ABN 92 491 228 162

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The Secretary
Senate Community Affairs References Committee
Suite S1 59
Parliament House
Canberra ACT 2600

## SUBMISSION

## THE AVAILABLITY AND APPROPRIATIVENENSS OF ACCOMMODTION FOR PEOPLE WITH SPECIAL NEEDS

Over the past 4 years I have been increasingly concerned about the lack of commitment of the aged care sector and the government to the homeless and disadvantaged aged. While the Department of Health and Ageing has specific guidelines for the numbers of concessional clients each facility must accommodate, there are indications that those who are most disadvantaged are being excluded. The current legislation places the homeless with the financially disadvantaged.

The promise of additional funding for training and education in the 2004 budget is welcome but will not go far enough in providing the specific skills required for those with complex needs including behavioural issues and mental illnesses.

Over the last 40 years, St Bartholomew's House has been providing services to those people experiencing any type of homelessness. Homelessness in this context being defined as "elderly people who are in non-permanent housing such as rooming houses, psychiatric hostels and caravan parks or who have an unstable history in public housing or who live in squats or in the streets". Many of these aged persons have significant substance use issues and/or mental illnesses.

As homelessness is a growing issue in the community, the sector needs to respond appropriately by making places available for this clientele. Currently there are only a small number of services who are willing to provide care to this group of clients and this appears to be dwindling.

At a recent ACSWA breakfast meeting a large Church provider outlined the positive future for aged care providers. His strategies for economic survival included the removal of small providers and the development of large 'home like' environments for aged care recipients and a number of economic models to ensure each provider would survive and make a profit in the future.

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If this is the plan for aged care, there does not appear to be a plan for the access of homeless people to these residential and community aged care services when they need them.

Access to Services

*Aged Care Definitions*

The current aged care funding system favours elderly people who are more financially secure and encourages low care facilities to admit residents who fit that criteria.
The Aged Care Act (1997) does make reference to financially disadvantaged people. This now does not go far enough in addressing the needs of the most disadvantaged in our society, those experiencing homelessness. I raised this issue when St Bartholomew's House received 14 housing linked aged care packages in 2001. In effect, the homeless were excluded from receiving care because of their extreme disadvantage by not having a home to receive care in.

*Aged Care Facilities*

The homeless elderly have difficulty gaining access to residential aged care services under the current definitions and also due to a negative image. There are no specific places for this client group. Very limited places are offered by some services and it is difficult to transfer clients to high care when they require it.

Often acute care facilities will discharge residents back to a low-care facility when they are still unwell and require nursing intervention that is not available. In addition to this, some facilities with care awaiting placement beds will make inappropriate referrals and transfers just to move the resident on.

Some Aged Care Assessment Team members have little understanding of the client group and will not consider services that may be required for those of a younger age who are prematurely ageing and are not traditionally recognised as an aged care responsibility.

In one case a doctor was extremely judgmental about a client's circumstances in his home in the community, even though this man had discharged himself from numerous residential and acute care facilities. The gentleman was well aware of his rights and care staff in the community has established a supportive network for him to remain in his rented accommodation. The medical/treatment model cannot be applied in the community.

Main stream services actively discriminate against this client group because of an expectation of challenging behaviours, substance and alcohol use, smoking, mental illnesses and personal hygiene issues.

*Providing Quality Aged Care to the Homeless*

Most homeless people have high and complex needs and require a different and intensive level of support.

- *Emotional Support*
  Homeless people may not have any contact with family or even friends. They require 1 : 1 interaction at the highest level. This involves staff establishing close links with residents, which may include hospital visiting, transporting to and from medical appointments and long discussions over ongoing treatment needs. Staff will endeavour to build self-esteem and interpersonal skills to improve the possibility of more interaction with their fellow residents. Many residents feel a sense of guilt about their relationship breakdowns and staff will try to establish some links with estranged family. A task, which is very difficult especially after a lifetime of abuse.

- *Behavioural Issues*
  Many aged people experiencing homelessness have a mental illness or have non-organic brain dysfunction because of excessive substance or alcohol use. Often these people have learned that in order to get what you want in the world you have to threaten or shout. They may have limited insight or short-term memory loss, which does not allow them to understand the consequences of their actions. There are considerable risks to staff when dealing with these clients, because of their volatile and changing temperament and they pose an occupational safety and health risk.

- *Personal Care*
  Clients have not traditionally got up and had a shower each morning and do not think it is important to participate in routine hygiene plans. They are reluctant to take off their clothes because they might lose them and there has been no reason to continually wash them according to their previous lifestyle.

- *Leisure Activities*
  Residents are mostly interested in ‘Happy Hours’ or any activities that centre around drinking and smoking. Staff have to plan 1 : 1 activities for each individual as most are reluctant to join any group activity. Although many residents express a desire to go out on outings, they usually cancel at the last moment and need to be encouraged and taken as individuals.

- *Medical and Dental Issues*
  Clients have a distrust of most medical interventions, are reluctant to take medications, because they believe alcohol solves all their problems. Clients are reluctant to obtain any dental health assistance and adjust their eating regimes to the number of teeth remaining.

- *Dependence of Alcohol*
  Some residents are unable to live in a residential aged care facility and are better managed in the community with assistance to ensure they have

security of tenure in their accommodation. They are then able to utilise their remaining funds for leisure interests such as drinking and smoking.

*Viability of Homeless Aged Care Services*

There are a number of concerns about the ability of those organisations serving homeless people being able to remain viable in the future. There also appears to be a lack of support in the aged care sector for these particular services.

St Bartholomew's House has managed to maintain its aged care services, both residential and community, by providing specialist services to homeless people over the aged of 18 years. By having a number of program services co-located, the House has achieved economies of scale, which allow sharing of catering, laundry, staffing and administration.

It is hoped that this style of operation can continue into the future, however the numbers of homeless elderly that can be accommodated it limited.

I have knowledge of a large aged care facility on Victoria that specifically caters for the homeless and is very successful. However they receive significant State funds to supplement their Commonwealth funding.

There would need to be considerable financially benefits offered for many mainstream services to accept the homeless and will the homeless and the 'homelike' environment be compatible with their lifestyle.

Conclusion

The homeless are a specific sub-set of the aged population and should be considered separately from those aged who have family support, are financially stable and do not have complex needs.

Many aged care services will not be including the homeless in their forward financial estimates or planning for places in the future. Many aged care facilities do not have staff with the skills and expertise to provide care and support to the homeless.

Consideration should be given to the needs of the homeless in the future and should include the special needs of those who currently have a placement.

Changes would need to be made to the Aged Care Act, which would make the homeless a 'special needs group' and therefore make them more attractive to those facilities chasing places. There would need to be strict criteria for entry or there is a risk of these places being 'gentrified'.

Recognition should be given to those facilities who are currently providing quality aged care to the homeless with strategies in place to assist to be classified as extra service facilities or similar, which recognise the intensive support in the care provided.

With regards to the Aged Care Standards and Accreditation Agency, I believe they have made a significant impact on improving health, care and safety in residential aged care.

For those services who do not provide care to the mainstream aged it has been a battle to ensure that the specific needs of their clients were understood by the Agency and acknowledged. However, I have found the assessment process to be positive and affirming.

I am in receipt of the magazine periodically produced by the Agency but do not consider that their role to date has been one of identifying best practice, providing information or education to aged care facilities. Having been involved in the acute care sector accreditation there as much more information sharing in that process.

The amount of paperwork has increased significantly and there are pressures placed on staff from the Department of Health and Aged Care and the Accreditation Agency. Even with an effective continuous improvement program the additional administration support required is costly to small operators.

Yours Sincerely,

Lynne Evans
Chief Executive Officer

References:
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