.P.M.A. £	OTHER £	TOTAL £	COST PER CLIENT £
St Michaels Hse	Grangemore	10	Moderate	35,114	-	3,703	6,994	764	924	624	N/A	26,825	20,280	2,143	97,371	9,737
"	St Brigid's	5	"	10,805	-	1,557	3,081	414	315	212	N/A	13,413	10,140	1,959	41,896	8,379
"	Rosshore	7	"	35,789	-	2,050	4,114	584	96	105	N/A	18,778	14,196	1,753	77,465	11,066
"	Kennington	6	"	30,171	-	1,552	5,858	621	565	323	N/A	16,095	12,168	3,199	70,552	11,759
Bros Charity	Cort (4)	27	"	87,519	-15,288	6,398	12,531	2146	751	2,753	1,698	99,279	60,642	2,065	291,070	10,780
	Costelloe (3)	15	"	42,381	- 1,366	6,324	4,860	1934	50	2,534	1,680	76,920	31,775	1,732	168,824	11,255
	Ballinasloe (2)	13	"	46,930	- 2,445	3,144	3,622	1143	1109	1,496	760	54,327	20,042	1,559	131,687	10,130
	Clarinmore (4)	30	"	79,945	1,169	5,431	10,699	1064	500	1,146	1,113	82,350	40,637	983	222,699	7,423
Sisters of St V.De P.	214 Navan Road	8	Moderate	19,200	-	D.P.M.A.	DPMA	DPMA	DPMA	DPMA	DPMA	22,400	16,224	2,600	60,424	7,553
"	44 Kinvara Ave	6	"	12,480	2,520	"	"	"	"	"	"	16,800	12,168	1,560	45,528	7,588
"	7 Whitestown Ave	4	"	12,480	390	660		311	"	"	"	11,700	8,112	1,456	25,109	6,277
"	4 Ashington Grove	5	"	12,480	-	D.P.M.A.	"	"	"	"	"	14,000	10,140	1,820	38,440	7,688
Sisters of La Sagress	Rosses Pt., Sligo	5	"	3,554	2,760	940	1,876	376	-	50	90	13,210	5,070	291	28,217	5,643
	"	6		14,215	NIL	1,409	2,745	462	300	100	120	15,852	6,084	347	41,634	6,939
	"	7	"	22,070	NIL	1,460	2,922	503	900	100	125	18,494	7,098	404	54,076	7,725
N.W. Health Board	-	6	"	27,800	NIL	1,200	2,860	N/A	500	365	N/A	15,852	12,168	1,317	62,062	10,344
St.John of Gods	6 Cedarwood	5	"	22,028	NIL	1,410	4,160	557	DPMA	DPMA	DPMA	15,000 (estimate)	2,390	3,524	49,069	9,814
"	Toreen Hse	5	"	29,424	NIL	1,396	3,120	775	"	"	"	15,000 (estimate)	9,560	3,524	62,799	12,560

TOTAL 1,568,952

∴ 170 = £ 9,229 Average Cost Per Person.

7 DAY HOSTELS - 1985 COSTS - MILD AND SEVERE HANDICAP

AGENCY	LOCATION	NO	HANDICAP	PAY & S.I. £	RENT & RATES £	HEAT & LIGHT £	FOOD £	PHONE £	CLOTHING & BEDDING £	FURNITURE £	CLEANING £	DAY CARE & SUPPORT £	DPMA £	OTHER £	TOTAL £	COST PER CLIENT £
A. Mild handicap																
St. Michaels Hse	Inisfallon	2	Mild	-	3,407	327	DPMA	DPMA	DPMA	DPMA	DPMA	3,212	4,493	356	11,795	5,898
St. John of God	Landscape Pk	5	"	1,287	Nil	DPMA	"	"	"	"	"	Nil	Nil	3,524	4,811	962
"	Westbrook Pk	4	"	9,558	2,160	1,227	"	183	"	"	"	8,000 (estimate)	9,556	3,524	34,208	8,552
													TOTAL		50,814	
													+ 11	=	4,619	Average Cost Per Person.
B. Severe handicap																
St. Michaels Hse	Lorcan Ave.	5	Severe	45,702	-	1,446	4,197	490	57	275	N/A	19,780	11,230	2,252	85,429	17,086
St. John of God	Montpelier	5	"	47,376	520	1,245	4,810	1,020	DPMA	DPMA	DPMA	30,000 (estimate)	2,389	3,524	90,884	18,177
Donard Road "	Donard Road	4	"	30,513	520	1,462	3,000	502	"	"	"	24,000 (estimate)	9,556	3,524	73,077	18,269
													TOTAL		249,390	
													+ 14	=	17,814	Average Cost Per Person.

PSYCHIATRIC HOSPITAL COSTS: MENTALLY HANDICAPPED PATIENTS. 1984 Costs

		VARIABLE COSTS					FIXED COSTS					
HOSPITAL	HANDICAP	NURSING	MEDICAL	FOOD	FURNITURE BEDDING & CLOTHING	TOTAL VARIABLE COSTS	PAY (NON-NURSING)	MAINTENANCE	HEAT & LIGHT	CLEANING	ADMIN & OTHER	TOTAL
St. Loman's (Mullingar)	Mild/Moderate	5,960	350	1,003	212	7,525	2,774	212	500	150	607	11,768
St. Sennan's (Enniscorthy)	"	6,825	432	380	213	7,850	3,165	670	454	112	473	12,724
St. Brigid's (Ballinasloe)	"	6,081	273	546	347	7,247	4,004	491	477	171	494	12,884
St. Columba's (Sligo)	"	6,083	265	905	261	7,517	4,146	305	492	430	737	13,624
St. Conal's (Donegal)	"	6,715	250	911	282	8,158	4,263	450	586	278	512	14,247
St. Ita's (Portrane)	"	4,179	309	724	288	5,496	2,423	490	552	148	220	9,329
St. Loman's (Mullingar)	Severe/Profound	14,125	350	1,003	212	15,690	2,774	212	500	150	607	19,933
St. Brigid's (Ballinasloe	"	9,121	273	446	347	10,187	4,004	491	477	171	494	15,924
St. Conal's (Donegal)	"	13,430	250	911	282	14,873	4,263	450	586	278	512	20,962

AVERAGE COSTS

Mild/Moderate Handicap : £12,429

Severe/Profoundly Handicapped: £18,906

APPENDIX II

DAILY ROUTINE FOR ACORN GROUP

8.00 - 8.15	Receive night report and keys
8.15 - 8.30	Get up in dressing gowns and slippers and toileted
8.30 - 9.15	Go to dining room for breakfast
9.15 - 10.00	Residents toileted and proceed to bedrooms for dressing programme
10.00 - 10.30	Self help programme, i.e. washing, shaving etc
10.30 - 11.00	Residents return to bedrooms to help make beds and tidy rooms. Put down rugs etc. Also tidy up corridor, put away skips, fill up trolley etc.
11 00 - 11.30	Walk or swings or soft play depending on weather
11.30 - 11.45	Help set tables for dinner
11.45 - 12.30	Dinner - encourage good table manners and eating habits
12.30 - 1.00	Toileting, and self help, wash face and hands
1.00 - 2.15	Rest period, t.v. music, socialization or swings
2.15 - 3.00	Wednesday and Friday - Bus run Monday and Thursday - walk weather permitting - Sensory training (jigsaws etc), educational rythmics Tuesday - painting, paper mache, crayons
3.00 - 3.30	Tea-break for residents with one resident helping. Monday - Barry, Tuesday - P J, Thursday - Hugh, Patrick
4.00 - 4.30	Monday, Tuesday, Thursday - music, socialization, communication
4.30 - 4.45	Setting tables and preparing for tea
4.45 - 5.15	Evening tea, encouraging table manners etc
5.15 - 5.45	Toileting and washing of face and hands
5.45 - 6.30	Free time, watch t.v. music etc
6.30 - 7.30	Bath-time, each resident encouraged to help collect his night attire, toileteries, towels etc and encouraged to help as much as possible with bathing. Other residents dressed for bed.
7.30 - 8.00	New clothes if necessary put out for next day. Bathrooms tidied, dirty clothes sorted for laundry. Write reports, fill up B.O. books etc.

John to help with all duties in the a.m. and p.m. Goes TO workshop during the day with Robert 10.30 - 4.30 pm approx.

John also to help empty bins, leave up and collect laundry, remove bedspreads, put out stools, pyjamas if necessary, and dressing gown and slippers for each resident.

Put out night trolley and mop bucket.

To help lock up and close curtains and help put away daily laundry.

John needs firm supervision and constant reminders to carry out his duties.

Hugh and P.J. on hourly toileting programme. These are on the back of the toilet door and are to be filled out daily.
