3 Miller, E. J. and Gwynne, G. V., *A Life Apart: a pilot study of residential institutions for the physically handicapped and the young chronic sick*, Tavistock, London, 1972.
* Britain's current Minister of Education.

Social Services

John E. Tibbitt

Masterton, G., Holloway, E. M., Timbury, G. C., 'Role of local authority homes in the care of the dependent elderly: a prospective study', *British Medical Journal*, 283, 22 August 1981, 523–4.
Ovenstone, Irene M. K. Bean, Philip T., 'A Medical Social Assessment of Admission to Old People's Homes in Nottingham', *British Journal of Psychiatry*, 139, 226—229.

The place of the old people's home within the range of provision for the care and treatment of the elderly is a matter of serious debate: a debate which becomes ever more urgent in the face of increasing numbers of frail elderly and a restricted supply of resources. The dilemma faced by local authority social services is whether to continue to admit to homes old people with the greatest dependency needs who are not being cared for elsewhere, or whether to select only those who require a level of care which maintains a manageable prevalence of disability in the home, given the level of skills of the staff and the desire to create a sufficiently 'homely' environment.

These two papers which report studies carried out in different areas, have something to say about the consequences of each of the above approaches. Ovenstone and Bean studied a sample of 272 consecutive admissions to seventeen old people's homes. All residents were given a full physical, psychiatric and behavioural assessment and a social 'questionnaire' within one month of admission to the home. The study revealed a high level of undetected medical and psychiatric pathology, and showed that over half the sample suffered some degree of dementia and eighty-three per cent were moderately or severely disabled. The authors comment on the low numbers of staff with nursing qualifications and on the apparently intermittent availability of various domicilliary social services to those in the community prior to admission. They conclude, on a basis that is not stated, that only a little over half the residents were correctly placed and one-third should have been in hospital care.

Masterton et al. conducted a two-year prospective study of eleven local authority homes, and used some of the same assessment scales as Ovenstone and Bean. They showed no increase in the degree of behavioural disabilities or the prevalence of dependency or dementia. The proportion of demented residents was unaltered at forty-one per cent with a slight shift from borderline dementia to unimpaired.

In both papers, the authors single out for discussion the admissions policy in the areas studied. Ovenstone and Bean see old people's homes as having become surrogate psychogeriatric/geriatric hospitals without the necessary facilities, and in present conditions see this as inevitable and 'not likely to be temporary'. They argue for more rigorous assessment on admission to improve the allocation of old people to the most appropriate care setting. Masterton et al. see a selection policy which rejects severely disabled people as residents of these homes as a realistic and desirable acknowledgement that the resources of their staff and buildings are finite. They argue that such a policy may expedite the development of more appropriate types of continuing-care unit whose appearance may already have been delayed by the remarkable tolerance of supporting relatives and the willingness of social services staff to look after highly dependent old people.

COMMENT

These papers are further contributions to the growing number of studies of the dependency characteristics of residents of old people's homes. They are both medically-based and have little to say about the social circumstances surrounding admissions. They imply an assumption that health needs should determine allocation to services. Whilst the consequences in relation to the meeting of health needs of differing admission policies needs to be understood, and these papers are welcome from that point of view, there remains a need for detailed studies of the decision-making processes which lead to admission if a full appreciation of the role of the old people's home is to be obtained.

(For a further and more critical view of the Overstone *et al.* article, see *Epidemiology and Community Medicine* below, Editor.)

Clark, Marleen, Miller, Leonard S., Pruger, Robert, 'Treating Clients Fairly: Equity in the Distribution of the In-Home Supportive Services', *Journal of Social Service Research*, 4, 1, Fall 1980, pp. 47–60.

The distribution of most social work services depends crucially on the discretion exercised by front line workers such as social workers and home help organizers and their interpretation of rules and guidance supplied by the agency according to their own perceptions of client needs in relation to the benefits to be gained from a particular service. That the decision-making of these workers may lead to an inequitable distribution of services has been recognized in Britain and in the U.S. This paper examines the implementation of the In-Home Supportive Services (IHSS) programme, a scheme similar to the home help service in the UK, in five different counties in California. The objective of the study is to make explicit the commonly held distribution rules of the IHSS workers in different offices, and to use them as the basis for a predictive device to allocate resources more equitably for clients with a given level of functional disability.

A client functioning assessment scale was developed based on a list of client characteristics workers considered important in assessment and items from a number of existing disability assessment instruments. Workers in each office were then asked to rate prospective samples of new clients on this scale and to indicate the level of service awarded. Using principal components analysis the large number of variables in the assessment schedule were combined into a number of factors and the factor scores for each client regressed against the levels of help allowed. The statistically significant factors were retained as predictors.

The analysis brings out differences in the way workers in different offices allocate resources. Whilst all workers considered the physical functioning of the client to be the basis of need additional variables emerged in each area, but with no consistent pattern between counties or offices. In addition, clients with similar characteristics were allocated very different levels of service from one county to the next. Thus, the paper demonstrates that workers in the different offices are probably following different 'rules' in awarding services to clients. Both the criteria for establishing need and the translation of need into service vary. The project went on to develop a micro-computer programme to indicate to IHSS workers a level of service predicted by application of the rules as they emerged across the sample. These levels are regarded only as guidance and not as commands. It is anticipated that the availability to the worker of this information will lead to greater equity in decision-making.

COMMENT

It is rare that the collective effect of the individual allocation decisions made by groups of workers can be demonstrated to the workers concerned. This paper has illustrated a method for providing 'instant consultation' with others having to make similar decisions which should provide an important additional piece of information for the worker in understanding the context in which he exercises his own discretion. A further study is required to examine the effects on equitable distribution the availability of this information may have.

Pegels, C. Carl, 'Institutional or Noninstitutional Care for the Elderly', *Journal of Health Policy and Law*, 5, No.2, 1980, 205–212.

Discussions about the health and social care of the elderly have usually been concerned more with the quality of the care provided and, with a few exceptions, less with the bleak topic of costs. This would appear to be true both in the U.S. and in the U.K. This paper by Pegels summarizes the arguments raised in a series of regional hearings on home care sponsored by the U.S. Federal Department of Health, Education and Welfare.

Opinion in the regional hearings consistently favoured non-institutional care for many elderly people as being the most desirable in terms of social, emotional and mental well-being. Home health care was also perceived by the majority of witnesses not only as socially beneficial but also as less costly. They also believed that a considerable proportion (variously estimated at 25 per cent–40 per cent) of persons were institutionalized because of the lack of alternative home health care and community support services.

The paper goes on to review studies of the extent to which home care can prevent institutional health care and of the costs of these alternatives. Judging from the material presented there is a paucity of research material on these topics but some evidence is provided which suggests that there are considerable savings to be made from greater use of home health care in many cases. However it appears also that as an individual becomes more impaired, the costs or values of home services increases and the proportion of that care provided by families and friends also increases. At the 'greatly impaired' level where the break even point in cost with institutional care is reached, it is reported that families and friends were providing over seventy per cent of the value of services received by older people.

COMMENT

This is a useful review of the debate about the quality of care to be provided for the elderly and of the costs involved. It is clear that evidence from cost-effectiveness studies or studies of opportunity costs of alternative forms of care is just as sparse in the U.S. as it is here.

Neugent, Mary C., 'Social and Emotional Needs of Geriatric Surgery Patients', *Social Work in Health Care*, 6, 4, Summer 1981, 69–75.

Even for individuals who may already have lost many loved ones and significant contacts, surgery is a social experience with considerable implications for the social networks of all those involved. This paper is a retrospective examination of a randomly selected sample of ninety patients from a population of almost 800 people over the age of sixty-five who received surgery in one year in one hospital in the U.S., undertaken in order to increase understanding of their social and emotional needs as they came to the notice of social workers involved with the cases.

The nature and extent of the surgery were not found to be predictive of the degree of stress or the coping capacity of the patient. Small surgery could expose a huge level of vulnerability while more critical surgery and complications could be handled well by an elderly person with greater personal and social strengths. The physician was seen as a key person in recognizing the need for and timing of social work intervention, as well as demonstrating his trust in the collaborative effort through referral to social work.

Patients experienced a wide variety of fears and social problems, focussed around such topics as adaptation to the health care system with its enforced dependence, the planning of after care, the effects of surgery or loss of privacy, loss of liberty, reversal of parent-child roles and powerlessness. Families also had a multitude of objective and subjective considerations to handle in assessing their ability to meet the demands of home care emotionally and physically, and additional tensions could result from feelings in sons and daughters of guilt for past neglect.

The review showed that early access enabled the social worker to evoke the patient's maximum capacity for self-determination, role fulfilment and social interaction. 'Solid' social work support enabled patients and families to handle emotional and social pressures related to the medical crisis, to make appropriate decisions about discharge, and to activate their natural support systems. A sustained social work relationship appeared critical to the movement of these patients from home to and from the various levels of care in the health system.

COMMENT

This paper, whilst giving little away about the methods used in the care reviews, nevertheless gives an interesting account of geriatric surgery as a crisis in social experience. It usefully serves to emphasize the multidimensional nature of such an experience, and draws attention to the need for professions involved in the care of patients to be seen to trust and value the contribution of others to the total care offered. This seemed to be one of the better accounts of the dimensions of health care with which social work might be involved.

Psychology and Psychiatry

Jeffrey Garland

Christie, A. B., 'Changing Patterns of Mental Illness in the Elderly', *British Journal of Psychiatry*, 1982, 140, pp. 154–159.

As the 'bulge' in the proportion of people over seventy-five continues to swell ominously over the next decade, we can expect to see many more such papers by consultants in psychogeriatrics, bemoaning with Dr Christie that 'the rising prevalence of dementia and the increasing survival of demented patients, is posing serious problems for the psychogeriatric services'. The problems from the patients' point of view aren't exactly trivial either, but the author, understandably, does not pause to consider this as he launches into this clearly-presented account of a thought-provoking study.

He describes a partial replication of the major investigation of prognosis of mental illness in old people reported from Graylingwell Hospital by Roth in 1955.[1] At the Crichton Royal from 1974 to 1976 all patients admitted to the psychogeriatric unit were followed up at six and twenty-four months following admission (as in the Graylingwell study). Unfortunately, due to differences in the lower age limit for admission and lack of two-year follow-up data for some of the Graylingwell patients, the original 450 of Roth's patients are reduced to 143 for this comparison, which is with 265 of the 343 Crichton Royal admissions during the period under review. Christie gives us no way of guessing whether the rump of Roth's cohort is representative of the original 450, and we can only hope that it is, in view of the many comparisons made here between the hospitals.

A key finding is that functional illness (affective psychosis and late paraphrenia) found relatively frequently at Graylingwell has given way at the Crichton Royal to dementia, not as a proportion of the patients admitted but in the number of beds employed for their care six and twenty-four months after their index admission (admission rates for the elderly with dementia have actually been falling recently as the prolonged survival of already admitted patients restricts the rate for new admissions).