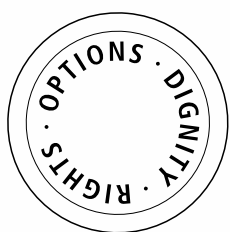


Wintringham



**MODELS OF CARE FOR ELDERLY PEOPLE WITH
COMPLEX CARE NEEDS ARISING FROM
ALCOHOL RELATED DEMENTIA AND BRAIN INJURY**

Dr Alice Rota-Bartelink

Wintringham

Written in collaboration with *arbias*
and The J O & J R Wicking Trust

May 2006

Preface and Acknowledgements

We trust that you will find the following review interesting and informative. The document was written as an explorative review of the services currently available to older people in Melbourne, Australia with particular focus on people with acquired dementia resulting from alcohol related brain damage (ARBD). Valuable contributions have been made to the writing of this document by: Bryan Lipmann AM, CEO Wintringham; Helen Small, General Manager Operations Wintringham; and Sonia Berton, CEO *arbias*. This review was undertaken to inform the writing of a proposal for a Major Strategic Grant from The J O & J R Wicking Trust.

This project has developed from the experiences of Wintringham as it delivers a daily range of aged care services for clients and residents, many of whom have an alcohol related brain injury. We have noted over the years that service models designed for homeless people, are often inappropriate for people suffering a brain injury. In response, staff at Wintringham, supported by specialist advisors from *arbias*, have developed new and innovative practice standards which assist with providing care to these people.

It is envisaged that this project will ultimately result in the documenting and trialling of a purpose-designed long-term residential 'model of care' specialising in supporting the complex needs of older people with ARBD. A major aim of this project will be to provide the aged care sector with a practical and reproducible 'model of care' that can be adopted by the providers of residential services, homeless services, medical and mental health services and alcohol and drug services, to better meet the needs of this group of people. As a community, it is only through an improved understanding and adequate provision of specialised services that we can hope to find a solution to the problems that ultimately lead to the sad and lonely lives that these people are currently subjected to.

The Project Partners

Wintringham

Wintringham is a not-for-profit organisation that provides aged care services specifically targeted at elderly homeless men and women (50 years and older) in Melbourne, Victoria. Services include low and high care residential facilities, an extensive choice of housing and support options and Community Care Packages. For further information visit Wintringham's website at www.wintringham.org.au, or contact:

Bryan Lipmann, AM
 Chief Executive Officer
 E bryan@wintringham.org.au
 PO Box 193
 Flemington, Victoria 3031 Australia
 T 03 9376 1122
 F 03 9376 8138

2

arbias

arbias is a not-for-profit specialist disability service in Melbourne, Victoria that works together with clients, families and service providers to assist people with acquired brain injury to live and function to their full potential in the community. Services include ABI assessment, case management, housing and support options, recreation, and education and training. For further information visit the **arbias** website at www.arbias.org.au, or contact:

Sonia Berton
 Chief Executive Officer
 E sberton@arbias.com.au
 PO Box 2229
 Fitzroy, Victoria 3065 Australia
 T 03 9417 7071
 F 03 9417 7056

ANZ Executors and Trustee Company Limited

ANZ Executors and Trustee Company Limited is a leading company in its field, providing governance, trustee, investment, and granting services to individuals, families and charitable foundations. Its philanthropic activity aims to create a better community. ANZ Trustees manage assets in excess of \$2 billion, including over 300 charitable foundations and trusts, with not-for-profit assets exceeding \$1 billion. ANZ Trustees is a wholly owned subsidiary of the ANZ Banking Group. For further information visit ANZ Trustees' website at www.anz.com/aus/fin/trustees/.

The J O & J R Wicking Trust

ANZ Trustees is sole trustee for The J O & J R Wicking Trust, which aims to achieve systemic improvements through enduring, positive impact in the areas of care of the aged, problems associated with ageing and Alzheimer's disease. The Benefactor of The Wicking Trust, John Oswald Wicking (1918-2002) was one of the great modernisers of Australian business. He and his wife Janet were notable philanthropists and benefactors to many institutions during their lifetime. Having been a prisoner of war in Germany during World War II, John Wicking would have experienced first hand the hardship associated with banishment and deprivation. In our view, John Wicking would have had empathy with the plight of our older, homeless people suffering ARBD who are in desperate need of understanding, respect and continuing support from our community.

We hope that our project will contribute to the achievement of the Wicking's goals by supporting a group of older people who are no longer capable of adequately supporting themselves and for whom the current service system has failed.

Dr Alice Rota-Bartelink
Research Co-ordinator
Wintringham
E alicerota@wintringham.org.au

Executive Summary

Currently Australia has a well developed community service system. Comprehensive 'mainstream' aged care services are generally effective in delivering appropriate levels of care and support to the majority of the aged population. Support and services for the aged in Australia are provided by a large number of government programs (Commonwealth, State/Territory and Local). Other service providers include the community and voluntary sectors, the private for-profit sector and the private not-for-profit sector. Aged care services are currently provided through at least 30 different funded programs with a range of eligibility criteria and access points. In the next 20 years the number of Victorians aged 55 and above is predicted to rise by over 25%. Whilst opinions may vary as to the effects that ageing may have on Australian society in the future, there is no doubt that policy adjustments will need to be made to reduce the rate of growth in future outlays on aged care services and support. Despite the richness of services available to older people in Australia, there are still groups of people in the community who are not gaining access to these services or not utilizing the full potential of these services to meet their needs. There are also some people for whom the services available lack the specialised skills or resources required to adequately address these needs.

4

In 2004, two population groups were identified by the Commonwealth government as requiring additional targeted service support. These were; people suffering from age-related dementias, and people requiring complex palliative nursing care. It has been demonstrated that over the age of 60, the incidence of acquired dementia in Victoria increases exponentially from 1% to 23% for people 85 years or above. This represents an increase greater than 10% over the past three years and is expected to rise by a further 8% over the next five years⁷. In recent years 'Dementia' has been made a National Health Priority resulting in an injection of funds being allocated to research, improved care, early intervention programs and new residential care supplements for its sufferers. Age-related dementia can be associated with varying levels of cognitive impairment and challenging behaviours, which at the extreme end of the spectrum results in the requirement for dementia-specific accommodation and facilities, which are separated, from 'mainstream' nursing homes and hostels. They generally support residents in smaller carer/client ratios in facilities with design features that are more desirable to dementia care including improved security, ease of observation and harm minimization strategies. The demand for these facilities greatly exceeds the number of places available for people who qualify for eligibility.

In theory it would appear that the level of specialised care provided by these types of facilities would suit the accommodative needs of people with other conditions such as long-term homelessness, those with acquired brain injury (ABI), alcohol related brain damage (ARBD) and even sufferers of such conditions as Huntington Disease. All of these conditions can result in dementia-like symptoms and a complexity of care needs that require higher levels of residential care. However, the average age of residents in dementia-specific nursing homes is significantly older than most people with these conditions. Currently in Australia there are over 6,000 people aged less than 65 years living in residential aged care facilities, including both high and low care. Approximately 1,000 of these people are aged less than 50 years, most of which have been admitted because they have permanent disabilities such as an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or a combination of these). The sedentary lifestyle and absence of like-aged and like-minded people in nursing homes has been demonstrated to exacerbate mental illnesses and disruptive behaviours in these people. This in turn, presents staff and co-residents with situations and circumstances with which they are unfamiliar and may not be capable of facilitating. It is also argued that the behavioural characteristics commonly associated with these other conditions can sometimes differ significantly from that of age-related dementia particularly with regard to social skills and social interactions resulting in a completely different set of complex care needs. The gap in the provision of specialised supported accommodation for these people, particularly older homeless people with acquired dementia resulting from alcohol related brain damage (ARBD), is the driving force behind the development of this project.

For older people who are homeless, or at risk of homelessness, there is a diverse and varied need for services that provide specialized housing support, personal care and support and health care. Their needs, lifestyles and values are often different from older people who already have secure and appropriate housing, and almost always different from younger homeless people. The homeless lifestyle often results in premature aging; therefore people may need to access aged-care services at a younger age than others and may not be eligible due to strict eligibility criteria. Older people who are homeless are not seen to be a 'natural' part of the homeless, housing or aged care systems and therefore these people frequently end up in shelters or inappropriate accommodation settings.

The difficulty in providing appropriate and adequate case management and accommodation to elderly homeless persons with high and complex needs has posed a problem for health care providers, social support agencies and housing agencies for decades, especially since the introduction of social policies involving deinstitutionalization and the promotion of community-based living. The people to whom we refer somehow fall in the jurisdictional cracks created by division and funding structure for health and social care. These people tend to transiently shuffle between organizations that cannot provide long-term care management solutions. Their mental well-being and chronic health status incrementally deteriorates to such a point that the increased reliance on hospital and emergency services reaches crisis level at which stage institutionalization remains the only viable option.

It has been recognized that the provision of secure, affordable and appropriate accommodation in conjunction with support services, cannot only postpone the need for entry into an aged-care or nursing home, but encourage long term positive health, psycho-social wellbeing and an increased sense of independence. Working with the elderly homeless presents particular problems for service delivery, in part because of often noted incidence of premature ageing, combined with a general reluctance to accept services due in part to a strong sense of independence and demeaning experiences with a range of previous health and aged care providers. Although a few organisations in the USA, UK and Australia, have developed services specifically for older homeless people, they all struggle to meet the needs of their clients. This is due largely to the limitations imposed by programmatic funding that has more to do with meeting mainstream aged care needs than the particular problems presented when working with homeless elderly people.

Wintringham is an organisation that provides aged care services specifically targeting elderly homeless men and women (50 years and older) in Melbourne, Victoria. Services include low and high care residential facilities, an extensive choice of housing and support options and Community Care Packages. What remains unique about this service is that it has continued to maintain its focus on the specialised target group and as a result the staff are trained to better understand and support the complexity of need associated with homelessness. Wintringham's philosophy that their clients are primarily regarded as being 'aged' and secondly as being 'homeless' has had a huge bearing on their ability to attract funds to provide appropriate care and support to its clients. Because of the high incidence of alcohol abuse within this population, the service has adapted its residential model of care to accommodate the complexity of need associated with age, homelessness and ARBD.

The following review has considered the services available in Melbourne, Australia and psycho-social models of care as they apply to elderly people, particularly with regard to complex care needs resulting from acquired brain injury and dementias associated with excessive alcohol consumption. Through this process inadequacies of the current Australian aged care system in its ability to meet this specialized need have been highlighted. Mainstream services need to be more flexible, accessible and creative when supporting those with enduring mental illness particularly in association with older age and homelessness. The gap that remains between mainstream aged care services and homeless service providers demonstrates the need still exists for a purpose-designed 'model of residential care' specifically aimed at providing long-term care solutions for older people with ABI and ARBD.

Table of Contents

1	Definitions and Acronyms	8
2	Introduction	13
3	Aged Care and Residential Services in Victoria	15
3.1	<i>Background and Overview</i>	15
3.2	<i>Funding Sources and Programs</i>	15
3.2.1	Residential Aged Care Programs	16
3.2.2	Community Care Programs	17
3.2.3	Public Housing Programs	18
3.2.4	Multiple and Complex Needs	19
3.3	<i>Gaps in the Provision of Services</i>	20
4	Homelessness	23
4.1	<i>Definitions of Homelessness</i>	23
4.2	<i>Funding Sources and Programs</i>	23
4.3	<i>National Homeless Strategy 2000</i>	25
5	Health Care within the Aging Population	27
5.1	<i>Acute Health Problems within the Aging Population</i>	27
5.2	<i>Acute Health Problems within the Aged Homeless Population</i>	28
5.3	<i>Chronic Health Problems within the Aging Population</i>	29
5.4	<i>Chronic Health Problems within the Aged Homeless Population</i>	30
6	Mental Illness within the Aging Population	32
6.1	<i>Chronic Mental Illness within the Aging Population</i>	32
6.2	<i>Chronic Mental Illness within the Aging Homeless Population</i>	33
6.3	<i>Dementia in the Aging Population</i>	35
6.4	<i>Acquired Brain Injury in the Aging Population</i>	37
6.5	<i>Alcohol Related Brain Damage</i>	39
6.6	<i>Alcohol Related Brain Damage in the Aged Homeless Population</i>	41
6.7	<i>Behavioural Disorders in the Aging Population</i>	43
6.8	<i>Behavioural Disorders in the Aged Homeless Population</i>	45

7	Existing Supported Residential Service Models for Older Homeless People with Complex Needs	48
7.1	<i>The United Kingdom</i>	51
7.1.1	Scotland	52
7.1.2	Wales	54
7.1.3	England	54
7.2	<i>The United States</i>	58
7.2.1	New York	59
7.2.2	Vermont	60
7.2.3	Seattle	60
7.2.4	Philadelphia	61
7.2.5	Chicago	61
7.3	<i>Canada</i>	62
7.4	<i>Australia</i>	63
7.4.1	New South Wales	63
7.4.2	South Australia	63
7.4.3	Tasmania	64
7.4.4	Victoria	64
8	Conclusions	68
9	References	70

1

Definitions and Acronyms

ABI

Acquired Brain Injury refers to any type of brain damage that occurs after birth.

ACAT/S

Aged Care Assessment Team /Service which is funded by the Commonwealth Government

ACFI

Aged Care Funding Instrument developed by the Commonwealth Government.

ACHA

Assistance with Care and Housing for the Aged Program which is funded by the Commonwealth Government.

ACMH

Aged Community and Mental Health Division which is funded by the State Government

8

ACSO

Australian Community Support Organisation

Adaptive Behaviour Syndrome

A condition characterised by poor planning and organisation, concrete and inflexible thinking, lack of insight, inappropriate behaviour and a lack of self-criticism¹²⁶

Aged

The terms 'elderly' and 'aged' are usually taken to mean people aged over 65 years of age. However the terms can apply to younger people within specific target groups with special support needs such as the long-term homeless and Indigenous people. It has been demonstrated that homeless populations have a higher rate of serious morbidity and premature mortality compared to the general population, with westernised countries reporting an average age of death between 42 and 52 years. Therefore, it has been recommended that the age of 50+ be used to define older homelessness.

Aged Care

Support and services provided to the aged population by a large number of government programs (Commonwealth, State/Territory and Local) as well as programs/support from the community and voluntary sectors, the private for profit sector and the private not-for-profit sector.

'Ageing in Place'

Aged Care Act legislation stating that people could remain in their home/accommodation (however defined) regardless of their increasing care needs

ANHECA

Australian Nursing Homes and Extended Care Association

APMHS

Aged Care Mental Health Services which is funded by the State Government

ARBD/I

Alcohol Related Brain Damage/Injury

arbias

Organisation which provides specialist services to people with alcohol and substance related brain injury to assist them to live and function to their full potential in the community

ASB

Anti-social behaviour has been described as a generic term that covers a range of behaviours that infringe on the right of individuals to enjoy their surrounding environment (e.g. home).

ATSI

Aboriginal or Torres Strait Islander

BPSD

Behavioural and Psychological Symptoms of Dementia

CACH

Commonwealth Advisory Committee on Homelessness

CACP

Community Aged Care Package Program which is funded by the Commonwealth Government

CAP

Crisis Accommodation Program provides funding to State Governments via a tied grant under the Commonwealth State Housing Agreement (CSHA) for the provision of crisis accommodation.

CBDATS

Community Brain Disorders Assessment and Treatment Service which is funded by the State Government

CCP

Community Connections Program which is funded by the State Government

CCU

Community Care Units

Challenging Behaviour

Generally described as behaviour that, either directly or indirectly, seriously disrupts or affects the lives or routines of other people or services

Cognition

The mental process of knowing, including aspects such as awareness, perception, reasoning, and judgment.

Complex Needs

A person whose needs and behaviours challenge health, human services and criminal justice systems due to a combination of two or more factors including mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, social isolation, family dysfunction and drug and alcohol misuse²⁰.

CPSV

Care Plan Assessment Victoria

CRU

Community Residential Units

CSAS

Major Crisis Supported Accommodation services which are predominantly funded through SAAP

CSHA

Commonwealth State Housing Agreements

Dementia

Describes a syndrome associated with a range of diseases characterised by a progressive impairment of brain functions, including cognitive skills, memory, perception, personality and language⁷⁷.

Dual Diagnosis

A term used to describe people who have a major mental health diagnosis and who are also substance dependent.

DVA

Department of Veteran Affairs which is funded by the Commonwealth Government

10

EACH

Extended Aged Care at Home Program which is funded by the Commonwealth Government

Executive Functioning

Includes the abilities of retrospective memory and prospective cognition for the promotion of strategic planning, including the delaying of responses to enable the consideration of options, consequences, strategic development and flexibility in ideas¹¹⁰

FLD

Frontal Lobe Dysfunction/Disorder

Forensicare

Victorian Institute of Forensic Mental Health which is funded by the State Government

HACC

Home and Community Care program which is jointly funded by State and Commonwealth Governments

HARP

Hospital Admission Risk Program which is funded by the State Government

HASP

Housing and Support Program which is funded by the State Government

HDDT

Homeless and Drug Dependency Trial initiative which received State Government funding

Homeless

The absence of housing and the marginalisation from social networks and community services²⁸.

HOPS

Homeless Outreach Psychiatric Services which is funded by the State Government

HSA

Housing Support for the Aged Program which is funded by the State Government

HUD

Department of Housing and Urban Development in the United States

Huntington Disease

An inherited, progressively degenerative neurological condition with early symptoms often characterised by challenging and/or antisocial behaviours and cognitive changes

IHDCC

Interfaith Housing Development Corporation of Chicago

Korsakoff Amnesic Syndrome (KS)

Characterised by intact immediate memory, a profound difficulty learning new information, poor recall of recent events, confabulation and lack of spontaneity.

Learning impairment/disability

A general term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities

Linkages

A case management program funded by the HACC program

MACN

Multiple and Complex Needs Initiative which is funded by the State Government

MISA

Mental Illness and Substance Abuse

NIAAA

National Institute on Alcohol Abuse and Alcoholism in the United States

NIDA

National Institute on Drug Abuse in the United States

OOH

Office of Housing. Provider of the State Government's Department of Human Services housing service, including emergency and transitional accommodation, long term rental housing, private rental and home ownership assistance.

PGATS

Psycho-geriatric Assessment and Treatment Services which is funded by the State Government

PRS

Psycho-geriatric Residential Services whose facilities are jointly funded by State and Commonwealth Governments

PSH

Permanent supportive housing program in the United States

Psycho-social

Comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services

RACF

Registered Aged Care Facility

RCS

Residential Classification System/Scale

RDNS-HPP

Royal District Nursing Services Homeless Persons Program which is jointly funded by the State Governments (Through the Supported Accommodation Assistance Program) and ACMH

SRS

Supported Residential Services which receive no government funding.

12

SAAP

Supported Accommodation Assistance Program which receives joint funding from the Commonwealth and State Governments through the Office of Housing

Thiamine

Vitamin B₁

VAHEC

Victorian Association of Health and Extended Care

VCCCP

Victorian Chronic and Complex Care Program which is funded by the State Government

Wintringham

Organisation which provides aged care services targeted specifically at elderly homeless men and women. Services include low and high care residential facilities, an extensive choice of housing and support options and Community Care Packages.

2 Introduction

Currently in Australia, mainstream aged care services have generally been effective in delivering appropriate levels of care and support to the majority of the aged population. Funding arrangements do not adequately support the provision of appropriate aged care services to older people presenting with special and complex care needs including dementia, challenging behaviours and homelessness. A recent Government funded review of the aged care industry by Professor Warren Hogan recommended the extension of funding supplements to three special needs groups: (i) people with short-term medical needs; (ii) people with dementia or who have palliative care needs; (iii) and people from a disadvantaged background such as Indigenous persons. In recognition of the system failure highlighted in the Hogan Review in 2004¹, the Commonwealth made 'dementia' a National Health Priority with initial funding being allocated to research and improved care and early intervention programs such as dementia-specific Extended Aged Care at Home places. In July 2006, new residential care supplements are to be introduced with the aim to better target assistance to people with dementia exhibiting challenging behaviours and to people requiring complex palliative nursing care. Despite this massive injection of funds into supporting dementia, there is a small subpopulation of the aging community whose needs have still not been adequately addressed.

For older people who are homeless, or at risk of homelessness, there is a diverse and varied need for services that provide specialized housing support, personal care and support and health care. Their needs, lifestyles and values are often different from older people who already have secure and appropriate housing, and almost always different from younger homeless people. The homeless lifestyle often results in premature aging; therefore people may need to access aged-care services at a younger age than others and may not be eligible due to strict eligibility criteria. The Hogan Review observed that the elderly homeless population, albeit small, are one of the most difficult groups to place in residential care. Homeless people often have poor interpersonal skills and are suspicious of people they don't know, including service providers, and it takes a great deal of time, which is not funded, to build up a relationship of trust. Other areas where homeless people require a different and intensive level of support include personal care, leisure activities, overcoming alcohol and/or drug dependency and medical and dental issues².

Historically support for the elderly homeless with complex needs has been managed, with varying degrees of success, in an uncoordinated, ad hoc manner by a range of service systems including; medical and emergency, social, residential, aged care, penal and mental health services. Chronic illness is also common among homeless people with hypertension, diabetes, peripheral vascular disease, respiratory problems, and liver and renal disease being the most frequent causes³. When conditions commonly associated with homelessness such as mental illness and alcohol related brain damage are added to the complexity of the person's need, often they do not fit neatly into any existing category of care. They 'fall through the net' at multiple points in the care pathway due to such issues as a inflexible eligibility criteria, a lack of communication and information, a lack of agreed local care pathways and segregated service provision systems⁹⁶. Currently the Commonwealth of Australia does not provide any funding supplements to support the specific need of the elderly homeless¹.

Recent evidence has demonstrated that an aged care residential model of care may best meet the needs of this target population. An extensive international World Health Organisation literature review in 2005, concluded that; "*A healthy housing policy acknowledges the need for health and social support as well as housing support and entails a shift from large-scale remedial institutional accommodation towards small-scale and individualized assistance*"⁸. For older Australians it has also been recognized that the provision of secure, affordable and appropriate accommodation in conjunction with support services, not only postponed the need for entry into an aged-care or nursing home, but encouraged long term positive health, a sense of independence, a reduction in the frequency of relapses back into homelessness, improved levels psycho-social wellbeing, as well as positive social and economic benefits for the community at large^{4,17,42}.

Based on this evidence we will consider psycho-social models of care as they apply elderly homeless people, particularly with regard to complex care needs resulting from acquired brain injury and dementias associated with excessive alcohol consumption. Through this process will examine the inadequacies of current Australian aged care services in their ability to meet this specialized need.

Older people who are homeless are not seen to be a 'natural' part of the homeless, housing or aged care systems and therefore these people frequently end up in shelters or inappropriate accommodation settings. As homeless older people represent a relatively small percentage of the homeless population, facilities, outreach and resettlement services that provide assistance to homeless people of all ages developed to meet the needs of majority of their service users – younger homeless people. In the past, the major reason why the homeless did not enter the aged care system was the reluctance of the mainstream providers to accept homeless clients. By focusing on their age rather than their homelessness, a shift in the paradigm away from homeless to mainstream aged care funding can be achieved⁵. However, even though this strategy, after extensive and tireless lobbying, has been successful in promoting and funding more appropriate levels of care for older homeless people, the aged care system still struggles to meet the financial requirements to adequately the complexity of the older homeless persons needs. When the older homeless person also suffers from mental illness as a result of ABI or alcohol related brain damage (ARBD) the problem is only exacerbated and the financial deficit widens.

3 Aged Care and Residential Services in Victoria

3.1 Background and Overview

In the next 20 years the number of Victorians aged 55 and above is predicted to rise by over 25%⁶. Whilst opinions may vary as to the effects that ageing may have on Australian society in the future, there is no doubt that policy adjustments will need to be made to reduce the rate of growth in future outlays on aged care services and support. For example, various incentives have been provided for self provision of retirement incomes through the superannuation system; changes have been made to the preservation age for superannuation; a pension bonus system has been introduced that provides a cash incentive to those who delay taking up the age pension and greater user pays has been introduced to the residential aged care sector. Currently, policy makers are looking at the provision of incentives aimed at stopping people from retiring 'early'⁷. In recent years the tendency in policy terms is for an increased emphasis on early intervention and 'healthy' ageing combined with 'ageing in place', that is, keeping older people out of health and residential facilities for as long as possible.

In terms of eligibility for most care and support programs the terms 'elderly' and 'aged' are taken to mean people aged over 65 years of age. It should be noted however; occasionally support for the aged is given to younger people within specific target groups with special support needs such as the long-term homeless and Indigenous people. It has been demonstrated that homeless populations have a higher rate of serious morbidity and premature mortality compared to the general population, with westernised countries reporting an average age of death between 42 and 52 years^{8,9,10}. Therefore, it has been recommended that the age of 50+ be used to define older homelessness. The low density urban developments present in many Australian communities present significant obstacles to the independence of seniors and their ability to access appropriate services¹¹.

Prior to the 1950s, the majority of non-income support and assistance for the elderly was managed by State Governments and the charitable sector. From the 1950s onwards the Commonwealth became increasingly involved in the provision of funding for nursing homes and community care services for the aged⁷. Presently the Australian Social Security system provides means tested flat rate income support payments to the elderly, those who are unable to work (sick and disabled) and those who are unemployed and the federal government also provides a supplementary housing payment to those people who live in private rental accommodation and receive social security payments. The Commonwealth also provides support and assistance to carers of the elderly, both in the form of support payments (for example, the Carer Payment and the Carer Allowance) and support services.

3.2 Funding Sources and Programs

Support and services for the aged in Australia are provided by a large number of government programs (Commonwealth, State/Territory and Local) as well as programs/support from the community and voluntary sectors, the private for-profit sector and the private not-for-profit sector. Aged care services in Australia can generally be divided into two service systems, home and community-based care and residential aged care. The Commonwealth Government is responsible for the funding and regulation of both systems. Aged care services are currently provided through at least 30 different funded programs with a range of eligibility criteria and access points. Community and residential care, together with primary care and hospital services are the main elements of aged care services. Community care provides services such as district nursing, home help, day care, respite care and food services. They are funded by Commonwealth and State/Territory Governments either separately or combined with Local Government contributions and modest consumer co-payments. Hospital care provides services such as acute health care, geriatric assessment units, rehabilitation units and a range of specialist community and ambulatory

services. They are funded through Commonwealth/State agreements and managed by the States. Medical care provides services such as general practice and specialist services and is funded by the Commonwealth Government on a fee for service basis.

3.2.1

Residential Aged Care Programs

Residential care services cover high and low-level care and accommodation and are funded by the Commonwealth Government together with co-payments from recipients¹². Funding for Residential Aged Care is provided through the Residential Classification System/Scale (RCS). This system classifies residents into eight separate needs levels and provides funding based on that level. The RCS does not recognise the full range of needs especially for people with higher and more complex needs. Even at the top rate, the classification does not adequately assess and financially support the level of care required. This is particularly the case for clients from disadvantaged groups, such as homeless people where social and emotional needs are not adequately recognised. The RCS also does not adequately recognise care needs of residents with difficult or challenging behaviours associated with dementia, previous psychiatric illness and acquired brain injury resulting in these residents being ranked as requiring a lower level of care. This can result in a lack of support for staff managing these behaviours¹³. The Commonwealth Government is looking to implement a new residential aged care funding tool to replace the RCS. The new funding tool, the Aged Care Funding Instrument or ACFI, is due for implementation in late 2006 early 2007. The Commonwealth has been running ACFI trials to measure the validity of the new instrument. Wintringham participated in these trials.

16

Currently in Australia there are over 6,000 people aged less than 65 years living in residential aged care facilities, including both high and low care. Approximately 1,000 of these people are aged less than 50 years, most of which have been admitted because they have permanent disabilities such as an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or a combination of these). As a result, these people have limited ability to care for themselves, to move around and/or to effectively communicate their care needs. For most of these people, residential aged care is not the most appropriate or preferred form of care, however alternative options offering more age-appropriate specialist supported accommodation, are not currently available to them¹⁴.

A recent study collected information from 626 aged care facilities providing data on 478 people under 60 residing in nursing homes in Victoria¹⁵. The study investigated their characteristics and examined their occupational participation by measuring their social contact, participation in recreation and community access. This study provided evidence that aged care facilities do not support younger residents with high clinical needs to participate actively in social, recreational and community activities. The authors suggested that this lack of engagement and activity could contribute to the loss of already limited abilities through lack of use. It could also trigger challenging behaviour resulting from boredom, loneliness and disempowerment due to limited opportunity to participate in the community or engage in meaningful activities.

From July 2006, the Commonwealth Government and States/Territories will provide funding of up to \$244 million to jointly establish a capped, five-year program managed by the States/Territories. The funding will aim to provide age-appropriate care for younger people with disabilities currently in residential aged care and reduce the overall number of younger people in residential aged care. The program will focus initially on people aged less than 50 years in residential aged care. Other people with disabilities inappropriately accommodated in aged care will also be eligible under the program, as well as people at risk of being placed inappropriately in aged care residences¹⁴.

3.2.2

Community Care Programs

The Home and Community Care (HACC) program supports people of all ages with moderate or severe levels of disability, to remain in their home as long as possible. The program is jointly funded by State and Commonwealth Governments. 'Linkages' is a case management program funded by the HACC which targets people at the more highly dependent end of the spectrum of HACC recipients and aims to assist frail older people with disabilities who have complex and changing care needs, remain living at home as independently as possible to avoid inappropriate or premature admission to long term residential care. There has been increasing demand for HACC services due to a number of factors including; increased number of older people as a proportion of the population, increasing number of older people with a moderate to severe disability and changes in the delivery of health and welfare services that have placed a greater emphasis on support in the community including the shift in balance from residential care to community care for older people²⁵ and from acute inpatient care to pre- and post-acute care in the community.

The State funded Housing Support for the Aged (HSA) program aims to improve the health and well-being of older people with unmet support needs who are entering direct tenure public housing. The HSA was developed by the Aged Community and Mental Health Division (ACMH) of the Department of Human Services. Prospective clients are identified through the Community Connection Program (CCP) outreach services. It is intended for people older than 50 years of age, who have unmet needs associated with conditions such as frailty, mental illness, alcohol and substance abuse and/or chronic health problems. These people commonly have a history of homelessness or insecure housing.

Established in early 1998, The Community Connection Program was set up with the focus of working alongside people with disabilities that live in the community. The agency's mission statement is, *"To assist people with a disability, their families, carers and others, to identify and pursue a range of options to meet their needs and create the lifestyle of their choice"*. CCP clients require comprehensive case management of service delivery and ongoing monitoring and review of their care needs. Without this support this client group would require admission to hostel-level care (corresponding to levels C5-C8 on the Residential Classification Scale).

The Community Aged Care Package Program (CACP) is solely funded by the Commonwealth Government and supports older people that require low level care (up to a C5 classification) to remain living at home within the community. This is achieved through coordinated and managed packages of care services. Many of the allocated packages in the CACP program are targeted at the financially disadvantaged elderly, allowing for specialist organisations such as Wintringham and the Salvation Army to further refine the allocation to the homeless or to those elderly people who are at risk of becoming homeless. However with the passing of time, the health (and/or personal circumstances) of some CACP clients who were initially classified as having low care needs, progressively deteriorates to a point where their needs have become increasingly complex. Despite the increasing need for specialist services, many of these clients continue to be supported by the program. There are various reasons for the delay in accessing more appropriate levels of care; however the more common reasons include a shortage of Linkages and EACH packages, long waiting lists for accessing residential care facilities and the personal circumstances of the client. Client-related issues can include poor insight into their level of ability and personal resistance to move out of their home due to preconceived perceptions of life in an aged care facility and a fear of loss of independence.

The Commonwealth Government's Assistance with Care and Housing for the Aged (ACHA) program supports low-income frail older people who are at greater risk of premature entry into residential care due to a reduced ability to access housing and community care services. This is achieved by providing outreach assistance to access secure accommodation and care services appropriate to their needs¹⁸. The ACHA program was a pilot program to trial approaches to assist financially

disadvantaged older people who were renting or who were homeless to meet both their accommodation and support needs. The pilot ran for three years, concluding in June 1996. An evaluation of the program indicated that ACHA was cost-effective, improved the circumstances of frail older people, reduced the number of admissions to institutions and had a positive effect on the health and well-being of frail aged Australians. Given the success of the model, ACHA has subsequently been funded recurrently. The program has experienced no net growth since its inception, but has achieved some remarkably consistent results in helping prevent homelessness among the aged and in assisting isolated elderly people in accessing the aged care system¹⁶. The Extended Aged Care at Home (EACH) program receives Commonwealth funding to provide services to help people who are eligible for high-level care, to stay at home. Eligibility for CACP and EACH funding is determined from the outcome of an assessment by the Commonwealth funded Aged Care Assessment Team/Service (ACAT/S) as does approval and classification for different levels of residential care.

18

While the Supported Accommodation Assistance Program (SAAP) funds organisations that work with homeless people of all ages, it is clear that the “generic homeless service system is not adequate for meeting the needs of older people who are homeless”¹⁷. Young people were the major group of people using SAAP homeless services, with 45% aged between 15 and 24 years. A SAAP background paper (SAAP Monograph, 2002) also highlights the multiple problems that older homeless people face¹⁸. In a recent publication examining services for people experiencing homelessness it was acknowledged that there was evidence that some men aged 75 years and older experienced difficulties accessing SAAP services. In 2003-04, a NSW review of the exclusion policy and procedures of SAAP agencies demonstrated that eligibility criteria prevented potential clients from gaining access through practices of exclusion such as early exiting, banning, blacklisting, eviction, time-out and background checks (NSW Ombudsman 2004). The most common reason for people being turned away from single men’s agencies was that of having a drug and alcohol problem. It was quoted that in NSW alone; an estimated 130 men were turned away for this reason within a 6-month period¹⁹.

Commonly older people with psycho-geriatric illnesses and acquired brain injury do not meet the eligibility criteria for most HACC or Commonwealth funded aged care services (community and residential). Eligibility criteria for these services tend to be biased toward ongoing functional impairment as a result of chronic physical disease processes and from dementia without significant behavioural and psychiatric co-morbidities⁸¹.

3.2.3

Public Housing Programs

The public housing sector in Australia is funded through the Commonwealth State Housing Agreements (CSHA) with matching funds from both the Commonwealth Government and the State/Territory Governments. The construction, management and ownership of the housing is a State/Territory responsibility. Housing services include the Crisis Accommodation Program which provides short term accommodation in the form of night shelters or women refuges, the Transitional Housing Management Program which provides medium term housing for those waiting for a long term vacancy to arise, the Housing Information and Referral services, which guide and refer the homeless to appropriate housing services and the Housing Establishment Fund which provides financial assistance for the purchase of basic goods for those in crisis situations. Eligibility for public housing is determined by the Public Housing Assessment Service. The overall aim of this service is to house someone on a permanent basis through Long Term Housing which is allocated via a ‘Segmented Wait List’ that prioritises the urgency of need. In many cases, people with a non-urgent classification can wait for 2 to 3 years for a place to become available.

There are other government support programs. The Older Person High Rise Support Program, an ACMH initiative, provides onsite support to isolated and vulnerable older people living in high rise public housing towers in Western and Southern Metropolitan Melbourne. The Homeless Outreach

Psychiatric Services (HOPS) targets homeless people with a mental health illness as part of the State Government's Community Mental Health Plan. The Royal District Nursing Services Homeless Persons Program (RDNS-HPP) provides direct health care and support services to homeless people, and the Department of Veteran Affairs (DVA) provides financial, health and support services to ex-service men and women.

3.2.4

Multiple and Complex Needs

In 2002, The Department of Human Services initiated a project titled, '*Responding to People with High and Complex Needs Project*' (Complex Needs Project) in response to concerns raised by service providers, clinicians, carers, The Office of Public Advocates, police, magistrates and others on the difficulty of providing services to a group of people with complex needs^{20, 21}. Factors considered in defining 'complex needs' included mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, social isolation, family dysfunction and drug and alcohol misuse. There was recognition that these people often move between services due to the absence of cross-jurisdictional case management or funding structure or because they failed to meet organisational eligibility criteria resulting in the inability or unwillingness to provide the appropriate level of care. The target population for this project comprised individuals at the extreme end of the continuum of complexity whose needs were unable to be met or sustained within existing service frameworks.

The findings suggested that an innovative response was required to build a more effective response to people with multiple and complex needs. Resulting from the Project was the Multiple and Complex Needs Initiative which targets adults with multiple and complex needs and provides time limited specialist interventions aimed at stabilising housing, health, social connection and safety issues. This is achieved through the pursuit of planned and consistent therapeutic goals tailored for each individual. It is designed with the aim of long term engagement in the service system.

The key elements of the Multiple and Complex Needs (MACN) Initiative are:

- The Human Services (Complex Needs) Act 2003 – The MACN Panel has the power under the Human Services (Complex Needs) Act 2003, to give permission to services to release information related to the individuals personal or health details with regard to decisions the Panel is making related to eligibility, Care Plan determination and Care Plan implementation;
- The regional gateway referral process – The MACN Regional Coordinator located in each Department of Human Services' region play a key role in the operation of the regional gateway and referral process. The effectiveness of their role is underpinned by their knowledge of human services systems, service provider agencies and issues, and the support needs of people with multiple and complex needs;
- Multiple and Complex Needs Panel – made up of a chairperson, five members and the Department of Human Services Secretary's delegate. Members of the Panel have been appointed who have extensive expertise and experience in relevant fields such as mental health, disability, and drug and alcohol dependency;
- Multidisciplinary assessment service – Care Plan Assessment Victoria (CPSV) is managed by a consortium of Australian Community Support Organisation (ACSO) and Victorian Institute of Forensic Mental Health (Forensicare), and is the assessment service component of the Multiple and Complex Needs Initiative;
- Care Plan – The Care Plan outlines areas of the individual's life which have been identified as a priority, and determines the priority goals of the individual. It identifies strategies to engage the individual and the appropriate services and supports required to meet the individual's needs. A crisis intervention plan is developed that is specific to the individual and it is determined when and how the Care Plan will be monitored and reviewed. The Care Plan will also identify a care plan coordinator either from the existing service system or, in some cases, from the new intensive case management service funded under the MACN Initiative;

- Care plan coordinator – The consortium of Western Region Health Centre, Salvation Army St Kilda Crisis Service and HomeGround Services, will provide the time limited intensive case management service, Indigo. The purpose of this service component is to undertake the role of the care plan coordinator where no appropriate regional option is available, for individuals referred by the Multiple and Complex Needs Panel;
- Intensive case management service – providing intensive case management support to those people who do not have an identified care plan coordinator. They work closely with the individual and local service providers to strengthen the capacity of the service system to provide support to the individual in their own community. They also ensure the successful transition of the care plan coordination role to a local service provider within the period of the Care Plan;
- Formal evaluation – a public tender process resulted in a company (KPMG) being contracted to determine whether the initiative was leading to better outcomes for individuals with multiple and complex needs with more coordinated planning and provision of services and adequate legislation to achieve this.

The MACN Initiative is underpinned by the Human Services (Complex Needs) Act. This Act establishes necessary and appropriate powers for a new approach to planning service delivery for some of Victoria's most vulnerable community members. For an individual to be eligible for the MACN Initiative they must meet the eligibility criteria outlined in the Act. An eligible person is a person who:

- has attained 16 years of age; and
- appears to satisfy two or more of the following criteria:
 - has a mental disorder within the meaning of the Mental Health Act 1986;
 - has an acquired brain injury;
 - has an intellectual impairment;
 - is an alcoholic or drug-dependent person within the meaning of the Alcoholics and Drug-dependent Persons Act 1968; and
- has exhibited violent and dangerous behaviour that has caused serious harm to himself or herself or some other person or is exhibiting behaviour which is reasonably likely to place himself or herself or some other person at risk of serious harm; and
- is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan under this Act that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

Referrals to the MACN Initiative may come from any source including; existing service providers working with the individual, self referrals, referrals from family members or significant others and referrals from Correctional and court support services through established protocols. The regional director determines whether a referral appears to meet the eligibility and priority criteria for the purpose of forwarding it to the Multiple and Complex Needs Panel.

3.3

Gaps in the Provision of Services

The aged care service provision system is intended to ensure that there is universal access to aged care services for all Australians, irrespective of wealth. The reality is somewhat different, with the aged homeless often struggling to gain access to quality aged care services. This experience is by no means unique to Australia, with a 1995 study demonstrating that the aged homeless in USA and a variety of Scandinavian and European countries were living largely outside of the aged care service system²². In its submission to the Second World Assembly on Ageing in 2002, the World Health Organisation observed that age-friendly built environments can make the: *"... difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical*

*barriers are less likely to get out and therefore more prone to isolation, depression reduced fitness and increased mobility problems*²³.

In Australia, housing choices and opportunities among the elderly are reported to interact with health and welfare services²⁴. Policy trends toward providing a 'home-based' delivery of services to frail or disabled older people and improving access to secure, affordable and appropriate housing are recognised as critical components in this interaction. The majority of older people who own their own home have an asset which can be used to obtain entry to a range of accommodation types, including retirement villages, self-contained accommodation within a supported environment, and residential aged care. A key theme in current debates in Australia concerning housing policies for older people is the need to achieve more flexible models of housing provision which encompass a wide range of settings whilst fostering supportive environments and facilitating the delivery of appropriate care services²⁴. There most common residential care options available to older people with complex needs include:

- Community Residential Units (CRUs) which generally provide 24 hour on site support (with a high staff to resident ratios). Mainly for people with intellectual disabilities;
 - Community Care Units (CCU) which provide 24 hour short to medium term intensive housing and clinical support for adults with psychiatric disabilities;
 - Pension-Level Supported Residential Services (SRS) which provide limited 24 hour on-site support and supervision (with a minimum staff to resident ratio of 1:30);
 - Commonwealth-subsided residential care facilities including specialist psycho-geriatric hostels;
 - People living in the community supported through outreach programs such as Linkages, CCPs, *arbias* case management and the Mental Health Housing and Support Program.
- It should be noted that the even intensive Mental Health outreach support, which operates on a EFT to client ratio of 1:<10, can not approximate the level of care available in residential care models²⁵.

Pension-level Supported Residential Services (SRS) are for-profit businesses regulated by the Department of Human Services that provide 24 hour accommodation, support and supervision for a fee. SRSs vary in the services they provide, the people they accommodate and the fees they charge. Pension-level SRSs commonly charge 85 per cent to 100 per cent of the resident's pension plus Commonwealth funded rental assistance. The sector receives no funding from the government but must be registered with the State Government and are monitored to ensure they provide certain standards of care and accommodation.

An SRS differs from a Boarding/Rooming House in that the staff are employed to monitor residents' health and well-being and refer to services where applicable, however this rarely occurs mainly due to lack of sufficient resources to do so. SRS's are usually run on a very tight budget, are usually located in older run-down buildings. The economic climate over the past few years has meant these places struggle to exist and frequently close down²⁶. A SRS Census was undertaken by DHS in 2003. It found that of 7,104 beds within 215 facilities, 34% were pension-level beds and 66% were above-pension beds. Some marked differences were noted between the resident groups with pension-level residents being younger (18% being eighty years and older versus 70 percent of above-pension residents), majority male (57% males versus 73% females in above-pension beds), and much more likely to have a psychiatric disorder (45% versus 5% in above-pension residents) or an intellectual disability (14% versus 1% for the above-pension residents)²⁷. SRS residents are often classed as being as 'at-risk' of homelessness as they are not protected by the Tenancies Act, do not have leases and only live from a fortnight to fortnight basis. Other private low-cost residential options are hotels, boarding houses, living with friends or relatives, caravan parks, bungalows and shared housing. The quality of housing and care provided in these options can vary considerably.

Despite the existence of housing and community care programs, there are still many homeless people who do not access these services. This can be due to a number of factors such as being withdrawn or reclusive, personal or cultural beliefs, a person's perception of charitable services,

a determination to make it on one's own or a transient lifestyle resulting in a person not staying in one place long enough to facilitate the referral process. Many people living in private housing options can have complex needs but do not have the skills or the motivation to access essential services that may assist them in improving their health and well-being, maintaining their housing or seeking more suitable housing.

Despite its success in bringing tailored packages of care to the frail aged, many people with mental and psycho-geriatric illnesses do not meet the recommended eligibility criteria for CACPs and most HACC/aged care services are not based on case management, rehabilitative or supportive therapy models of care⁸¹. Despite being a relatively small service, the ACHA program has demonstrated great success in reaching these isolated individuals and seeking their acceptance of support⁹⁷. The ACHA outreach workers can be proactive in their approach to accessing the elderly homeless through investigation and liaison with local community service organisations. They can broker services to these people in a personalized, non-threatening manner. Unfortunately, resource limitations have restricted such services from reaching their full potential and there are still aged people living in emaciated or inhospitable conditions not receiving the appropriate care for a complexity of needs.

4 Homelessness

4.1

Definitions of Homelessness

Homelessness has been described as being more than the absence of housing as it also involves marginalisation from social networks and community services²⁸. Other factors (both structural and individual) that have been attributed as causes of homelessness include market failure (e.g. inadequate supply of affordable housing, unemployment), inadequate community service programs (e.g. poor access to services, inadequate level of assistance, inappropriate service models), social dislocation involving the particular circumstances or responses of the individual (e.g. family breakdown, health disability, psychiatric illness, poverty, substance abuse, domestic violence) and social values (e.g. deinstitutionalisation), have all been identified as contributing factors^{29, 30, 31}. These issues are rarely reported to occur in isolation. Generally, there is a correlation between the degree of homelessness and the complexity of contributing causal factors²⁸. Similarly the type of accommodation in which the homeless person resides can vary considerably ranging from inadequate or unsuitable housing to living on the streets.

The cultural definition of homelessness identified by Chamberlain and MacKenzie (1992) identifies three segments in the homeless population:

- 1 **Primary Homelessness**
People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, using cars, railway carriages for temporary shelter, or living in improvised dwellings.
- 2 **Secondary Homelessness**
People who move frequently from one form of temporary shelter to another. This covers people using various types of emergency accommodation such as hostels and night shelters; teenagers staying in youth refuges; women and children escaping domestic violence (staying at women's shelters); people residing temporarily with other households (because they have no accommodation of their own) and those using boarding houses on an occasional or intermittent basis.
- 3 **Tertiary Homelessness**
People who live in single rooms in private boarding houses, hotels, caravan parks and pension-level Supported Residential Services on a medium to long-term basis. They do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained, and they not have security of tenure provided by a lease³².

4.2

Funding Sources and Programs

Prior to 1974, services for homeless people in Australia were provided and funded by religious and other private welfare agencies. In 1974 the Commonwealth Government introduced the *Homeless Persons Assistance Act* which provided financial assistance to private agencies for the provision of food, shelter and personal services, but services for the homeless remained diverse and fragmented. In 1983, a review of all Commonwealth and State/Territory programs for homeless people and victims of domestic violence recommended an integrated and jointly funded national program. A coordinated national approach to homelessness emerged in the mid 1980s with the advent of the Supported Accommodation Assistance Program (SAAP) and the Crisis Accommodation Program (CAP) both of which commenced in 1985. SAAP and CAP programs provide funding to State and Local Governments and not-for-profit agencies for the provision of accommodation and support services for homeless people. The success of these programs led to them becoming the main national programs for assisting homeless people. The fundamental difference between these two programs is that SAAP is jointly funded by the Commonwealth and State/Territory Governments and provides assistance via non-government agencies, whereas CAP

provides funding to State Governments via a tied grant under the Commonwealth State Housing Agreement (CSHA) for the provision of crisis accommodation¹⁷.

The Older Persons Outreach Program (OPOP) is a State funded service within the Community Connections Program that is designed to provide assistance to older people who are financially disadvantaged and may be experiencing problems with housing, health and other support issues. The OPOP aims to prevent the premature institutionalisation of elderly homeless men and women through the provision of housing, information, referral and advocacy and the distribution of Flexible Care Funds. This program funds specialised agencies, such as Wintringham that support the aged homeless population. Outreach Services to the older homeless people can therefore be funded through the Commonwealth Department of Health and Ageing Program (ACHA) or through the State's Department of Human Services (Community Connections Program OPOP and HSA).

Across Australia, Supported Accommodation Assistance Programs provide transitional supported accommodation and related support services to people who are homeless. In the year 1999 to 2000, SAAP agencies supported 90,000 homeless clients³³. A description of high need amongst homeless people from the perspective of SAAP is summarized by the presence of the following factors:

- have a diagnostic condition;
- exhibit difficult behaviours;
- may have complicating cultural factors;
- require the involvement of multiple agencies;
- have a history of crisis;
- require a higher level of support³³.

This description provides an overview of the compounding issues that can exacerbate homelessness among the elderly. With regard to older homeless people, it has been recognised that although they may share a number of characteristics with the general homeless population, they are not a homogenous group. Purdon (1991) developed a classification system that divided them into five sub groups:

- older people in crisis who need crisis accommodation;
- frail aged who require extensive support;
- older people who require extensive support, but who are not frail;
- older people who can live independently with some support;
- older people who require minimal support to live independently³⁴.

After examining the plight of older homeless people, Purdon observed that older homeless people are, in general, *“chronically homeless and unlikely to be able to make a transition to independent living, and will require a range of supported accommodation options”*. It was also noted that elderly women, elderly homeless Aboriginal people, and people from non English speaking backgrounds were particularly disadvantaged. The study also found that the majority of frail aged homeless people tend to live in the same general geographic area as the services they use. Although frequently reluctant to utilise these services, once contact was established, continuity of these same services has been shown to be very important to these people.

Toward the end of last decade, the Commonwealth Government recognised that homelessness had been a growing problem in Australia and that the demand on services had been increasing. The Government recognised that homelessness was related to structural factors including unemployment, low income and lack of access to affordable, safe and secure housing rather than the previously accepted assumption that homelessness was linked to personal flaws or bad choices made by homeless individuals³⁵. As a result a discussion paper was produced to outline the position of the then current programs and initiatives in the prevention and management of homelessness and to set out the framework for a consultative process designed to put those programs into context. Future directions and possible new approaches were also discussed.

Recent emphasis has been on early intervention, case management, transitional accommodation and support to enable self-reliance and independent living. It was noted that the problem could no

longer be generalised to a population of men who were reaching or had reached the end of their working life, but included increasing numbers of single women, families and young people. It was also noted that Indigenous Australians were over-represented in the homeless population. These changes were attributed to changes in societal structure resulting from:

- changes to family formation, including increased family breakdowns;
- the deinstitutionalisation of people with psychiatric illness and physical and intellectual disabilities;
- an increase in the incidence of women and their children fleeing domestic violence;
- a decrease in rooming-house and other low cost accommodation options;
- significant shifts in patterns of substance abuse and the availability of illicit drugs; and
- changes to the structure and nature of the labour market that have led to fewer jobs for low skilled people³⁰.

Prior to adopting a universal social welfare system in Australia, religious charities principally supported the needs of the homeless in large institutionalised establishments, where accommodation, hot meals and a shower were provided on a nightly basis. The population that frequented these facilities consisted mainly of unskilled, transiently employed men of Anglo-Saxon descent who often engaged in heavy drinking. In the mid to late 1980s, the Commonwealth and State Ministers for Community Services implemented the redevelopment of Melbourne's Homeless Accommodation services (Gordon House, Ozanam House and The Gill Memorial Home) which contributed to the development of new approaches in the management of homeless services³⁶. The aim of the redevelopment was to provide relevant, high quality, sensitive supported accommodation and related support services to enable the men, women and children who were homeless and using the three facilities to function in the community to their maximum capacity.

Wintringham's philosophy that their clients are primarily regarded as being 'aged' and secondly as being 'homeless' has had a huge bearing on their ability to attract funds to provide appropriate care and support to its clients. *"This is not merely semantics, but generates a whole new paradigm that has enormous implications for the funding of services to our aged homeless clients. If we say a person is homeless and aged then it seems appropriate to provide for that person within a homeless persons service system such as SAAP. If on the other hand we say that primarily the person is elderly then it seems self-evident that they should be part of the aged care system and that their care should be resourced by that system"*¹⁶.

4.3

National Homeless Strategy 2000

The Commonwealth Government launched a discussion paper on a National Homelessness Strategy in May 2000 and appointed a Commonwealth Advisory Committee on Homelessness (CACH) in October 2000. The CACH undertook consultation across Australia in 2001 and in 2003 a report titled 'Working toward a National Homelessness Strategy – A response to consultations' was produced³⁷. A number of Commonwealth funded research and demonstration projects have generated from the National Homelessness Strategy.

The final goals for older homeless people elucidated by the strategy were:

- To increase the support services available to older people experiencing homelessness;
- To increase the number of homeless older people obtaining places and receiving appropriate care in universal aged residential and community care services;
- To increase the provision of designated public housing for older people together with appropriate supports;
- To reduce social isolation among older people who are homeless or at risk of becoming homeless;
- To reduce the number of older people becoming homeless;
- To improve the health and longevity of older people experiencing homelessness.

In order to achieve these goals, the Strategy made the following recommendations:

- Make the homeless a special needs group in the National Aged Care Strategy;
- Prevent homelessness among older people by providing necessary support services to those who have difficulty living independently;
- Increase the supply and accessibility of affordable, safe, secure and appropriately located private and public housing for financially disadvantaged older people;
- Provide programs to address the social isolation of older people who are homeless or at risk of becoming homeless;
- Improve the operation of national aged-care programs to provide for the needs of older people experiencing homelessness;
- Promote awareness of the special needs of homeless older people among private and public health, housing and welfare services;
- Bring ACHA, CACP, HACC, Residential Aged Care and related programs for the elderly together under a specialist unit within the Department of Health and Aged Care that is also responsible for fostering cooperation with State and Territory agencies;
- Expand, refine and better target ACHA services to build the capacity of agencies working with homeless older people;
- Ensure that future Commonwealth-State Housing Agreements better reflect the needs of older people with high support needs;
- Re-introduce capital funding for residential aged-care facilities that undertake to provide more than 90 per cent of their places to concessional residents.
- Adjust National Aged Care Planning ratios to allow for homeless men and women who are younger than the national averages;
- Fund a demonstration residential aged-care facility to provide exclusively for homeless older people with high and complex needs³⁷.

There has been criticism levelled at the effectiveness of the National Homeless Strategy in its ability to reduce homelessness through its failure to effectively liaise and communicate with State Homeless Strategies and its relative inaction with regard to initiatives beyond the realm of research³⁸. State Homeless Strategies have much in common with the identification of need in the areas of housing, transitional support, Indigenous issues, health and mental health, complexity of need and targeting priority groups, drug and alcohol issues, public housing stability, community education etc. They have engaged in significant policy activity to address the issue of homelessness. Uniquely, the Victorian Homeless Strategy has developed a charter of rights for homeless people, strengthened the State's complaints mechanisms and been instrumental in the identification of issues for older people in tenuous private rental situations³⁸.

5 Health Care within the Aging Population

With increases in the aging population and the life expectancy of the aged, the maintenance of good health is a critical issue. Older people have a higher rate of admission to hospital than the general population and account for 33% of all hospital separations (estimated at 2.0 million in 2001), while comprising only 12% of the total population²⁴. With older people being the heaviest users of health services the impact of ill health extends across the entire population from individuals to healthcare and community services and government organisations.

Mainstream programs such as the hospital systems, the services of medical practitioners and the pharmaceutical benefits scheme provide the bulk of the health care for older Australians. The Australian health care system has both public and private sector involvement. Private medical practitioners provide primary and specialist care in the community and a mixed public (State-controlled) and private hospital system provides comprehensive acute services. Medicare, an Australia-wide health system, provides older people with equitable access to medical and hospital services at little or no cost. Older people with hearing problems are eligible for vouchers supplied by the Commonwealth to enable them to access various hearing services. As well, private health insurance premiums are community rated, which ensures that older people cannot be charged a higher premium because they are older or chronically ill.

5.1 Acute Health Problems within the Aging Population

Primary health care to homeless people is provided by a small number of general practitioners who bulk bill (no out-of-pocket fee for service), by walk-in medical centres, by voluntary agency primary care clinics and by hospital emergency departments. Patients can access public hospitals through emergency departments where they present either on their own initiative, or via the ambulance services, or after referral from a medical practitioner. Unless they choose private treatment, patients in public hospitals are charged nothing for their treatment, food or accommodation. Emergency department and outpatient services are free. The most common diagnoses for older people who have visited a hospital are; cardiovascular disease (13%), tumours (11%), diagnoses associated with the digestive system (10%), and diagnoses associated with the eye (6%) and external causes of injury such as complications of medical and surgical care and falls²⁴.

During 2003-04, an all-jurisdiction Care of Older Australians Working Group developed the National Action Plan 2004-2008 for improving the Care of Older People across the Acute-Aged Care Continuum. The Plan focused on aspects of the Acute-Aged Care Continuum that could improve the health and wellbeing of older people. The plan was endorsed by the Australian Health Ministers in July 2004. It recognised that there was a shortfall in health and aged care services for older people and reported on a national hospital census which found that older people waited for extended periods in acute care hospitals to access more appropriate services (step-down, rehabilitation and aged care services)³⁹. Despite developments in other health care services, such as hospital-supported patient care being provided in the community/home, in 2001 it was demonstrated that there was a 24.8 per cent decrease in the provision of these services relative to the growth in the population aged 70 years and over.

The national census of older people in Australian public hospitals found that for 21 per cent of older people in hospital (on census night), the health professionals responsible for their care considered that another form of care was more clinically appropriate. Of these, 74 per cent had a formal recommendation for another type of care: approximately 33 per cent were recommended for another form of hospital based care (often within the same hospital) and approximately 77 per cent had a recommendation for residential or community based aged care services. The Plan also reported on evidence that waiting for extended periods in acute settings for access to other services, whether hospital or aged, may impact adversely on older people's level of function³⁹.

In a Housing Deficit Report undertaken in 2002 by the Northern Residential Mental Health Services Reference Group covering the Melbourne's northern municipalities of Darebin, Whittlesea, Banyule

and Nillumbik, the cost of maintaining a person in critical care unit or inpatient hospital bed was compared with that of supported community care options⁴⁰. The CCU bed day rate was found to be substantially more than the cost for one person, per day to live in permanent community housing with clinical and psychiatric disability support. The inpatient bed day rate was shown to be even higher. Thirty per cent of the total individuals admitted to the Northern Hospital Inpatient Unit per year were shown to have housing and support issues, which on average, doubled their length of stay (28 days compared with the average of 14 days). The annual cost of staying 30 per cent longer was estimated at \$984, 300 conservatively. Therefore, the report concluded, that the provision of housing and support would reduce inpatient unit hospital stays creating substantial financial savings.

5.2

Acute Health Problems within the Aged Homeless Population

In a report on the Homeless Person's Program of the Royal District Nursing Service, it was stated that with regard to the utilization of health and support services by homeless people,

"... their lives are characterised by trauma, uncertainty and fear. They have experienced negative interactions with the public health system, may lack confidence to negotiate the complexities of the system, and frequently experience embarrassment in relation to their circumstances and the potential judgement of those service providers they come in contact with. As a result they may be suspicious, frightened, or lacking in motivation to seek health care" (p. 8)⁴¹.

As will be discussed later, people who are homeless have higher rates of illness, drug dependence and injury than the general population. It is been documented that homeless people are generally reluctant to seek treatment for health problems until a condition reaches the severity at which they are forced to attend a hospital Emergency Department. Once admitted to hospital, homeless people may be more inclined to discharge themselves before their treatment has concluded. For those who stay, medical conditions that would normally be manageable at home may result in longer periods of hospitalisation due to home accommodation settings that may lack appropriate care support and levels of hygiene. Often the compliance of older homeless people with discharge instructions and follow up appointments is poor, particularly for those with psychiatric conditions, alcohol or drug problems and/or cognitive impairment⁴².

Currently in Australia, homeless people are not reliably identifiable in standard hospital databases. Unlike the UK and USA, we are yet to define the conventions for recording 'no fixed abode' on hospital admission records. However one study reported on admissions of patients with a SAAP address of 'no fixed abode' to South East Health hospitals in NSW⁴³. This group was defined as representing a homeless population. More than 50% of homeless people's admissions come through the Emergency Departments, compared with 23% for the accommodated community. In over 50% of admissions, the three main reported reasons were 'schizophrenia', 'drug use disorder and dependence' and 'alcohol use disorder and dependence'. Homeless people stayed less than half the number of days in hospital than did people of fixed abode, and were readmitted more frequently. Older people were shown to be more likely to be hospitalised than younger people and homeless Aboriginal or Torres Strait Islander people were admitted at 16 times the rate of the accommodated ATSI population.

The following table (Table 2) summarizes the cause of death for people who were identified as having been likely to be homeless in Seattle (USA) hospital emergency departments⁴⁴. In the UK, a similar pattern of causes were shown to be responsible for the need of emergency treatment for 135 homeless patients who attended the Guy's Hospital, London⁴⁵. There were high rates of hospital admission among homeless people over 50 compared to the general public. Forty-two per cent of the sample had had at least one admission to either a general, psychiatric or detoxification ward in the preceding year, compared to 14 per cent of 65 to 79-year-olds in a national survey⁴⁶. It was found that 91% of patients were male with an average age of 40 years and that alcohol was the principle

cause for seeking emergency medical help. It was also reported that the local homeless population were the most likely to use the A&E department as a substitute for primary care even in the presence of homeless healthcare facilities in the community.

Primary Cause of Death (categorized)	Number	(Percentage)
Acute intoxication 11	20	(24%)
Trauma Related (total):	15	(18%)
<i>Trauma – Homicide 12</i>	4	(5%)
<i>Trauma – Suicide 12</i>	4	(5%)
<i>Trauma – Unknown</i>	5	(6%)
Secondary Infection following Trauma	2	(2%)
Cardiovascular Disease	10	(12%)
Infection/Condition Secondary to Alcohol or IV drug use	8	(10%)
Pneumonia	7	(9%)
Cirrhosis	5	(6%)
Cancer	4	(7%)
Died in a Fire	3	(4%)
Drowning	3	(4%)
Hypothermia/Environmental Exposure	1	(1%)
Tuberculosis	1	(1%)
Other	5	(6%)

Table 1 Percentage frequency of the primary causes of death for homeless people in Seattle USA⁴⁴.

5.3 Chronic Health Problems within the Aging Population

The Hospital Admission Risk Program (HARP) was established by the Victorian Government’s Department of Human Services in 2001 to develop preventive models of care involving hospitals and community agencies focusing on people with chronic and complex conditions. Priority was given to high volume and/or frequent users of the acute public hospital system. The program was completed in 2004. The Department has now moved from a focus on ‘innovation’ and ‘experimentation’ to embedding successful models of care within the service system through such programs as the proposed Victorian Chronic and Complex Care Program (VCCCP). This program is aimed at increasing the capacity of the service system to address the continuum of care for people of all ages with chronic diseases (such as heart and respiratory disease) and complex needs (such as people with complex psycho-social needs) who have a likelihood of preventable hospitalisation by linking services such as primary care, community care, health promotion, rehabilitation, acute care, sub-acute care and residential care⁴⁷.

With the aging of Australia’s population an increase in the incidence of people with a disability will result. At present, one in 25 Australians (3.9%) aged under 65 years has a profound or severe core activity limitation (that is, they need help with one or more of self-care, mobility or communication). Among people aged 65 years and over this proportion rises to almost one in four, and among people 85 years and over it rises to 54%⁴⁸.

5.4

Chronic Health Problems within the Aged Homeless Population

The amount of published literature on the characteristics of the homeless population in Australia^{49, 50, 51, 52, 53} and overseas^{54, 55, 56, 57} is extensive. They cover issues arising from chronic and/or multiple problems, including mental illness, intellectual disability, poor health, alcohol and drug abuse, behaviour disorders and post-traumatic stress. There has also been a great deal of literature examining associations between socio-economic status and chronic illness^{58, 59, 60, 61}. Much of this literature focuses on the range of needs of homeless people and broad service responses concerned with clinical or specialist treatment programs. Very few articles specifically address the needs of older homeless people and the complexity of problems prevalent in this population often created by long-term homelessness compounded by the effects of ageing^{62, 63}.

With the trend for public hospitals to provide more intense, short-term stay treatment strategies and the demand for hospital services increasing by three to four percent per annum, well beyond that which would be expected as a result of population growth and aging, the care of people with chronic and complex problems will increasingly stress the health care system⁶⁴. While hospitals play a crucial role in the management of acute illnesses and emergencies, the rising cost of upkeep of a hospital bed renders the use of such beds for persons suffering from chronic illness economically unviable. Because the care needs for such people can differ significantly from those with acute illness, the expertise required to provide a satisfactory level of care may not necessarily be available in all facilities. These inadequacies are particularly evident when other complicating factors related to excessive alcohol, frailty associated with aging and long-term neglect and low socio-economic status are added to the complexity of these needs. It has also been demonstrated that older homeless people do not place a high priority on their health needs⁴¹.

Apart from a report by Bisset et al (1999) on appropriate responses for homeless people whose needs require a high level and complexity of service provision prepared for the Department of Family and Community Services, few studies have addressed the special needs and gaps in service delivery for this segment of the homeless population in Australia²⁸. Bisset et al (1999) considered various classification systems used to define a person with high or complex needs, many of which adopted systems based on clinical diagnoses. They presented a classification model based on the perspective of the service provider (Table 2).

Nature of High Needs:	Implications for Service Provision
<i>Multiple</i>	Several workers or services required. Case management is the preferred service response.
<i>and/or intense</i>	More intensive response for a longer time. Alternative (non-standard) responses may be necessary.
<i>and/or complex</i>	Intensive one-to-one support, specialised case management, multi-disciplinary case management, alternative response.
<i>and/or ongoing</i>	Ongoing relationship necessary to assist client 'maintain' linkages and correct further crisis.
<i>and often accompanied by difficult behaviours</i>	Skilled support required and occupational health and safety issues to address.
<i>and complicated by cultural marginalisation</i>	Individual, tailored response required, use of interpreters, appropriate staffing, culturally appropriate referrals.

Table 2 Framework for understanding high needs from the perspective of service providers (Reproduced with permission from Thomson Goodall Associates Pty Ltd).

Based on past literature, Bisset et al (1999) discussed the difficulties encountered in determining the incidence of 'high need' amongst the homeless population. This was attributed to differences in the classification systems employed by various studies and agencies and because, due to underlying issues, some client's needs are objectively greater than others and require more intensive care responses. The following list of underlying issues adapted from Bisset et al's 1999 report, demonstrate the extent of difficulties that may be encountered.

- Depression and other mental health and personality disorders;
- lack of self-worth, poor self-esteem or sense of purpose;
- history of poor, exploitative or violent relationships;
- rejection and exclusion by families, parents, service providers and society in general;
- history of transience and long-term utilisation of crisis services;
- history of chronic or persistent abuse, including sexual abuse;
- history of institutionalisation (jail, hospital, mental health hospital, etc);
- history of long-term substance abuse and it's secondary negative health effects.

The most frequently cited diagnoses associated with high need amongst homeless people are:

- behavioural disorders;
- chronic health problems;
- addictive disorder (including alcohol, gambling and other forms of substance abuse);
- mental illness;
- intellectual disability²⁸.

For many individuals, vulnerability to homelessness may be limited to a period of crisis precipitated by such factors as family breakdown or the death of a loved one. However, for some people chronic health problems or disability may make them vulnerable to longer terms of homelessness. And while lack of adequate shelter is a common thread amongst homeless people, individual experiences will depend upon a unique pattern of contributing factors. Without an adequate response to these factors their influence may compound personal crises and entrench homelessness. The experience of homelessness has therefore been described as being spread across a continuum, where if interventions are not timely or adequate, there is a tendency for the intensity and complexity of that experience to increase⁶⁵.

6 Mental Illness within the Aging Population

In 2001, the prevalence of self-reported mood or affective disorders in Australia was shown to decrease substantially in older age groups⁶⁶. This result was also evident in the 1997 Survey of Mental Health and Wellbeing of Adults, where persons aged 65 years and over reported the lowest rates of mental disorders¹¹¹. However, the use of medications for mental wellbeing has been shown to increase with age. The most prevalent psychopathology in the older population is depression. Similarly, anxiety and substance abuse disorders are also common among older persons, often coexisting with depression⁶⁷. Nearly without exception, people with mental disorders have an increased risk of suicide⁶⁸. However, the psychiatric diagnoses associated with suicide change with age. While personality disorders or schizophrenia are more frequently encountered in young suicidal individuals, mood disorders (e.g. depression) peak in late life⁶⁹. Suicide among older persons without a diagnosable mental disorder is rare.

It is thought that older people are particularly prone to depression because of the increased likelihood that they will be experiencing stressful life events. Life events that are known risk factors for depression include physical illness (especially long-term illness and those illnesses that are associated with permanent disability), isolation, chronic pain and bereavement. Even though older people may have an increased risk of depression, there is evidence that the signs of depression often go unrecognised in this age group. Signs of depression are also frequently dismissed as changes relating to the ageing process, dementia or other illnesses¹¹¹.

6.1 Chronic Mental Illness within the Aging Population

An Australian Institute of Health and Welfare report shows that the prevalence of Australians with a psychiatric disability of a profound or severe nature ranks fourth out of all disability groups with only physical disorders including arthritis and circulatory disorders ranking higher⁷⁰. An increase has been noted in the prevalence of chronic mood and anxiety disorders among the aged population. While these conditions are also prevalent among younger adults, there is growing awareness of differences in the determinants and presentation among older persons¹²². The true extent of the prevalence of mental illness among this population has been difficult to elicit due to issues related to the use of standard and modified specialist assessment tools, the validity of which are questionable especially when it comes to the assessment and monitoring of mental health among particular subgroups of older adults, such as people with dementia or high rates of medical illness, and individuals living in residential care. Yet, these populations appear to be most at risk, with international research reporting very high prevalence of depression among nursing home residents. Despite this, detection rates are low, with large numbers of individuals with depression and anxiety receiving no treatment¹²².

The Aged Persons Mental Health Services (APMHS) provides assessment, treatment and support to older people with a mental illness with an emphasis on community based care. Service types include:

- Psychogeriatric Assessment and Treatment Services (PGATS);
- Psychogeriatric Residential Services (PRS);
- Acute Inpatient Services.

In 1999/2000, the Mental Health Branch (ACMH) significantly enhanced the capacity of the PGATS to respond to the needs of older people with a mental illness who are at risk of homelessness. The funding was used to support an additional 15 effective full time positions and provide 35 specific care and support packages for clients for whom no appropriate service currently exists. Older people with a mental illness living in pension-level Supported Residential Services are a priority group. Psychogeriatric Residential Services (PGRS) provide short-term 24-hour care to older people who require specialist psychiatric nursing and allied health support in a residential setting. PGRS cater for people who can not be cared for in a mainstream residential setting due to challenging behaviours. The Commonwealth and State Governments jointly fund this service.

The State funded Community Brain Disorders Assessment and Treatment Service (CBDATS) team is comprised of members from various disciplines, including medical, nursing, psychology, neuropsychology, occupational therapy and social work. The team responds to requests from a variety of professionals, patients or families who require assistance with assessing a person's emotional, psychiatric or behavioural state in the setting of brain injury and recommending treatment options. They also assist existing services to collaborate more effectively when dealing with challenging cases by providing structured and informal education on the assessment and management of psychiatric and behavioural aspects of brain impairment. The team is geographically located at the Royal Talbot Campus of the Austin Health Network, but provides services across Victoria.

6.2

Chronic Mental Illness within the Aging Homeless Population

Mental illness is common among older homeless people, the problems ranging from depression to psychoses and dementia. Based on studies in the UK and United States, it was estimated that 40-68% of older homeless men were depressed and that approximately 50% of older homeless women experienced psychotic symptoms or memory problems⁷¹. In the Four-City Study, older homeless women were more likely than the comparable men to have mental health problems, and a high proportion of both sexes who were sleeping rough (75%) had such problems. Less than one-tenth of the study subjects were, however, receiving psychiatric medication. The survey of London's hostel residents in August 2000 found that *older* residents were more likely than their younger counterparts to be suffering from mental health problems⁷². The prevalence of mental illness increased with age, and rose steeply among women.

In the early 1990s a few studies examining mental illness among the homeless were undertaken in Australia. Teesson and Buhrich (1993) observed that one in four men in refuges have schizophrenia, and 36 per cent meet criteria for substance abuse at some time during their lives. They observed that one in four men showed severe cognitive impairment, which they attribute largely to alcohol abuse. However, early estimates of prevalence were often based on specific target groups and service models, and therefore not appropriately generalized to the broader homeless population¹³².

Estimates of prevalence depends on both the definition of homelessness and the definition of mental illness. In the literature that has focused on single men with a long-term experience of homelessness, a strong correlation has been observed between homelessness, and mental disorder and alcohol and other drug abuse therefore increasing the perceived proportion of people among the 'homeless' population with a mental illness. Most of these research reports acknowledge significant difficulties and challenges associated with the assessment and measurement of need among homeless people.

In 1998 a study on the prevalence of mental disorders and related disabilities among homeless people in inner Sydney, 160 men and 50 women of all age-groups were interviewed in hostels, refuges and day facilities¹¹⁶. Hodder et al identified five common mental disorders prevalent amongst homeless people in inner city night shelters in New South Wales; schizophrenia, alcohol use disorder, drug use disorder, mood disorder and anxiety disorder. The study concluded that 75 per cent of homeless people (73 % men, 81 % women) had at least one mental disorder (including schizophrenia, alcohol and drug use disorders and mood and anxiety disorders) in the previous twelve months. Forty-nine per cent of men and 15 per cent of women had an alcohol use disorder. Thirty-four per cent were dependent on drugs and 33 per cent lived with a major mood disorder of which depressive disorders were the most prevalent (22 per cent of men and 38 per cent of women). Compared with the prevalence of such conditions in the general community being; 1% for schizophrenia, 9% for alcohol abuse in men and 4% in women, 2% for drug use disorders, 6% for mood disorders and 10% for anxiety disorders, it becomes markedly clear that the presence of such disorders in the homeless community are some four to five times greater that of the general population (Table 3).

Mental Disorder	Inner Sydney Homeless Population	
	(General Population)	
	Males	Females
≥ one mental disorder	73%	81%
Alcohol	49% (9%)	15% (4%)
Drugs		36% (2%)
Major mood disorder		33% (6%)
Depressive	22%	38%
		33% (6%)
Schizophrenia	23% (0.5%)	46% (1%)

34

Table 3 *The Prevalence of Mental Health Disorders among 210 homeless people aged between 17-87 years from eight major hostels providing emergency accommodation in inner Sydney compared with the General Population*¹¹⁶.

Fifty percent of older clients (average age \approx 59 years) using Salvation Army Services in Melbourne in 2002 were reported to have had ongoing chronic drug and alcohol abuse issues¹⁰. Excessive alcohol consumption may result in immediate or short-term effects involving almost all of the body's systems affecting the brain, the gut and pancreas, the heart and circulation, sleep control and sexual functions.

Within the general population there are some groups that are at greater risk from the effects of alcohol than others. These include: women, children, adolescents, older people and people on medication or drugs³⁹. Alcohol consumed at sufficient levels over time increases the risk of nutritional deficits, infections, skin problems, some cancers especially of the mouth, throat and oesophagus, cirrhosis of the liver, brain damage, memory loss, confusion, depression and some types of heart diseases and strokes⁷³. Therefore, there is a high probability that older homeless people with a history of excessive alcohol consumption would regularly seek public health services.

Mainstream substance misuse services often fail to address the needs of older people with mental health problems. It has been suggested that substance misuse training be available to generic workers working with homeless people⁹⁴. An integrated approach would provide addiction and psychiatric treatments in the same milieu by the same staff enabling clients to receive a core approach to their treatment of both categories of disorders. This approach has been piloted in the United States⁷⁴.

Although the mainstream homelessness services sector has a broad target group, which does not exclude people with a mental illness; it does not always have the skills or resources to provide an effective response to those who have more complex needs. In addition, the homelessness sector is principally designed to provide a crisis and transitional response. In 1999, the Victorian Government responded to this need by making a commitment to expand services to homeless people with a mental illness and complex needs. Over a three-year period this resulted in the development and/or expansion of services, which now form the components of the Mental Health Homelessness Program. They are:

- **Homeless outreach psychiatric services (HOPS)** were first established in 1994 to provide a specialist clinical and treatment response for people who do not engage readily with mental health services. HOPS work in partnership with homelessness services and use assertive outreach to locate and engage with their clients. There is a strong focus on people experiencing primary homelessness. The HOPS also provide assessment and secondary consultation to homelessness services and other mental health workers;

- **Psychiatric disability intensive outreach support services** provides short- to mid-term support to assist people to move out of homelessness. The more intensive nature of the service recognises that many people in this situation will require high levels of support. Services will use assertive outreach to engage people experiencing primary homelessness, but will also work closely with homelessness sector and HOPS to assist them identify and refer potential clients; and
- **Care and support packages for older people with a mental illness** provide care and support packages for older people who are homeless with a mental illness are delivered through Psychogeriatric Assessment and Treatment Services (PGATS). It recognises that older people (over 65 years) also face homelessness and that there is a need for a specialist response. These services focus on assisting people whose accommodation is at risk and supporting them to find and maintain more stable and appropriate options⁷⁵.

In 2002 the Victorian Homelessness Strategy, demonstrated that the provision of long-term housing and support for people with a mental illness significantly reduces inpatient hospital stays. Therefore demonstrating that effective care in the community can reduce the cost to Government of frequent and/or extended hospital stays as well as facilitating a greater quality of life⁷⁶.

The Victorian Government's Housing and Support Program (HASP), is a program aimed at improving the lives of tenants with mental illness by providing assistance with gaining access to secure and stable housing, community resources and intensive disability support services. The underlying principles of the HASP model are:

- the house is a 'home', not a residential treatment service;
- choice of housing is based upon consumer preference;
- consumers are community members, not residents of a program;
- control of the environment is moved from staff to the consumer;
- houses are 'normal' houses, dispersed throughout the community;
- support occurs in the persons home rather than a transitional environment;
- support is individualised and flexible, according the persons needs and wants consumers define the level of support they require at any given time⁴².

6.3

Dementia in the Aging Population

Dementia describes a syndrome associated with a range of diseases characterised by a progressive impairment of brain functions, including cognitive skills, memory, perception, personality and language⁷⁷. Because of difficulties in identifying people with mild or moderate dementia there are no definitive estimates of the number of people affected in Australia, however the prevalence of dementia has been estimated to double every 5.1 years of age after the age of 65⁷⁷. Other research projections estimate that from 1995 to 2041 the incidence of dementia will increase by 254%, compared to general population growth of only 40%⁷⁸. Dementia is a major determining factor in precipitating entry to residential care. At least 60% of people in high care facilities and 30% of people in low care facilities have dementia with many more having varying degrees cognitive impairment (90% high care; 54% low care)⁷⁸. It has also been demonstrated that the incidence of acquired dementia in Victoria increased exponentially from 1% for people aged 60 years, to 23% for people aged 85 years or older. This represents an increase greater than 10% over the past three years and is expected to rise by a further 8% over the next five years⁶.

There are a variety of types of dementia. The most common are:

- Alzheimer's disease – is the most common form of dementia, estimated to be responsible for 70% of dementia cases;
- Vascular dementia – where damage is believed to develop as a result of narrowing of the arteries supplying the brain;
- Dementia with Lewy bodies – in which abnormal brain cells (Lewy bodies) form in all parts of the brain;

- Pick's disease and frontal lobe dementia – in which damage starts in the front part of the brain commonly resulting in personality and behavioural disorders early in the disease process;
- Parkinson's disease – dementia is more common in people with Parkinson's but not everyone with Parkinson's develops dementia;
- Alcohol- and drug-related brain damage – in which brain function deterioration is caused by excessive alcohol consumption, particularly in conjunction with a poor diet low in vitamin B1 (thiamine);
- Huntington's disease – an inherited disorder of the central nervous system.
- Creutzfeldt-Jakob disease ('Mad Cow Disease') – in which nerve cells swell and die⁷⁷.

In the early stages of dementia a person may experience difficulty with familiar tasks such as shopping, driving or handling money. As the dementia progresses, more basic or core activities of daily living such as communication and self-care practices (e.g. eating, bathing and dressing) are also affected. Therefore, the care needs of people with dementia grow as the disease progresses. The more common effects of dementia have been reported to include:

- memory problems, especially for recent events (long-term memory usually remains in the early stages);
- communication difficulties through problems with speech or understanding language;
- confusion, wandering, getting lost;
- personality changes and behaviour changes such as agitation, repetition, following; and depression, delusions, apathy and withdrawal⁷⁷.

The Commonwealth Government of Australia supports dementia-specific aged care services by:

- The introduction of a new Residential Care Supplement in 2006, to better target assistance to people with higher care needs by supporting the provision of care to people with dementia exhibiting challenging behaviours and people requiring complex palliative nursing care;
- Committing \$11.6 million over a four year period to strengthen culturally appropriate aged care from 2005;
- Supporting a range of targeted dementia services including the Dementia Education and Support Program, the National Dementia Behaviour Advisory Service, the Early Stage Dementia Support and Respite Project, Carer Education and Workforce Training, and Psycho-geriatric Care Units in addition to HACC, CACP and EACH packages;
- Establishing a National Framework for Action on Dementia designed to co-ordinate a strategic, collaborative and cost-effective response to dementia leading to the development of a draft National Framework;
- Making 'dementia' a National Health Priority with a \$320.6 million package over five years (from 2005) targeting better prevention, treatment and care including:
 - 2000 new dementia-specific Extended Aged Care at Home places and
 - Dementia training for up to 9 000 residential aged care workers and 7 000 people in the community who come into contact with people with dementia, such as police, emergency services and transport staff⁷⁹.

In 1997 the concept of 'ageing in place' was enshrined in the *Aged Care Act* which legislated that people could remain in their home/accommodation (however defined) regardless of their increasing care needs. This concept aims to give all people the opportunity and support to choose where they live as they age. The choice of where to live is underpinned by a comprehensive range of support services for the person with a disability and their carer⁸⁰. People with special needs are defined in the *Aged Care Act 1997* and the Aged Care Principles as people from Aboriginal and Torres Strait Islander communities; from non-English speaking (culturally and linguistically diverse) backgrounds; who live in rural and remote areas; who are financially or socially disadvantaged (including homeless people); or who are veterans, including spouses, widows or widowers of veterans.

It is often difficult for homeless people to 'age in place' both because of accommodation difficulties, and their cognitive and behavioural limitations. Their lack of security of tenure and the shared facilities of their accommodation make community care options and modifications to their homes very difficult. Often their low cost accommodation is threatened by redevelopment or reduced in availability. For frailer homeless people who enter hostel care, there can be issues of affordability, social 'fit', inability to provide for clothing and other needs, inability to drink and no additional income to be provided by relatives.

In 2003, after allegations of poor nursing home standards, understaffing and inadequate safety levels for residents and staff, a Senate inquiry was launched into aged care services. In a published response to the Enquiry into Aged Care in 2004, it was noted that there was no policy or funding framework currently available in Australia for concept facilities that are purpose-built to support people with dementia and related co-morbidities that were severe enough to impact on their care needs⁸¹. It was also acknowledged that the development of this type of facility was crucial for the delivery of quality of care for residents who would otherwise be at risk of receiving sub-optimal care in unsuitable environments. Several problems in the current service delivery system were also identified including; the fact that any facility could be labelled as being dementia-specific regardless as to whether it has incorporated purpose design, there are no clear best practice guidelines for the design and model of service delivery for dementia-specific facilities, the few purpose-built facilities that do exist do not have policy or funding incentives that allow them to accept older people with a complexity of need. This includes people with non-Alzheimer's-type dementias, Alzheimer's-type dementia with moderate to severe challenging behaviours, mental illness in conjunction with early to moderate dementia and people with Acquired Brain Injury (ABI).

6.4 Acquired Brain Injury in the Aging Population

The incidence of ABI in Australia has been reported to range between 100 to 377 people per 100,000 people each year⁸². The exact number of people with an ABI living in Victoria is unknown, but is estimated to be around 72,800 of which 31,000 have some need of personal assistance or supervision⁸³. It has been suggested that these estimates are conservative and the actual number of people affected is much greater due to difficulties in differentiation between ABI and other conditions such as dementia. These difficulties are attributable to:

- Imprecise use of terms and definitions;
- Differentiation of ABI from the memory changes associated with normal aging is difficult or impossible;
- Because the symptoms of normal aging, depression, and mild dementia are quite similar, misdiagnosis does occur when the clinician confuses signs and symptoms of dementia with those of other disorders. Depression often occurs as a complication of dementia, however depression is also frequently accompanied by cognitive problems, especially in older persons; and, in some cases, these cognitive problems are severe enough to be misdiagnosed;
- The signs and symptoms of neurologic disorder accompanied by dementia (e.g. Alzheimer's, Huntington's, Alcohol related brain injury, and Parkinson's disease) may have some overlap with those of depression;
- No sound method for testing and demarcating the boundaries between (1) intellectually intact depressed elderly individuals; (2) others who have significant affective symptoms and substantial cognitive impairment, where the intellectual deficits can be reversible following vigorous therapeutic intervention; and (3) those who suffer a progressive neurological disease which manifests itself with the behavioural symptoms of both conditions⁸⁴.

ABI refers to any type of brain damage that occurs after birth. The specific symptoms or losses of functioning depend on which brain areas are affected. There is a wide range of causes of ABI, some of which include:

- Alcohol or drugs – alcohol related brain damage (ARBD);
- Disease – such as AIDS, Alzheimer’s disease, cancer, multiple sclerosis or Parkinson’s disease;
- Lack of oxygen – called anoxic brain injury (for example, injury caused by a near drowning);
- Physical injury – such as an impact to the head, which may occur in car or sporting accidents, fights or falls;
- Stroke – when a blood vessel inside the brain breaks or is blocked, destroying the local brain tissue⁸⁵.

The changes in mental functioning caused by an ABI are complex. The diversity of symptoms can include impairments in executive functioning, ability to learn (learning difficulty), thought processes and emotional regulation. The terms ‘learning impairment’ or ‘learning difficulty’ can incorporate a wide variation of problems with memory, perception, problem-solving, and conceptualizing resulting in the person having significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. The condition is attributed to a heterogeneous group of disorders including, cerebral palsy, epilepsy, neurological impairment, autism or acquired brain injury. People with ABI are more likely to suffer from mental health problems that may precede the injury or occur as a result of major disruption to their health, functional capacity and lifestyle following the injury¹²⁵. Although the group of people with ABI constitutes only a small proportion of the total number of residents with dementia, they pose severe and ongoing challenges for residential aged care facilities. Most problematic is the frequency with which significant problems with impulse control, social skills and self-awareness accompanies the diagnosis of ABI.

38

Mental health services receive both Commonwealth and State/Territory funding. Commonwealth funding enables people to access GPs and private psychiatrists, while State funding covers community health services and specialist public mental health services. However, because these services are targeted at people with serious mental illness, people with ABI sometimes encounter difficulty accessing them. This is because the significant cognitive, emotional and behavioural disturbances that can result from an ABI can be difficult to distinguish from those of a co-existing mental illness. In Australia, all community-based clients with an ABI requiring treatment for mental illness are referred to the Specialist Mental Health Service System. This service provides clinical services managed through public hospitals and psychiatric rehabilitation services managed through non-government community organisations. The Brain Disorder and Injury service at Royal Talbot Rehabilitation Centre is the major ABI-specific service funded by the Mental Health Branch of the Victorian Government. It provides specialist assessments, treatment, rehabilitation and extended care for traumatic brain injury and /or organic brain disorders¹²⁵. Other services include:

- The Royal Melbourne Hospital Neuropsychiatry Service – providing in/outpatient assessments and treatment;
- The Bouverie Centre at the Victorian Family Institute – providing state-wide specialist services to families and professional health carers.

Treatment for ABI can include a combination of interventions including:

- Cognitive/behavioural remediation;
- Psychotherapy;
- Pharmacotherapy¹²⁵.

Current research suggests that alternative intervention treatments may be as effective as antipsychotics or other drug treatments for some conditions. These may potentially be less expensive and have fewer side effects than medication; however they rely on a greater degree of expertise and training of support staff as well as careful planning and execution of care plans⁸¹. Behaviour management therapy involves a process of understanding what reinforces and sustains maladaptive behaviours and designing methods or teaching skills that reduce or eliminate them⁸⁶. These therapies are being investigated for use in many different disability groups including the treatment of socially unwanted behaviours or antisocial behaviours (ASB) that commonly accompany acquired brain injuries.

6.5

Alcohol Related Brain Damage

The consumption of alcohol is intrinsic to the Australian culture yet it has been demonstrated that beyond the aspect public awareness campaigns such as 'drink-driving', Australians have limited understanding of the extent of alcohol related harm through its chronic abuse⁸⁷. The consumption of alcohol has been estimated to have resulted in 31,133 deaths in Australia between 1992 and 2001 through associated disease or injury. Alcohol misuse in older people is of particular concern as this population group is particularly vulnerable due to limited access to opportunities or appropriate services. The misuse of alcohol among older people is often described as a 'hidden' or 'neglected' area of research⁸⁸.

At present the most frequent drug of abuse among the elderly is alcohol⁹⁷. However, there is an emerging population group who has experienced greater exposure to illicit drugs and therefore may influence the incidence of drug-induced ABI over the next decade. All drugs of abuse act in the brain to produce their euphoric effects; however some of them also have severe negative consequences in the brain such as seizures, stroke, and widespread brain damage that can impact all aspects of daily life. Drug use can also cause brain changes that lead to problems with memory, attention and decision-making. Drugs that can cause neurological problems include: cocaine, GHB, inhalants, marijuana, MDMA, methamphetamine, nicotine, prescription stimulants and Rohypnol⁸⁹.

Alcohol problems in older people are increasingly common^{90,91}. It has been found that significant numbers of people over 65 exceed recommended drinking limits⁹². These limits are usually set for the general population representing adults of all ages and therefore represent excessive amounts for older people. Although generally, the amount individuals' drink decreases with age⁹⁴, in USA it has been found that up to 15% of older people had problems associated with alcohol⁹¹ and in the UK, it was found that between 3-9% of older people drink to excess⁹³. The frequency of under-diagnosis of alcohol problems and ARBD in older people is considered to be significant. The principal cause of this under-diagnosis is thought to be due to the awareness of ARBD being low among frontline workers in health and social care^{96,94}. Alcohol problems may not be identified by GPs or other primary care and frontline staff and older people rarely access specialist alcohol services. Alcohol use by older people is often found to be associated with cognitive impairment caused by ARBD.

When the effects excessive or inappropriate alcohol consumption is considered in an aging population, alcohol related ill health is a compounding factor. The physiological changes that occur with aging result in increased vulnerability to the effects of alcohol and increased risk associated with mixing alcohol with prescribed medication⁸⁸. The negative health effects of chronic alcohol misuse for older people are well documented. Traditionally alcohol services have not been available for older people and there has been a lack of appreciation of the problems associated with alcohol for older people⁹⁰.

These problems include an increase in the:

- risk of chronic heart disease, hypertension and stroke;
- incidence of mal-absorption;
- incidence of pancreatitis and liver damage;
- risk of falls and accidents;
- likelihood of incontinence and gastrointestinal problems;
- prevalence of memory loss and the development of dementia;
- incidence of Parkinson's disease and delirium tremens;
- effects of self-neglect, such as poor nutrition and hygiene;
- risk of developing psychiatric problems such as depression, phobias and anxiety;
- risk of suicide^{88,95}.

Although varying degrees of recovery from an ABI can occur, there is typically some degree of

permanent impairment. For people recovering alcohol related brain damage (ARBD) however, there is evidence of improved cognitive functioning over the first two weeks of abstinence but conflicting evidence as to the possibility of further improvement over a longer period of time⁸⁸. Estimates of the incidence and prevalence of ARBD are particularly difficult to obtain because of under-diagnosis, and the estimates that are available are difficult to compare because of different methodologies and different study populations. Autopsy studies in Australia have produced estimates of the prevalence of Wernicke-Korsakoff syndrome (a type of alcohol related brain injury associated with thiamine malnutrition) of around 2% for the adult population⁸². The early identification of ARBD is difficult due to the diversity, complexity and variability of individual symptoms. The resulting diversity of individual needs has led to the recommendation that ARBD requires a person-centred approach⁹⁶. However, the social stigma attached to ARBD, resulting from its association with alcohol, mental health problems and dementia, needs to be addressed beyond the individual to institutional and societal levels. It has been suggested that future strategic development of information, advice and health promotion services would go a long way to addressing these issues⁹⁶.

40

There is a growing body of research examining the effects of aging in association with long-term alcohol abuse; however the increased complexity of these two factors in the homeless population has received little attention. In a recent study in Melbourne 43% of an elderly homeless population reported having issues with alcohol⁹⁷. Problems were more commonly reported by men (48%) than women (28%) with nearly half the men admitting to heavy drinking or alcohol dependence. However, when case workers were questioned as to their client's level of alcohol consumption, there is evidence of significant underreporting with alcohol related problems being reported in 77% of the male population and 44% of the female population. Similarly, in the UK it was found that the number of women with reportedly high levels of alcohol consumption decreased as their socioeconomic position decreased, however for men there was an upturn in consumption levels (particularly in relation to excessive drinking) among the poorest income groups and unskilled social class⁸⁸. However, much of this research stems from population groups known to demonstrate a high incidence of excessive alcohol consumption, such as the homeless.

More recent evidence suggests that the problem is much more wide spread and that alcohol abuse among the older population is being grossly under diagnosed^{90,94}. This may be due to such factors as a lack of acknowledgment of alcohol problems among staff working with older people, a lack of accurate screening or assessment tools and the social stigma associated with alcohol abuse. Older people who have the financial means to afford private residential aged care and those with family who may fear the 'labelling' of their aged relative can, and do, enter mainstream aged care residential services provided that they are over 65 years of age. However, as discussed earlier many people with ARBD often experience premature aging and are younger than 65. They commonly have issues around their alcohol problems which generic services may not be designed to cope with. Therefore it has been acknowledged that some specialist aged-care service providers such as Wintringham allow younger people in target populations to access their older peoples' services.

Overall, there is a lack of services for younger people with dementia such as people with ARBD. Many younger people with dementia including people with ARBD are inappropriately placed within services for older people⁹⁶. Research in the UK has highlighted the fact that more younger people with dementia are found to die in residential and nursing homes today than a decade (or more) ago suggesting that more younger people with dementia are inappropriately placed within residential and nursing homes for older people⁹⁸. This evidence suggests that there are a considerable number of people with ARBD who have been inappropriately placed within mainstream residential aged care facilities⁹⁴.

There are three major sources of ethical dilemma associated with the care and management of individuals with ARBD. The first involves the balancing and individual's right to autonomy with an acceptable level of protection for themselves and others⁹⁶. The second involves the balance between the provision of individual specialised clinical care, often focused around institutions, and the

facilitation of a community-based lifestyle. And the third involves the debate surrounding the practice of abstinence versus a carefully managed harm reduction/minimisation especially for long-term drinkers with severe ARBD and associated health and behavioural issues, for whom withdrawal from alcohol can be a dangerous and sometimes life-threatening experience.

In many ways the level of care required by people with ARBD and complex care needs are similar to those provided to elderly people living with dementia. Dementia can be associated with varying levels of cognitive impairment and challenging behaviours, which at the extreme end of the spectrum results in the requirement for dementia-specific accommodation and facilities, which are separated, from 'mainstream' nursing homes and hostels. They generally support residents in smaller carer/client ratios in facilities with design features that are more desirable to dementia care including improved security, ease of observation and harm minimization strategies.

In 1996, there were 4.7 dementia-specific beds per 1,000 people over 70 years of age. For hostels, estimates for the presence of moderate to severe cognitive impairment were approximately 20% and in nursing homes 68%⁹⁹, therefore the demand for these facilities greatly exceeds the number of places available for people who qualify for eligibility. Generally selection for eligibility for dementia-specific facilities is not based only on a diagnosis of dementia but also on the basis of whether the resident is considered to be behaviourally disturbed, disruptive or unable to be appropriately cared for in mainstream environments. In an overview of dementia-specific care in Australia, Rosewarne et al compares dementia-specific facilities with mainstream aged-care and describes the facilities as being, 'more modern and less institutional' and the living environments as, 'domestically styled'¹⁰⁰. They stated that, "*Dementia-specific accommodation provides the opportunity to more appropriately accommodate and support people with higher levels of behavioural disturbance and cognitive loss in secure, modern, small-scale environments*".

In theory it would appear that this type of facility would provide the ideal solution for the accommodative needs of people with ARBD and complex care needs, however; the average age of residents in these facilities would be significantly older than most people with this diagnosis. Even if they did manage to circumvent the stringent eligibility criteria, the sedentary lifestyle and absence of like-aged people could exacerbate depression and disruptive behaviour in the relatively younger, more active and fiercely independent persons with ARBD. This could present staff and co-residents with situations and circumstances that they had not previously had to deal with and may not be capable of facilitating.

6.6

Alcohol Related Brain Damage in the Aged Homeless Population

The relationship of alcohol and drug use to homelessness is interactive and iterative in that it can be both a cause and an effect of homelessness¹⁰¹. Although homelessness is often cited as a contributing factor to alcohol misuse among the elderly, the full impact of the coexistence of all three factors on individuals and their care providers has generally been overlooked. When we consider that pathways into homelessness can include:

- Poverty;
- unaffordable, insecure and inappropriate accommodation;
- long-term unemployment;
- social dislocation and isolation;
- substance abuse;
- inadequate support and care of people with complex health problems; and
- poor management of de-institutionalisation¹⁰²,

it has been demonstrated that in most cases, the physical and mental health of such individuals has already been compromised. With the added complication of alcohol related ill health, the complexity of the individuals' care needs increases exponentially. In particular, problems associated with behavioural disorders make the ability to maintain stable accommodation more difficult.

In principle and design the Multiple and Complex Care Needs Initiative appears to be ideal for people with complex psycho-social and medical care needs. According to the terms of reference many older homeless people with chronic, long-term alcohol related brain injury and associated behavioural issues would qualify as a member of the Complex Needs Project's target population. Unfortunately the process of referral is long and complex and there are only a limited number of places available each year to people of all age-groups. The Initiative primarily supports short-term crisis or acute models of care more suited to rehabilitative, return-to-the-community programs appropriate to the majority of younger people with complex needs. However, for older people with complex needs associated with a long history of homelessness and/or alcohol related mental and physical health issues, long-term residential models would be more appropriate. This is where the shortcomings of the current system are highlighted. Which residential facility would best meet the older person's needs? A 'mainstream' residential facility would be able to adequately address the medical needs of the individual, but are poorly equipped to facilitate the addictive, challenging and anti-social behaviours that may be a constituent of the complexity of their need.

42

When significant proportions of already limited financial resources are spent by someone who is dependent on alcohol or other substances, the maintenance of stable housing becomes increasingly difficult. It is also difficult for an individual to focus on substance abuse treatment when their basic survival needs for food and shelter are threatened. The stress and danger associated with homelessness also may feed back into the cycle of relying on alcohol or other substances as a coping strategy. Homelessness may result from poorly planned discharge from residential treatment, institutionalization, hospitalization, or incarceration secondary to substance involvement. Traditional treatment options with detoxification and abstinence, although recognised as the best option from a health perspective, are not generally as effective with the homeless population compared with the general population^{101, 103, 104, 105}. 'Mainstream providers' are generally reluctant to accept referrals for homeless alcohol abusers because of their frequent unpredictable behavior, high-risk medical problems, and extensive demands/needs¹⁰¹.

Dual Diagnosis describes people who have coexisting substance abuse (drug and/or alcohol problems) and mental illness or psychiatric disability. Homeless persons who are dually diagnosed with severe mental illness and substance use disorders constitute a particularly vulnerable subgroup with complex service needs¹⁰⁶. There is increased understanding that an effective model of treatment for mental illness and substance abuse disorders is to integrate both treatment programs into the one program providing a multi-disciplinary service team of both mental health and substance treatment professionals. This system is about integrating knowledge, skills, resources and experience resulting in better outcomes for consumers and leading to a reduction in people falling between the gap created by separating mental health services and drug and alcohol services. These patients are well known to have a poorer prognosis than patients with exclusive substance addiction, with a higher incidence of hospitalisation, medication non-compliance, criminality, homelessness, and suicide. Because of such complicated diagnostic and morbidity issues, patients identified as having dual diagnosis require specialised treatment for a successful outcome¹⁰⁷. Various organisations and agencies are now establishing and testing treatments for dual diagnosis clients. However, these treatments are largely operating independently of each other, with no overall governing body. Organisations including the Alcohol and other Drugs Council of Australia, SANE Australia and the Mental Health Council of Australia are currently working to make dual diagnosis a health care priority¹⁰⁸.

Alcohol related brain damage (ARBD) is caused by a combination of Thiamine (vitamin B1) deficiency, general cerebral shrinkage (secondary to alcohol consumption), and a range of other insults to the brain including repeated head injury or assault⁹⁶. The process of metabolising alcohol increases the metabolic demand for Thiamine, which plays an important role in ensuring that the brain receives a steady supply of sugar. In addition alcohol dependence also decreases the absorption of Thiamine from the gut. And because alcohol-dependent people are prone to deprivation their nutritional status is generally poor increasing their vulnerability to ARBD.

Of the older clients using Salvation Army Services in Melbourne in 2002, 75% were reported to have cognitive impairment; the majority being alcohol related brain injury¹¹⁵. A common symptom or ARBD is impairment in executive functions, which process and co-ordinate all neural information. These functions involve self-awareness of strengths and limitations, the ability to set reasonable goals. Kodituwakku, Kalberg, and May (2001) refer to the concept of executive functioning as, “... deliberate, or effortful, actions that involve various abilities, such as holding and manipulating information ‘in the head’ (i.e. working memory) and focusing on one task at a time (i.e. inhibiting task irrelevant habitual responses)” (p.192)¹⁰⁹. In this way, executive functioning includes the abilities of retrospective memory and prospective cognition for the promotion of strategic planning, including the delaying of responses to enable the consideration of options, consequences, strategic development and flexibility in ideas¹¹⁰.

Socio-economic disadvantage and related socio-demographic factors have long been recognised as important determinants in health¹¹¹. Social position factors such as education, occupation and income have been hypothesised to impact on a person’s health¹¹² however, the methodology used in much of the research investigating this relationship have been questioned^{113, 114}. There are however indisputable associations between a homeless lifestyle and its effect on health. Of the older clients (average age 59 years) using Salvation Army Services in Melbourne in 2002, 50% were reported to have had serious multiple health issues with the potential to result in premature death¹¹⁵. The incidence of chronic physical health conditions in a homeless population in Sydney in 1998 was also found to be very high with 50% of people reporting at least one of twelve chronic conditions of which the most prevalent were liver problems (13 %), asthma (13 %), high blood pressure (13 %) and hepatitis B or C (12%)¹¹⁶. In another Sydney-based study (2002), 66% of aged homeless men had a physical disability that restricted their activity, especially affecting their mobility¹¹⁷. In Melbourne in 1996¹¹⁸, the incidence of self-reported chronic health problems by 383 homeless people was; asthma (19.8%), bronchitis (46.7%), for gastroenteritis (19.1%), heart problems (10.2%), endocrine disorders (4.7%) and neurological disorders (7%).

In the United States, between 1988 and 1993, twenty-three demonstration projects were funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), in consultation with the National Institute on Drug Abuse (NIDA) to provide and evaluate community-based alcohol and drug abuse treatment and rehabilitative services for individuals with substance use disorders who were homeless or at risk of becoming homeless. The overall findings indicated that individuals with substance use disorders that were homeless needed (1) services that addressed their tangible needs for housing, income, and employment; (2) allowed them access to flexible, low-demand interventions; and (3) facilitated long-term continuous treatment and support. Researchers found that short-term treatment was ineffective with this group¹¹⁹.

In 2001, the Victorian Government funded a 3-year Homeless and Drug Dependency Trial (HDDT) initiative. The trial, utilising Melbourne’s major Crisis Supported Accommodation Services (CSASs), focused on intense case management and an accessible service approach to assist homeless people who have issues with drug use. The initiative was aimed at reducing the person’s drug dependence, minimising the harm they do to themselves and building pathways out of homelessness and drug addiction toward secure accommodation and stable lifestyles. The trial was developed in direct response to an increase in the number of homeless people with problematic drug dependency issues that utilized crisis supported accommodation services in Melbourne. A key finding of the trial was that the majority of the homeless participants had a high level of need and required long-term responses and strategies in order to build and maintain pathways out of homelessness and drug misuse. The program is now funded on an ongoing basis and services have been expanded to include long-term primary case management treatment options¹²⁰.

6.7

Behavioural Disorders in the Aging Population

The management of dementia is often complicated by behavioural and psychological symptoms of dementia (BPSD), such as psychosis, depression, agitation, aggression and disinhibition (i.e. unrestrained behaviour resulting from a lessening or loss of inhibitions or a disregard of cultural constraints). BPSD is an umbrella term for a heterogeneous group of non-cognitive symptoms that frequently accompany dementia. Rates of BPSD vary according to how symptoms are ascertained, thresholds of severity, and setting¹²¹.

While research seeks to understand the interactions between BPSD symptoms and biological, environmental, and social factors, there is little empirical data available on appropriate interventions. In the residential setting, many residents displaying these behaviours are managed through the use of physical and chemical restraints, and high rates of psychiatric hospital admission. Pharmacological interventions are most commonly employed for BPSD, despite receiving criticism for limited outcomes and frequent side-effects¹²². Alternative strategies, such as tailoring individual psycho-social interventions for residents or delivering specialist training in psycho-social strategies to facility staff to improve the overall care of residents with dementia, appear promising. However, it is not yet clear which type of approach is most effective.

44

Psycho-social models of care have been described as, *“The process of facilitating an individual’s restoration to an optimal level of independent functioning in the community ... While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services”*¹²³. Most psycho-social models practiced and reported on in the context of dementia-specific residential aged care are based principles of ‘emotion-oriented’ behaviour modification, although they also contain, in varying degrees, elements of a ‘consequences’ model of care. These models are used not only as a theoretical framework for research, but also in the provision of care. Despite the fact that most models are being used increasingly in the psycho-geriatric field, not many have been tested empirically¹²⁴.

Similarly, an ABI can cause symptoms similar to psychosis and dementia as well as to significant problems with impulse control, social skills and self-awareness. These problems may manifest as agitated, difficult, disruptive, inappropriate and/or aggressive behaviour which may or may not be associated with a serious mental illness or disorder¹²⁵. Behavioural disorders can also result from two common syndromes associated with long-term alcohol abuse and ARBD. They are the Korsakoff Amnesic Syndrome and the Adaptive Behaviour Syndrome:

- The Korsakoff Amnesic Syndrome is characterised by intact immediate memory, a profound difficulty learning new information, poor recall of recent events, confabulation and lack of spontaneity;
- The Adaptive Behaviour Syndrome is characterised by poor planning and organisation, concrete and inflexible thinking, lack of insight, inappropriate behaviour and a lack of self-criticism¹²⁶.

Anti-social behaviour (ASB) has been described as a generic term that covers a range of behaviours that infringe on the right of individuals to enjoy their surrounding environment (e.g. home). It can involve such minor activities as dropping litter to more the extreme activities of criminal behaviour such as theft and assault¹²⁷. In the social housing context, although the number of residents engaging in ASB may not be large, their activities can have a disproportionate effect on the quality of other residents’ lives. ASB has increasingly gained greater prominence in the Australian public housing sector¹²⁸. There is debate as to the level of social structure responsible for the presence of ASB. As a result there is a division in the literature as to the most effective management strategy. On the one hand there is the theory that ASB occurs as a result of emerging developments in social

policy resulting in a resident population that have little opportunity to exercise choice and may therefore, be predisposed to such behaviours¹²⁷. For example, in recent years the assessment criteria used for accessing social housing has been tightened resulting in a significant increase in the proportion of tenants with acute needs, with a disproportionately large number of households suffering from mental illness and exhibiting characteristics associated with poverty and stress. On the other hand there is the theory that responses aimed at the individual are the most effective¹²⁹.

In Australia State housing authorities recently implemented a community-based, multi-agency program in response to ASB. In most instances on-site cooperative resolution is encouraged, however in some instances, involving more serious incidents or persistent ASB offenders, individual punitive responses are implemented¹²⁷. As reported by Jacobs and Arthurson (2003), some of the more successful management strategies adopted to minimise the incidence of ASB have focused on the presence of long-term housing staff who work directly and informally with tenants in a relationship based on trust¹²⁷. These workers effectively used their knowledge of the locality and of the individual traits of tenants to inform their decision-making. The importance of effective communication and the dissemination of 'good news stories' within the locality were also emphasised as was the need to provide specialist training and resource support to housing staff. Occupational Health and Safety (OH&S) issues must also be addressed as these can lead to a refusal to accept older adults with a history of mental health disorders or challenging behaviours into aged care facilities.

Some older people with a mental illness, persistent psychiatric symptoms, challenging behaviours and a lack of social skills, may actually have low personal care needs yet high psycho-social needs. As a result of this increasing need, a person who is no longer able to live independently within the community, may also be ineligible to enter a low level Commonwealth funded residential care facility. This occurs as a result of inadequacies in the current Resident Classification Scale assessment system which may not accurately reflect the full extent of the person's behavioural support requirements. The housing options available to these individuals are severely restricted. Often these people are admitted into an SRS facility. People with a mental illness living in pension-level SRSs are often readmitted to acute inpatient units when their condition worsens due to insufficient support. While older people with a mental illness are likely to be less transient than their younger counterparts, some are effectively homeless as they move between acute wards, rooming houses, different hostels and SRSs, unable to be supported to the degree required²⁵.

6.8

Behavioural Disorders in the Aged Homeless Population

Over the last two decades, in Australian and international literature, there has been increasing use of terms such as 'complex needs'¹³⁰ or clients with 'high complex behaviours'¹³¹. However these terms more often are used to refer to people whose needs and behaviours present significant, sometimes intractable challenges to all health, human service and criminal justice systems. Representing a very small proportion of the population but requiring considerable resources, a significant proportion of these people also experience homelessness from time to time¹³².

Over the last decade, there has been an increased interest in homeless people with 'high and complex needs'. Much of this research has largely been in the area of homeless people with mental illness and substance abuse issues. The main aim of these projects has been to measure the type and extent of mental illness among homeless people in the community following deinstitutionalisation in USA, UK and Australia from the late 1970s onwards^{29, 55, 140, 131}.

The literature suggests that approximately 50 per cent of the homeless population have some sort of diagnosable condition including mental illness, drug and alcohol disorders, behaviour disorders, and intellectual disability as well as chronic health problems^{133, 134, 135, 136}. In turn, these people often have multiple care needs requiring a greater complexity of service provision for longer periods of time. In addition, homeless people often demonstrate challenging behaviours that may have

contributed to their homelessness or alternatively, the experience of homelessness may have exacerbated these problems. Challenging behaviours are generally described as behaviour that, either directly or indirectly, seriously disrupts or affects the lives or routines of other people or services¹²⁷. These may include other clients, residents, neighbours, support services staff, families and communities. Frequently these behaviours interfere with the person's ability to learn; and may place the person, others or property at risk of injury or damage.

Several co-occurring disorders have been associated with presence of challenging behaviours ranging from clinical disorders to other factors, including brain damage, borderline intellectual disorders, other mental disorders and substance abuse¹³⁷. People with high and complex needs demonstrating challenging behaviours may require a disproportionate amount of service resources such as the requirement for special residential units which provide an environment that adequately meets occupational health and safety requirements, specialist workers who have been trained to work effectively and intensively in such environments and the provision of appropriate recreational and lifestyle opportunities^{138, 139}. As a result many people demonstrating such behaviours fall through gaps in the health and community services system¹⁴⁰.

46

Very often ASB is associated with excessive alcohol intake and alcohol related brain injury. Disorders of awareness are closely related to ARBD, particularly frontal lobe dysfunction (FLD)¹⁴¹. In more severely affected individuals with FLD 'disorders of control' may result. This condition is characterised by a reduction in impulse control and often the individual is disinhibited in their behaviour. This may be the underlying cause of ASBs and challenging behaviours in someone with ARBD. The term 'challenging behaviour' refers to a wide range of actions and behaviours that are perceived by others/society to be either inappropriate or difficult to manage, understand or facilitate. A mildly challenging behaviour could be, for example, reluctance to shower, while a more extreme challenge could involve aggressive outbursts. It is often difficult to differentiate it from ASB with often only the degree of severity separating the two terms, especially when the terms are defined differently in different service delivery sectors, e.g. the children's educational services versus adult residential services.

Behavioural traits common among the long-term elderly homeless can include:

- paranoia and fearfulness;
- suspicion, jealousy and resentment;
- withdrawal, social isolation and depression;
- anti-social;
- poor motivation and resistive;
- delusional and fabrication;
- ritualistic and obsessive/compulsive;
- overly protective of property and hoarding;
- restlessness, wandering and absconding;
- intrusive;
- verbally abusive and provoking;
- manipulative and attention seeking;
- physically violent and sexual harassment;
- non-compliance – medication, health interventions, hygiene etc;
- unrealistic expectation of own ability/health;
- unsafe smoking habits and butt stooping;
- gambling¹⁴².

When these behavioural factors are considered in conjunction with the mental health problems cited as being associated with alcohol misuse, including:

- dementia;
- anxiety and depression;
- amnesia;
- alcohol hallucinosis;

- morbid jealousy;
- Wernicke-Korsakoff and Marchiafava-Bignami Syndromes;
- cerebellar degeneration and central pontine myelinolysis;
- psychotic illnesses – acceleration or precipitation of psychiatric disorders;
- social disintegration – family, work, social networks, criminal behaviour⁹⁵,

the outcome is a resident who generally requires a high level of care due to significant health issues; however the behaviour-management aspect of their care can not be accommodated in 'mainstream' aged care or homeless care facilities. The end result is often an endless shuffle between different organisations and facilities, often with intervening intervals of living 'rough', hospitalization or the criminal justice system.

Although the frequency of the coexistence of alcohol misuse, alcohol related brain damage (ARBD) and the homeless population has clearly been demonstrated, it would be naive to believe that the problem is exclusive to this group. There are several reasons as to why the incidence of ARBD within the general aging population is grossly under-reported. These include such factors as:

- the symptoms of alcohol related psychosis can often mimic symptoms of psychiatric illnesses making it difficult to make an accurate assessment of the problem⁸⁸;
- different aetiological basis of the disease;
- the self under-reporting of levels of alcohol consumed; and
- societal and family pressure to conceal the presence of alcohol misuse.

Although the symptoms of ARBD may mimic other psychiatric illnesses, there is evidence that there is some characteristic behaviour unique to the diagnosis¹⁴³. Often a failure of the mainstream aged-care system is to recognize and acknowledge their existence and to adequately address the challenge of their care and management. There is a rapidly growing body of documentation on evidence-based models of care appropriate to age-related dementias; however the management of ARBD has generally been left to the domain of such specialty services as Wintringham and *arbias*.

arbias was established in 1990 to provide specialist services for people with alcohol and substance related brain injury. It is a not-for-profit company managed by a board of management. *arbias* is a specialist disability service that works together with clients, families and service providers to assist people with acquired brain injury to live and function to their full potential in the community¹⁴⁴. Often *arbias* works collaboratively with Wintringham in providing specialty care to their clients.

Unlike mainstream aged care programs, Wintringham provides aged care services targeted specifically at elderly homeless men and women. Services include low and high care residential facilities, an extensive choice of housing and support options and Community Care Packages. What remains unique about this service is that it has continued to maintain its focus on the specialised target group and as a result the staff is trained to better understand and support the complexity of needs associated with homelessness. Because of the high incidence of alcohol abuse within this population, the service has adapted its model of care to accommodate their complexity of need.

7

Existing Supported Residential Service Models for Older Homeless People with Complex Needs.

Although statutory housing, health and social services have a responsibility to help vulnerable and needy people, it has been shown that these services are organised and delivered in such a way that many vulnerable people fall through the gaps in these services' frameworks. There are currently a number of gaps in the services available to meet the local needs of older residents requiring psycho-geriatric low care and high care. Access to residential services able to cater for psycho-geriatric residents is currently very limited and the need for nursing homes and hostel beds has been recognised¹⁴⁵.

In contrast, voluntary sector organisations for more than a century have played a dominant role in service provision for single homeless people, and the indications are that their role in housing and supporting disadvantaged and vulnerable people will continue to grow. Mainstream residential care providers are facing increases in the number of residents who have had life-long psychiatric diagnosis and present different challenges to those developing psycho-geriatric illnesses. Many of these people have ended up in supported residential services which too are in decline due to a sustained trend away from the 'pension end' towards the more profitable 'up-market end' of the industry¹⁴⁶. There is a need for the development of innovative programs that allow staff to work flexibly and intensively with various client groups in supported housing models. There are four suggested key elements that need to be considered in the design of a psycho-social model of care. They are listed in Table 4 below.

48

Clinical Care Tools

Advance Care Planning, Clinical Assessment, Bereavement, Pain Management, Psycho-social...

Evaluation Tools

Clinical Quality, Community Assessment, Cost Utilization, Education, Organizational, Programmatic...

Educational Tools

Clinician Education, Community Education, Patient/Family Education.

Organizational Tools

Enrollment Criteria, Informed Consent, Organizational Assessment...

Table 4

Four key elements in the design of a psycho-social model of care¹⁴⁷.

Although the literature on the effectiveness of psycho-social rehabilitation in the field of mental illness is convincing, a limitation is that the published studies have examined intervention strategies individually rather than in combination. Consequently, we do not know which combinations and amounts of interventions produce optimal effects for which subjects, nor do we know what the additive population effects might be. A suggested guide to issues that should be addressed in future research on psycho-social rehabilitation interventions is presented in Table 5.

Model for future research on psychosocial rehabilitation

Independent variables and research questions		Dependent variables and research questions			
Client status	Intervention	Short-term outcomes	Long-term outcomes	Risks	Cost and benefits
Functional severity	Quantity of service	Support networks	Life satisfaction	Psychiatric relapse	<u>Costs</u>
Diagnosis	Service duration	Skill learning	Vocational outcomes	Family stress	Interventions
Housing status	Service mix	Skill retention	Residential outcomes	Legal problems	Outpatient mental health services
Health status	Model fidelity	Skill use	Hospital use	Financial problems	Inpatient mental health services
Socioeconomic status	Provider competence	Life stressors	Self-esteem		Social services
Rural or urban residence	in psychosocial rehabilitation	Consumer goals and motivation	Income		Income entitlements
Work history					Other health services
Years of disability					<u>Benefits</u>
Prior hospitalization					Income and productivity
					Tax payments
					Reduced service use
<i>Which kinds of consumers benefit?</i>	<i>From how much and which services?</i>	<i>Through which mediating processes?</i>	<i>In which combination to achieve outcomes?</i>	<i>With how much risk of negative side effects?</i>	<i>At what cost-benefit ratio to the consumer and the taxpayer?</i>

Table 5
A detailed guide to key issues to be addressed in the design of a psycho-social model of care⁴⁴⁸.

Not every homeless person will be able or willing to 'rehabilitate' or make the transition to fully independent living in the short, medium or long-term. This especially true for older substance misusers and those with entrenched patterns of use for whom these options may not be appropriate. In some cases the appropriate support package may be one that recognises that substance misuse might not end and the role of support may focus on reducing harm, nuisance, offending, debt or other factors that result in a loss of accommodation. For individuals with long-term alcohol issues, supported accommodation that allows drinking to continue and offers a safe, supportive atmosphere is sometimes available. These facilities play a useful part in helping long-term alcohol users to reduce gradually or to effectively manage their current drinking levels. Whilst such programs can be difficult to manage, they offer considerable value to older, long-term alcohol users in providing appropriate support and access to health care.

Drawing on Australian and international research, a report by Purdon (1991) contends that large hostels are a wholly inappropriate form of accommodation for older homeless people and that most older homeless people would prefer 'ordinary housing', although the transition to new accommodation would be unsettling and difficult for many older people¹⁴⁹. The report concluded that for these people, a private room was essential in supporting the common need for:

- a place to retreat and be unobserved;
- security for both person and possessions;
- opportunities to nurture self esteem and one's identity;
- freedom of choice.

Similarly, housing for people with serious mental illnesses historically has been in some type of congregate setting such as a group home, but preference studies show that people with serious mental illnesses want to live in integrated, regular housing rather than in segregated, mental health programs^{150, 151}. With regard to housing strategies, it has been suggested that there are four general categories of client for whom there should be different models of care. The four categories are:

- 1 People with multiple or complex needs, such as mental health problems and substance misuse, offending, or learning disability. They are likely to need help from more than one source, or from a service that offers both generic and specialist support;
- 2 People who are hard to reach, in that they are resistant to services, or perhaps have been excluded from services due to behaviour difficulties or non-compliance with the regime. They may have entrenched and long-term problems requiring high levels of individualized support;
- 3 People who are high risk, in that they could pose a danger to others or to themselves. Certain categories of mentally disturbed offenders come into this group, as do some people with challenging or disruptive behaviour which creates risks for others within the service or in the wider community;
- 4 People who are remote from services and hard to find, rather than hard to reach. This brings in people with mental health problems in some minority ethnic communities, including refugee communities, which have little or no connection with formal social care or similar services. It also applies to people who rely on informal support, such as young adults with mental health problems living with their parents¹⁵².

With the exception of the United Kingdom and United States, there is little documentation reporting on residential aged-care service delivery models for the homeless. When it comes to the detail of specific processes and guidelines for specialized models of care and facility design, there is even less documentation available. Similarly, there are no documented large-scale, experimental studies with a longitudinal aspect or comparison between matched groups for service delivery models supporting older people with mental health disorders. Much of the available literature either reports on research or the support and social care aspects of community-based services rather than on the housing itself. There are no documented comparative research studies exploring different types of housing-based services which include studies of costs, outcomes and effectiveness. More specifically, the potential of appropriate housing in promoting the health and wellbeing of its residents has yet to be properly investigated¹⁵⁵.

Much of the research on supported housing has focused on studies conducted late last century. In the 1980s and early 1990s research concentrated on hostel and shared housing accommodation, while in the later 1990s it shifted away from accommodation-based services to examine floating support models. The development of self-contained supported housing, such as small-scale schemes of clustered flats or local networks of dispersed housing, has been largely undocumented in the research and evaluation literature. The limited evidence that can be obtained from case studies and qualitative interviews within wider research projects suggests that these newer models of supported housing with integrated care are popular, both with tenants and with service providers¹⁵³.

While the initial capital costs of clustered or grouped housing, and therefore rents, tend to be high, such projects are perceived to offer good quality accommodation, security, opportunity for social contact and a high degree of flexibility in the level and form of support. However, their effectiveness in meeting housing needs, or their contribution to the aims of helping people to recover from mental illness, move back into work or training or overcome social isolation have not been assessed. In 2001, a United States study tracked 4,679 individuals who were placed in such housing and compared their use of other services or facilities before and after their placement (psychiatric hospitals, emergency shelters, medical services and prisons) with those of a control group of homeless people who were not in such housing. The study found that a homeless mentally ill person in New York used an average of \$40,499 worth of other publicly funded services in a year, while those in the housing used an average of \$12,148 per year. The cost savings in these areas amounted to 95% of the costs of building, operating and providing services in supported housing¹⁵⁴.

The following sections in Chapter 7 provide a brief overview of some international and local organisations and/or facilities that provide care to older homeless people with complex care needs. The organisations chosen for this selection represent those that are known to Wintringham and *arbias* or have publicly accessible information available on the web. This list is by no means exhaustive. We expect that there are many other organisation/facilities world-wide that provide excellent levels of care and support to these people. Hopefully the distribution of this review will encourage further communication and exchange of information on strategies designed to better serve the needs of our clients.

7.1

The United Kingdom

The emerging trends in supported housing for the homeless and mentally ill in Australia have closely followed those in the UK where, in the mid eighties, un-staffed group homes predominantly (84%) provided accommodation for people with mental health problems. These facilities provided low-level support to their residents relying on contributions fully subsidized by benefit payments. Later in the 1980s, large and small-scale shared housing facilities were developed by housing associations in an attempt to facilitate people with higher support and care needs. In the 1990s, changes to the capital and revenue funding for housing associations encouraged a growth in self-contained, independent housing and support services¹⁵⁵. Around this time, shared housing began to lose popularity and resources were directed into either upgrading existing facilities to provide private facilities, or developing self-contained clustered housing.

More recent developments in the UK have been in the 'Supporting People' scheme amalgamating the capital and revenue funding streams for supported housing. This scheme, together with improved strategic directions for local authorities following increased demand among health and social services commissioners for schemes accommodating people with more intensive and complex needs, is reported to offer positive future directions¹⁵⁵. The National Homeless Alliance is unique amongst national homelessness charities in that it is the only organisation specifically established to work with and support local front-line agencies. It was launched in July 1997, and it leads, supports and co-ordinates more than 1,000 homelessness agencies throughout England and Wales who provide housing and support for more than 30,000 homeless people every day. Large specialist housing and support providers have been encouraged to improve their capacity to

meet diverse needs, and generalist housing associations have begun to work more effectively with highly specialized support providers.

Since the early 1990s, there has been major development of housing-related support services for people living in their own homes and those moving into independent accommodation. These are generally referred to in the UK as 'floating support' services and are distinguished by the fact that the tenancy and the support are not tied together¹⁵⁵. The accommodation is usually based within the general housing stock (social rented or private housing). Supported housing differs from floating support in that the housing and the support are both integral to the service and the support is tied to living in the accommodation and can include; shared accommodation, clustered or grouped self-contained housing and dispersed self-contained housing which is specifically designated for the service. The support may be provided on a visiting basis or through on-site staffing (including full 24-hour staff presence). Across all housing and support services for people with mental health problems in England (floating support and supported housing), just over half (52%) had a named secondary needs group. People with learning disabilities are the secondary needs group in 29% of the 'complex need' services, while 22% of these services have homeless people as their secondary group and a further 22% refer to 'other complex needs' as their secondary group. 'Other complex needs' generally refers to drug or alcohol misuse or a history of offending¹⁵⁵. The following are examples of long-term residential programs specifically designed for the older homeless population with complex needs in the UK.

7.1.1

Scotland

The Talbot Association in Glasgow provides a total of 260 residential places, of which 130 are in the three specialist Older Persons' Projects. The majority of the Talbot Association's residents are white, male and over 55 years old, though there are a smaller number of older female residents who are 70 years old and over. Long-term alcohol dependence has been a major feature in the lives of the majority of residents and, although a large proportion of them no longer drink heavily, chronic alcohol related health problems are common. A social work Care Needs Assessment is required in order to access those projects that have registered care home status. The unregistered services operate on a direct access basis, and most of the residents in these projects have either referred themselves or were referred by housing workers, prison staff, social workers or staff from the council's hostels.

Most places are occupied by long-term older residents, though the direct access hostel provides short-term accommodation and support to approximately 600 new clients a year, many of whom are younger. One facility provides a 67 bed direct-access hostel for homeless people aged between 17 and 70; another provides a 23 bed alcohol rehabilitation unit, and 12 place homeless mental health unit. Seven small shared houses are also available to which floating support is provided.

24-hour staff cover is provided in all Older Persons' Project facilities, although the size of the staff team can vary from project to project, depending on the number of residents and their level of care needs. Each project has a project manager, an assistant manager, a number of care officers, senior care officers and domestic and clerical staff. A number of the Association's staff are professionally qualified and have backgrounds in nursing, social work and housing. The organisation works to raise funds from other sources for new developments, capital works and additional resources for its residents. The organisation works in close conjunction with a wide range of other agencies, including health services, social work departments, housing providers and the Benefits Agency. The association also enjoys strong links with alcohol and drug counselling services and social, recreational and educational providers. The older persons' projects generally run at full occupancy and most older residents remain with the Association until they die. Three Talbot Association facilities; Buchanan Lodge, Hill Street and Bob McTaggart House, provide specialised care to older homeless people.

Buchanan Lodge in Glasgow which is a newly renovated unit, providing continuing care for 40 older homeless people in single bedroom accommodation. The building has several communal areas, including a kitchen and dining area, a laundry and extensive gardens. Funding from Help the Aged has enabled an in-house café-bar to be installed; where residents of Buchanan Lodge and the association's other older homeless units can enjoy social evenings in a relaxed, non-institutional setting. Buchanan Lodge is located near to shops and churches of various denominations and is on a main bus route. The majority of the residents are older men who have spent 30 years or more on the rough sleeping/ hostel scene. Most are vulnerable due to physical and mental health problems related to decades of unsupported living and chronic alcohol dependency. Very few individuals have any family or social networks outside the Talbot Association. The project was re-developed in partnership with Glasgow City Council social work and property and regeneration departments. Further funding from Help the Aged has enabled the project to buy an adapted mini-bus, which provides transport for residents from all its older homeless units for social purposes.

Hill Street provides continuing care to 20 older homeless women aged 50 and over. Work is due to begin shortly on a new building for the project, with single bedroom accommodation, improved facilities and an enclosed garden.

Bob McTaggart House is a 53 bed long-term supported hostel for older homeless people aged 50 and over. Most of its residents are long-term homeless, older men. The project offers individual care planning via a key-worker system and accommodation is provided in a purpose-built unit.

The William Simpson's Home was constituted through an Act of Parliament 1832 and purpose-built for the purpose it still serves today – the care of men. Initially it served to care for men with service backgrounds but as social work has evolved and developed, the home has risen to the challenges of the social care market. The home has contract schedules of agreement with unitary authorities covering a very large area of Scotland including; Fife, Aberdeen, Stirling, Falkirk, Clackmannanshire, Perth, Kinross, Midlothian, Edinburgh and North Lanarkshire. The admission criteria select men with ARBD and mental health needs. The age of William Simpson's clients ranges from late 40s to late 80s. Those in their late 40s have generally been in the home since their late 30s. The resident group is reported to be a very challenging group to work with¹⁵⁶. Equally as challenging is the task of preparing holistic care and support plans, and the completion of accurate risk assessments. All clients have had a long history of transition through various care facilities and as a result, The William Simpson's Home is often referred to as 'The Last Hope Hotel'.

Clients are admitted initially for a 6-week review period. Those clients with complex needs are given a mid-review with all parties present (service user, relative, social worker, key-worker, manager, and occasionally a community psychiatric nurse or psychiatrist when applicable). Long-term residents undergo an in-house review 6 months after admission, followed by yearly multi-disciplinary reviews. From time to time ad hoc reviews may need to be arranged depending on problems arising.

The William Simpson's Home's main residential unit is a 44-bed facility set on 20 acres in Stirling which provides ample space for residents both inside and outside the home. The home has three floors and is a listed category B building which was brought up to full disabled standards in 2005 to comply with the disability discrimination act. This involved the installation of an 8 person lift, ramped paths and a new reception area. There are 14 double bedrooms and 16 single rooms. There are 3 lounges (one for smoking) and an activity room set up with snooker table dart board audio-visual equipment. There are also 2 sitting areas where the residents can smoke. There are full disabled toilets and shower facilities at least 4 on every floor. The meals are prepared in the kitchen in the home and all dietary needs are met from the kitchen. The dietician prepares menus and provides any advice needed based on a nutritional risk assessment carried out as part of the resident's care planning.

The William Simpson's Home is not a dry facility because, in the past, a dry policy has resulted in driving the consumption of alcohol 'underground' making the management of difficult behaviours even more challenging¹⁵⁶. The consumption of alcohol is therefore supervised and managed. This presents a challenge to care staff to constantly reinvent care strategies with an emphasis on self-esteem, dignity, respect and privacy. If a resident decides that he no longer wants to stay at the home and it is perceived by care staff that by returning to the community he would create risk to himself and/or others, guardianship is then sought. This process involves having to go to court. Legally the client must abide by the Sheriff's decision as to the most appropriate address to reside. Likewise, where there are financial problems, financial guardianship is sought and again the sheriff decides who is legally responsible to manage the client's finances. Staff are trained in Crisis Intervention and are taught to deescalate hostile situations through communication not restraint. The Organisation is an approved centre for Scottish Vocational Qualifications levels 2, 3 and 4. It is recognised that The William Simpson's Home staff are employed in a professional vocation and need qualifications and ongoing education to facilitate the acquisition of knowledge and skill in what is now recognised in Scotland as a highly skilled and specialised sector.

7.1.2

Wales

Carenza Care provides support, consultation and care for people of all ages with ARBD and Korsakoff Syndrome (KS) in Northern Wales. Services include:

- Providing outreach monitoring and supporting people with KS/ARBI and their families/carers;
- Providing specialist consultation to carers/families workers and services that provide assistance to people with KS/ARBI/AP who wish to make changes in their lives developing Care Plans;
- Provide assistance and support to people with ABI to maintain independent living;
- Planning and budgeting new and future developments in the area of younger persons with dementia, ARBD and KS;
- Case Management to develop care packages appropriate to individuals independence, physical and funding needs in residential settings/individuals homes;
- Activities – Daily Living Assistants provide transport and support to clients unable to access appointments, community services or activities due to their inability to use public transport;
- Recreational and community programs to people in other residential settings who have KS/ARBI.
- Supported Residential Services including:
 - Arbennig Unit in Old Colwyn is a 12 bed home working exclusively with Korsakoff's /alcohol related brain injury. It also has 6 residential independent living units.
 - The Cedars in Crickhowell in a neurological unit divided into three areas: Mental health unit 12 beds; 15 beds specialising in mobile clients with challenging behaviour; and 14 beds specialising in vulnerable people requiring nursing care.
 - A new 10 bed rehabilitation unit is located in Worksop, Nottinghamshire.
 - Further residential units are under development in Leeds and Birmingham.

7.1.3

England

Bristol – Salvation Army runs a 127 bed direct access accommodation centre for single homeless people. The building has its own rehabilitation centre for those wishing to detoxify from alcohol and opiate use. This comprises a 12 bed pre-admission unit, a four bed detoxification unit and 12 rehabilitation beds, of which three are designated for women. Accommodation in the main part of the hostel is for men only and is provided in three six bed dormitories and 81 separate bedrooms. A cluster of five of these individual rooms is set aside for older people who are preparing for resettlement and prefer a quieter environment. During 2000 a quarter of the Bristol Salvation Army hostel population was over 40. Staff felt that many of these older people needed specialist

resettlement support if they were to move successfully into permanent housing. It was also felt that there were gaps in service provision for older homeless people in the city and that existing homelessness teams were not picking up as many of this age group as might be expected. From January 2001, a full-time resettlement worker based at the accommodation centre was appointed to support residents of the hostel aged 50 who wanted to move into permanent accommodation.

The project aims to assist older residents to choose and access appropriate rehousing, prepare them for independent living and support them through the move and beyond. Funding was also obtained for a part-time worker to undertake research to evaluate the project, increase understanding of the resettlement process for older people and identify gaps in service provision in Bristol for this client group. The outcomes of the project state that, *“There are difficulties linking some of the older homeless client group into mainstream older persons’ services, as they tend to have very different needs and backgrounds”*. One of the key recommendations was that, *“There is a need for sheltered-type accommodation but catering for those with higher support needs, especially around alcohol use and mental health”*.

London – 217 Harrow Road (St. Mungo’s Housing Association) is one of St. Mungo’s 11 hostels that work specifically with men and women over the age of 50, many of whom would not normally access mainstream hostel provision for fear of violence and intimidation. The project is located in Westminster, Central London. The project changed its status from a registered care home to a direct access hostel funded by the Rough Sleepers’ Unit (RSU) in November 2000. Its aim is to house older entrenched rough sleepers within the terms of the RSU, offering access to primary and specialist health care and resettlement services as well as providing accommodation. The hostel can accommodate up to 41 individuals in separate rooms. The project provides breakfast, an evening meal, sandwiches twice a day and hot drinks that are available at all times. Approximately half of the residents have serious alcohol problems and about a third have mental and/ or physical health needs that require primary health care. Residents are allowed to drink alcohol in their own rooms and in one of the communal spaces. Another lounge is designated as a ‘dry’ area.

Each resident has a key-worker from the staff team who works with him or her to develop an individual care plan. Accommodation is provided under the terms of a licence agreement and the length of stay in the hostel is flexible, though the intention is to facilitate resettlement after 18 months to three years wherever possible. The staff team consists of 19 full-time, one part-time and one sessional worker. Workers have a variety of skills and backgrounds and have received different levels of in-house training. An activities worker provides two days of activities each week, both in one-to-one and group sessions. At least four staff are on duty during the day and two workers provide night cover. The project has strong links with health care providers. Nurses from the Health Support Team (HST) visit on a weekly basis, assisting GP registration and providing primary health care to residents. Hostel staff refer individuals to the Community Mental Health Team who visit the residents at the hostel by appointment. St. Mungo’s feels that Harrow Road has generally been successful in attracting and retaining its target client group and resettlement into appropriate long-term housing such as St. Mungo’s semi-independent housing or independent tenancies accessed via the RSU clearing house. It is likely that other residents, especially some of those with chronic alcohol problems, will need to move into mainstream registered care homes.

London – Brixton Hill Group (Thames Reach Bondway) is voluntary sector organisation based in a large four-storey house that provides a group home for seven older men (aged 50-70s). The building is divided into shared flats on each floor and a communal living area on the lower ground floor. There is a pleasant rear garden. The lower ground floor also provides an office base for the staff, which are on site every weekday 9-5, and are on call during evenings and weekends. Nearby are eight other houses with lower-level support (generally a weekly visit); most of these residents are a little younger (mainly in their 40s). Residents have Assured Tenancies. The staff team consists of a manager, a deputy manager, two project workers and a support worker. Between them they cover nine houses and 50 residents. Staff ensure that residents are registered with a local G.P and work closely with individual residents’ existing Community Psychiatric Nurses and alcohol workers and

refers those in need of these services for assessment. Brixton Hill is planning to expand the number of houses in the group homes project from nine to twelve and the staff team will increase accordingly. It is likely that some of these houses will provide specialist supported accommodation to older people with substance use problems.

London – Graham House (Thames Reach Bondway) is a voluntary sector organisation based in purpose-built premises in Vauxhall. The hostel provides 69 individual bedrooms, a kitchenette on each floor and both 'wet' and 'dry' communal lounges. Breakfast and evening meals are provided. It aims to provide its residents with accommodation, support, referrals to other agencies such as mental health services and assistance to move-on into longer stay or more independent accommodation. A key-worker system is in operation and each project worker provides structured individual support to up to 8 residents who can remain at Graham House for up to 18 months. The facility accepts men and women aged 30 years and over however the majority of their population are white males aged between 50 and 60 years old. The project targets older rough sleepers with long histories of homelessness and high or complex needs. Almost all of the residents have alcohol problems and many have co-existing mental health conditions. The majority of clients are long-term rough sleepers who have been homeless for ten years or more. The project employs 4 managers, 8 full-time project workers, 3 night workers and 6 ancillary (administration, cleaning and catering) staff. The staff team also includes a health worker, a benefits worker, three C.A.T. (outreach) workers and a volunteer co-ordinator. The paid staff are supported by between 12 and 14 volunteers who undertake 6-month placements assisting in day-to-day project work such as bathing clients, accompanying them to appointments, etc. The hostel enjoys close working relationships with other local service providers and workers from the local mental health team visit individual residents when required. The primary healthcare team offers a weekly on-site nurse surgery and a G.P. attends the project as necessary.

56

London – Robertson Street (Thames Reach Bondway) is voluntary sector organisation that provides services to meet the needs of older drinkers in night shelters. It was developed in response to the difficulty encountered by these people in accessing suitable long-term accommodation for older shelter users who wished to continue drinking but who were becoming too vulnerable and frail to stay in the shelter. It is a high-support housing project for older people funded through Housing Benefit, rather than using the registered care home model. Residents have a long history of homelessness and many remain heavy drinkers. The facility consists of a new-build two-storey housing development on a corner site with clusters of single rooms around informal sitting/eating areas. It provides a permanent home for 40 residents, both men and women. There is a pleasant enclosed rear garden with a garden of remembrance where former residents' names are recorded and their ashes scattered.

There is 24-hour staff cover and meals are provided. The staff team consists of 2 Project Workers and 10 Support Workers, working a shift rota to provide 24-hour cover. A minimum of three staff are on duty during the day and two (waking) staff provide cover at night. A part-time (17 hours per week) Activities Worker aims to involve residents in both in-house and community-based activities. Staff have developed ways of working effectively with residents whose motivation is often very low, and self-care poor. Success is often measured in making and sustaining small improvements in personal hygiene, and reductions in alcohol intake or disruptive behaviour. There is close liaison with local Social Services and a GP service provides a clinic for residents at the hostel once a week. The organisation aims to provide a 'home for life' for older homeless people, therefore turnover at the project is very low. Residents occasionally move on where their care needs have increased beyond the hostel's capacity and residential or nursing care is necessary.

Nottingham – 32 Bentinck Road (Framework Housing Association) is a specialist residential project for older homeless people aged 55+, providing a permanent home with a high level of support and care for residents who have aged prematurely due to homelessness, poor nutrition, mental health and alcohol problems. It is registered as a care home with Social Services. Residents cannot drink in the public rooms but can drink in their own rooms. There are 11 residents, usually all male (although

there has been the occasional female resident), with ages ranging from 45 to 82. The staff team consists of 7 supported housing workers, 4 night workers, one deputy manager and a project manager. The project encourages staff to take a pro-active approach with residents: key workers and individual care plans ensure that residents identify their strengths, and staff build support and care around what residents themselves are able to achieve. Staff and residents have meaningful relationships with each other, and this helps to discourage residents from turning so much to alcohol as a comfort because of loneliness and isolation. Framework has close links with a range of statutory and voluntary agencies in Nottingham. At present, the existing house provides 14 beds in shared rooms but there are plans to upgrade and enlarge the accommodation to provide single rooms, with the possibility of some additional linked supported housing for older people who need a lower level of care.

Nottingham – Albion Supported Homes ASH (Framework Housing Association) provides a range of supported housing for older people in Nottingham. It aims to provide medium to long-term supported housing for homeless men who are trapped in emergency accommodation due to issues around alcohol and/or other drugs or mental health. Thus it is able to work with homeless drug users and heavy drinkers in supported housing, where they can continue drinking while addressing their problems and work towards independent living. Except for one house for young people who are drug users, the six other ASH houses are for people who are still drinking, and most of them are aged 40+. The two or three-bedroom houses are owned by Framework, most being within walking distance of The Albion. Staff visit each house 365 days a year to maintain contact with residents. Residents have either licences or tenancies depending on the policy of the landlord (council or housing association). There is a key worker system and personal development plans for all residents, with specific targets which may include domestic tasks such as changing sheets regularly, or personal development such as developing hobbies. Staff also accompany residents to medical appointments if necessary, try to keep up their access to health care, and assist with benefits, managing money and arranging social activities.

The success of ASH is measured by maintaining residents in their homes, or facilitating a move to a more appropriate setting (such as an independent tenancy or a care home: see discussion below). However, given the client group, inevitably some residents abandon their accommodation or have to be asked to leave because of behaviour which is unacceptable in shared housing. The ethos is to keep people if possible, because they are unlikely to get another chance elsewhere if they fail to maintain their ASH housing. Although there are inevitably tensions within shared housing, the program reports that it does offer companionship when relationships between residents are working well. The smaller two-bed houses are having been found to be generally more successful than larger houses because there are only two people sharing. There is only limited consultation with existing residents about new residents moving in, and they do not have a veto. Increasing frailty can make it difficult to continue living in ASH houses because of constraints such as stairs. Shared living demands a certain level of capability and it is not appropriate for other residents to become carers, over and above the normal sharing of tasks.

Swansea – Cyrenians Cymru was set up in June 2001 and provides four bed-sitter flats for men and women over the age of 45 who have experienced homelessness and require a degree of support in order to live independently. The project was developed in response to a gap in provision for this age group as many of the clients had been in institutions for some years and feared the social isolation of an individual tenancy, but did not want to live in longer-stay communal settings with younger people. Several of the older people who had been resettled before but were unable to cope in independent tenancies and had subsequently become homeless again. The specialist project thus aims to combine privacy with supported communal living for older homeless people. The flats are located within a three-storey block. On the ground floor there is a communal lounge, reading room and laundry and there are two bedsits and a shared kitchen and bathroom on each of the two upper floors. The length of stay is flexible and the flats are offered under a licence agreement for the first six months, after which an assured tenancy would normally be granted.

The project employs a part-time worker who visits the project on a daily basis to provide floating support to residents. The worker responds to any arising issues, befriends and supports the residents and works with them to promote their integration into the local community. The scheme is located in close proximity to the direct access hostel and, where necessary, residents of the flats can contact the hostel staff by telephone 24 hours a day. The project aims to maximise the resident's involvement in decisions about the scheme. Residents' are consulted on the facilities, decoration and furniture in the flats and are involved as far as possible in letting vacant flats, although this must clearly be undertaken with regard both to equal opportunities and the confidentiality of applicants.

7.2

The United States

In the United States, homeless assistance programs are administered by the Department of Housing and Urban Development (HUD)¹⁵⁷. In 1987, the Congress passed the Stewart B. McKinney Homeless Assistance Act to provide a comprehensive federal response to address the multiple needs of homeless people. HUD is responsible for administering a number of key McKinney Act programs, including the Emergency Shelter Grants program designed to help improve the quality and increase the availability of emergency shelters for homeless people, the Supportive Housing Program designed to promote the development of supportive housing and services that will help homeless individuals and families transition from homelessness to living as independently as possible, the Shelter Plus Care program provides rental assistance for hard-to-serve homeless people with disabilities along with supportive services that are funded from other sources, and the Section 8 Single-Room Occupancy program designed to bring more standard single-room occupancy units into the local housing supply and makes them available to homeless individuals. For these four programs, HUD provides federal funds to State and local organizations through either formula or competitive grants so that communities can develop housing and services for homeless people.

Permanent Supportive Housing programs were developed in the United States during the past decade. The project focuses on people for whom traditional programs and services have not produced solutions to homelessness. One group in particular, people with co-occurring mental illness and substance abuse has traditionally been seen as 'resistant to treatment'. Permanent supportive housing (PSH) has evolved from the following two models:

Housing First place people directly from the streets into permanent housing units with appropriate supportive services, with no requirement that they be 'housing ready'. The sole requirements are those that are usually expected of any renter-pay the rent, do not destroy the property, and refrain from violence. Housing is provided immediately, with few, if any, demands with respect to abstinence or accepting mental health treatment or other types of care, although these are offered and available. The fundamental belief underlying Housing First and most other low demand housing strategies is that individuals should not be left homeless simply because they are unable or unwilling to maintain abstinence.

'Safe haven' is a term used by HUD and others to describe a special type of housing program for chronically homeless people with serious mental illness, often with co-occurring substance abuse. A safe haven program usually takes a Housing First approach, and it may be either transitional or permanent housing. Most safe haven programs we talked with will let residents stay 'as long as it takes' for them to feel comfortable moving on. Data from Philadelphia's four safe havens indicate that the average length of stay is 1.3 years, and that most residents move on to PSH or to housing in the community, either independently or with family¹⁵⁸.

Also in the United States, the innovative 'Closer to Home Initiative' program was developed to foster new approaches to helping homeless people with multiple problems and disabilities. The research focused on six programs that aimed to engage and house people whose combinations of

disabilities, long histories of homelessness, and repeated use of emergency services had marked them as ‘difficult to serve’. The study was designed to describe the program models, document their implementation and development over time, and assess outcomes achieved by an initial cohort of individuals. The housing programs sought to provide settings and services needed to sustain housing for people with unstable residential histories and other problems.

The programs drew from diverse homeless service settings, targeting individuals with health and mental health problems, long homeless histories, and heavy use of shelters and emergency services. A final report on the program details the housing models, key findings and outcomes¹⁵⁹. Although the program was not age-specific, there were some distinct characteristic differences noted in the older participants,

“We note particularly the contrasts between those who had become entrenched in the shelter/lodging and those recruited to enter the housing programs: shelter/lodging house residents were significantly older, had been homeless much longer, and were less likely to have recent support from entitlement programs. Notably, there were no significant differences in health or mental health problems, although shelter/lodging residents were less likely to be in treatment for psychiatric disabilities (as measured by use of medications) and were less likely to have lifetime diagnoses of alcohol or drug abuse or dual diagnoses... We conclude that it is important to develop housing that addresses the needs of those who have not yet settled in to permanent residence at particular shelter sites to avoid replenishing the extremely long-term portion of the homeless population”.

59

The various participating housing programs offered a variety of strategies for balancing the needs of the program community while accommodating individual tenants. These included:

- screening for willingness to participate in treatment;
- structuring the program to set limits to disruptive behaviour;
- organizing the program around a division of responsibility between property managers (who maintain the financial and physical health of the building and establish and enforce rules to circumscribe destabilizing behaviour) and support service providers who work with individual tenants during periods of psychiatric or substance abuse relapse and advocate on their behalf;
- providing tenants with ease of movement between the permanent housing and sites that can accommodate and better contain behaviour that can become destabilizing or disturbing to others.

The study concluded that screening and structure could create supportive environments for disabled, long-term homeless individuals who agree to structured environments and participation in treatment and services, but harm reduction approaches are also effective and necessary to ensure housing for broad segments of the homeless population with significant barriers to stable housing. The harm reduction approaches divided responsibilities for individual tenant support and property management, and offered ongoing access to treatment and support during relapse. Unfortunately the program involved a number of different facilities with different program designs.

Some examples of long-term residential programs specifically designed for the older homeless population with complex needs in the United States include the following.

7.2.1

New York

The Long-Term Shelter Stayers Project. This New York based project run by the West Side Federation for Senior and Supportive Housing (WSFSSH) provided permanent housing for older, formerly homeless men and women with serious mental illness and long histories of homelessness. WSFSSH was formed in 1976 by a coalition of social agencies, religious institutions, and community organizers to create new housing to meet the diverse needs of older people and persons living with handicaps. In 1983, the agency expanded its mission to include housing and supportive services for homeless adults. Its facilities include independent apartments; permanent supportive SROs; a transitional shelter; and several Adult Residential Care facilities. All programs except the transitional shelter provide permanent housing. All residents receive three meals a day; security and

supervision; housekeeping in all common areas of the building and in the rooms as needed; and laundry facilities and assistance as needed. Health and mental health services include individual support for treatment, on-site nursing consultations, groups and activities, crisis intervention; medication monitoring and supervision, on-site psychiatric treatment with volunteer psychiatrists, and money management and budgeting assistance.

The program also provides residents with a structured environment. All residents are expected to follow medication regimens, maintain sobriety, meet regularly with their case manager, and adhere to a set of comprehensive house rules that cover issues of safety, room assignment, keys, reporting needed repairs, guest policies, prohibitions (of excess noise, verbal or physical abuse, illegal activities, unsanitary behaviour), and a variety of behavioural expectations in the room and in the building. However, service plans are individualized and the staff actively seek creative ways to encourage and support residents through periods of psychosis or relapse.

Encore Community Services in New York began as a denominational service in 1977 supporting disadvantaged and isolated elderly people did not have family support and lived in single room occupancy hotels in Manhattan. Today, it has grown into a multi-purpose nonsectarian organisation that provides support services to 14,000 seniors annually. In 1998, Encore responded to the critical shortage of supported housing for elderly homeless people, many with mental illness, by developing the Encore 49 Residence, an 89 unit single room occupancy residential facility. Referrals come mainly from the Department of Homeless Services and community. Homeless or at risk of homelessness, aged 55 or over are eligible for the service, however they must be interested in living independently within a supportive type of housing and willing to participate in activities and programs. All residents must undergo an initial evaluation by a psychiatrist and agree not to undertake active substance or alcohol abuse and be motivated to maintain sobriety. No violent, disruptive or socially aggressive behaviour which constitutes a danger to self or others is tolerated.

7.2.2

Vermont

Lakeview Community Care Home in Vermont is a 17 bed program offering housing with nursing support for unlimited lengths of stay. Residents are adults who are not able to live on their own. Services provided include 24 hour staff (awake overnight) that supports residents to improve their quality of life by maintaining a healthy lifestyle. Staff also supervise medications and involve residents in community activities. **Shelter Plus Care** offers unlimited stay housing for six adults whose behaviour has resulted in their being chronically homeless. Services provided include part-time day and asleep overnight staff who offer support for tenants to live together cooperatively. Residents are linked with the appropriate services to address their economic, medical and psycho-social needs. Staff also assist tenants to increase their quality of life by developing independent living and social skills.

7.2.3

Seattle

The Lyon Building. A 64-unit service-enriched housing facility in downtown Seattle developed by AIDS Housing of Washington and operated by Downtown Emergency Service Centre. Residents are prioritized for occupancy with preference given to homeless, single adults disabled by multiple causes, including HIV/AIDS, mental illness, and chemical dependency. The goal of this project is to promote housing success for those multiple-disabled individuals who have failed in previous housing environments as measured by:

- housing longevity;
- clinical and social stabilization (e.g. decrease in crisis needs, reduction in harmful behaviours, accessing of resources to meet all basic needs, strengthening of clinical relationships with providers);

- the quality of residents' lives (as judged by residents themselves, and as evidenced through the development of friendships, displaying less reclusive behaviour, volunteering in the building and participating in activities and work programs).

In order to achieve these goals, support services are offered on-site, and the facility is staffed 24 hours per day.

All Lyon Building residents are referred by a service provider who commits to the provision of continuing services. Comprehensive services are then provided to the residents through a combination of services from the referring service agency, Lyon Building service staff and other resources. Clinical Support Specialists are responsible for the coordination of treatment/service planning efforts for all residents in conjunction with case managers from outside provider organizations. Frequent contact with Lyon Building residents allows professional residential staff to establish trust, monitor progress, and provide services defined in a Residential Services Plan developed with each case manager and resident. Additional support services are provided by on-site Residential Counsellors.

Behavioural problems are dealt with in a collaborative manner with residents and staff who will discuss the nature and causes of the problem. The residents have a role in developing plans to achieve more stable and cooperative living in a way that avoids future rules violations and preserves housing. Staff members will help residents to establish regular support groups for residents with histories of substance use and/or abuse. These groups may include Alcoholics Anonymous, Narcotics Anonymous, 12-Step support groups, a group for methadone consumers, a group for MICA (mentally ill and chemically-affected) residents, a use reduction group for residents unable to abstain, a group for those wanting to begin recovery, a group for those newly sober, or other groups for which residents express a need.

7.2.4

Philadelphia

Resources for Human Development (RHD) is a Permanent Supportive Housing provider in Philadelphia that assists chronically homeless people with disabilities move off the streets and into stable housing. RHD has served 121 consumers since 1995 in its Supported Adult Living Team program and another 25 (since 1989) in its Boulevard Apartments. RHD provides supportive services to seriously mentally ill people living in scattered-site residential units or multi-unit building rent subsidized apartments. Of these 146 consumers, 45 came directly from homelessness. Most of the remainder, all in the Supported Adult Living program, had significant periods of homelessness although their immediately prior residence was various transitional housing situations.

7.2.5

Chicago

Interfaith Housing Development Corporation of Chicago is a non-profit organization that creates long-term, locally generated solutions to homelessness by serving as pathfinder, technical assistance provider and partner to faith-based neighborhood groups seeking to provide stable long-term housing and related services for very low-income people who are homeless, or at risk of homelessness¹⁶⁰. Interfaith Housing joins in partnership with neighborhood groups, helping them to fulfill their dreams of creating supportive housing and other facilities for their clients and neighbors. Since 1992, the Interfaith Housing Development Corporation of Chicago (IHDCC) has created more than 300 units of permanent supportive housing serving more than 400 men, women and children in Chicago's most impoverished neighborhoods. These units are home to families overcoming chronic substance use, women who were formerly incarcerated, individuals and families living with HIV/AIDS, homeless veterans and the elderly. IHDCC has worked with more than a dozen faith- and community-based organizations, acting as partner and pathfinder in the ever-changing and complicated world of urban housing development. IHDCC provides

implementation planning tools, expertise and the long-term commitment necessary to create permanent solutions to homelessness in Chicago.

Ruth Shriman House, has 83 apartments that serve senior citizens whose access to affordable housing was jeopardized by gentrification in the Lakeview and Uptown communities on the north side of Chicago.

Interfaith House, is a sixty-bed respite program facility providing homeless persons discharged from area hospitals with the medical care and shelter they need to continue healing. Interfaith House uses the recovery period as a window of opportunity to introduce patients to programs that will help them regain a foothold in the community. Interfaith House was planned by Interfaith Housing and the Interfaith Council for the Homeless. It has served over 3,000 homeless individuals since opening in June, 1994.

Inner Voice House, was opened in February, 1994 and is home to 14 veterans who have completed chemical dependency recovery programs at local veterans hospitals. Inner Voice House provides a structured, supportive environment which includes counselling, job readiness training, money management and other activities that instill self-reliance.

62

Lakefront Supportive Housing is a non-profit organisation in Chicago founded in 1986 to stem the loss of single-room-occupancy housing in Chicago. Over the years, single-room-occupancy hotels (affordable shelter for individuals teetering on the brink of homelessness) were rapidly disappearing from Chicago's housing scene¹⁶¹. In response to growing numbers of homeless people, and the subsequent loss of affordable housing, Lakefront sought to provide safe, permanent housing for men and women who would otherwise find themselves on the street. Lakefront aims to provide all the services people need to remain permanently housed and to reach their full potential. Each tenant has both a case manager and property manager. While the case manager works with the tenant on his or her needs, the property manager works with the tenant on taking responsibility through paying rent and being a good neighbour. Case managers work closely with clients in developing and maintaining a supportive services program based on an understanding of exactly what tenants need to feel valued and to move back into the social and economic mainstream. Lakefront SRO operates nine supportive-housing buildings in Chicago's districts and manages some 1,000 units of permanent housing for formerly homeless people. For residents that have higher needs the Wentworth Commons provides a number of units that are available only to homeless persons with disabilities; however the organisation has recently shifted its emphasis to meet the increasing demand for housing for homeless children and families.

7.3

Canada

Some examples of long-term residential programs specifically designed for the older homeless population with complex needs in Canada include the following.

Groupe Harmonie is a non-profit organisation in Montreal, Quebec, Canada which supports people aged 55 and over, with medications, alcohol, or other drugs use problems. The facility does not support people with severe mental health problems or suicidal tendencies or serious medical conditions. With regard to the consumption of alcohol by residents, Groupe Harmonie claims that, *"We do not focus on the substance, but on the individual. We offer the person support all the way through the process of behavioural change. We encourage them to reduce or stop consumption, according to their needs. We do not aim at abstinence at all costs. ... (And) we have confidence that anyone can improve their situation at any age"*. Treatment interventions include case management, multidisciplinary case conferencing, assessment (In-facility and via outreach), individual therapy (In-facility and via outreach) and family therapy (In facility and via outreach).

Older Persons Unique Solutions (OPUS-55) in Toronto, Ontario is a non-profit organisation that supports people aged 55 and over, with a substance misuse problems. It practices a harm reduction philosophy to provide client-centred care through an eclectic mix of narrative therapy, solution-focused therapy, cognitive therapy, behavioural change therapy. Clients must self-refer. If there

are barriers such as language, culture or hearing problems, referrals can be facilitated by other people. Treatment interventions include case management, multidisciplinary case conferencing, assessment (In-facility), individual and group therapy (In facility), supportive housing and residential care. Staff include a Clinician/registered nurse and a social service worker trained in narrative therapy, solution-focused therapy, cognitive therapy, and substance misuse.

7.4

Australia

Some examples of long-term residential programs specifically designed for the older homeless population with complex needs in Australia include the following.

7.4.1

New South Wales

The Matthew Talbot Hostel in Sydney provides comprehensive, long-term, personalised care to homeless men (not age-specific) through case management. Many of the men also suffer from some form of mental illness. The Talbot is the largest hostel for homeless men in Australia open every day of the year. The Talbot is the safety net for the homeless men of Sydney. From the basic crisis support of healthy meals and a safe place to sleep, the Talbot's services extend to home-support or 'Outreach' centres and training to help the men regain an ordinary life. Under this SAAP-designed initiative, a medical and nursing clinic within the hostel operates seven days a week and a psychiatrist and other specialist health practitioners provide in-situ services on a regular basis. The Matthew Talbot Hostel's Outreach program provides a range of medium to long-term accommodation facilities. Assessment based options range from individual beds to supported housing throughout the city. Case-dedicated workers work in partnership with the client in developing a personal plan for treatment and management of their lives. Apart from clinical care of illness, components including literacy and other educational programs, vocational training, living skills development, creative and recreational activities provide men with skills and confidence to reconnect with the community around them.

Currawong House in Hornsby NSW, provides long-term housing and support for mentally ill people with a substance abuse problem (MISA) based on a group home for 3 people (men and/or women). Its primary focus is on a harm minimization model in which residents will be expected, over time, to reduce and perhaps cease substance abuse.

Cumberland Avenue House in Lower North Shore Sydney provides individuals with alcohol and other drug problems with long-term accommodation for up to 5 residents. Its primary focus is on housing support. Alcohol and other drugs are generally excluded from the house, but individuals are not evicted due to use.

7.4.2

South Australia

The Accommodation in the North Project. Over the past couple of years, five housing and accommodation support demonstration programs have been set up in South Australia¹⁶². Based on a partnership model for the provision of services, these programs provide housing, non-clinical and clinical mental health outreach services to people with moderate to higher level support needs. The Accommodation in the North Project has been evaluated as being a highly successful model. Outcomes include a dramatic reduction in the length of hospital stays, decreased costs incurred by the SA Housing Trust due to debt and damage and for the consumer an increased quality of life with greater housing stability, health and wellbeing. These five programs provide services to approximately 65 people in specific geographical locations. More funding is urgently required to extend these and other existing programs that are achieving positive outcomes.

Linsell Lodge is a residential care facility commonly used to accommodate elderly homeless. Linsell Lodge is a 59 bed aged person hostel situated within the inner city in close proximity to Whitmore Square where the night shelters are located. It is operated by the Salvation Army and was originally designed as a basic boarding house for the target group. While the hostel remains fully occupied and has a high proportion of financially disadvantaged people, its facilities and amenities are limited and quite basic. Other hostels are also situated in close proximity to the city such as **Helping Hand Hostels** in North Adelaide (Rotary House – 109 places), or specific hostels including **War Veterans Homes** at Myrtle Bank, the **Aboriginal Elders Hostel** located in the northern suburbs, and various ethno-specific hostels.

Multi Agency Community Housing Association (MACHA) in the inner city of Adelaide originally operated as a medium term provider of housing and support to homeless people. It was established through the cooperation of a group of welfare organisations and undertakes the function of a landlord, pursuing housing development opportunities, while member agencies provide support services to tenants. All tenant referrals are taken from member agencies. If applicants are then approved they are put on a waiting list and placed in housing as it becomes available. After applicants have been housed, MACHA works closely with member agencies in the ongoing management of tenancies. Many of the support services provided to MACHA tenants are funded through SAAP, but also draws on funding through other Commonwealth, State and Local Governments, churches and other charitable organisations. Clients have a history of chronic homelessness and typically have multiple problems e.g. mental illness, drug and alcohol abuse, ill-health, physical and sensory disabilities, and poor social functioning. MACHA has an annual turnover of approximately 16% and an average length of stay of almost 2 years. This organisation has been able to develop a growing level of stability for its tenants and has been successful in its attempts to provide for this special needs group. **Roofs** was established to provide housing for people with a diagnosed mental illness or personality disorders. Tenants may also have associated problems such as a lack of living skills, difficulties with relationships, a lack of motivation, low self-esteem, and a lack of employment opportunities. Housing stock is well integrated into the community.

7.4.3

Tasmania

Barrington Lodge is located in the inner suburb of Newtown, approximately 3 kilometres from the Hobart city centre, and adjacent to the suburb of Glenorchy. Barrington Lodge is a purpose-built 10 bed aged persons hostel for men. It is in receipt of recurrent funding from Department of Health and Family Services. The hostel provides each resident with a single bedroom and ensuite, and access to a communal dining room which is shared with residents from the adjacent crisis accommodation facility. Current Salvation Army policy does not allow residents of the hostel to drink alcohol on the premises or to return to the hostel in a drunken state which severely restricts the service from providing appropriate and flexible care to all elderly homeless men and women.

7.4.4

Victoria

Yandina: Housing for Complex Needs – Richmond Fellowship of Victoria.

Yandina is situated in the Eastern Metropolitan Region of Melbourne and aims to provide support and/or housing (where possible) to assist clients with complex needs in addressing their homelessness. It operates as a transitional support service although some residents have remained for longer periods due to the complexity of their need. Their objective is to help break the cycle of homelessness in single adults aged 25-55 years with an established history of homeless and with complex needs.

Yandina has well defined links with SAAP, homelessness shelters/outreach services, crisis agencies, refuges, public mental health services, drug and alcohol services; and other community based

services. Yandina has also developed strong links with a local counselling service to assist clients to address underlying issues that may be a challenge. As a service offering support to clients with high needs, Yandina has established a partnership with a clinical psychologist within the homelessness sector who provides staff with secondary consultation on a regular basis. This enables staff to be aware of issues clients can be faced with and also educate and develop staff's abilities towards a best practice program. Links have also been developed with the regional drug and alcohol service and financial counsellor. There are 4 full time support workers and one manager. Support workers provide support to 12/13 clients. Yandina also has access to a limited number of transitional housing properties.

An 'Individual Personal Plan' is developed by the client that will guide the worker about the goals, objectives and recovery planning issues that the client wishes to address. The development of the Case Management Plan involves developing an understanding of the Resident's mental health needs, including specific knowledge of risk and protective factors. It includes education, stigma reduction and develops strategies to manage these issues. It also encourages a process by which people who have been seriously affected by mental illness are supported to make their own decisions rather than to have decisions imposed eg: discharge, recovery, crisis plans. It facilitates timely access to the whole range of services that support wellbeing and early intervention in times of increased service need. Yandina's service is one of flexibility without being a crisis service and it recognises the need for an expanded range of treatment and community support options for people who have experienced mental illness eg: housing, employment, holistic treatment.

Yandina client's are encouraged and supported to link into other services to address substance abuse, financial issues, mental health monitoring by GP's and clinicians and to speak about mental health issues before there is a crisis. Clients are also informed about alternative supports such as community counselling services and day programs. At Yandina client outcomes are not always based on data collected or evaluations. Clients are asked to complete an evaluation on closure with the service, and a positive outcome around client wellbeing is very important. The organisation notes the challenge created by the restriction of time allocated to the term of service provision. Longer terms of support are not recognised through the SAAP funding model. The Yandina organisation has reported that the retention of staff is difficult when working with high levels of complex clients¹⁶³.

Sacred Heart provides residential aged care to 83 men and women across three sites. Two sites, Grey Street and The Annexe, are co-located and linked at 101 Grey Street, St Kilda (53 beds), the other facility is located close by in Robe Street. Sacred Heart also provides an unfunded bed linked to the HARP program in the Annexe. Sacred Heart provides services to those aged from 50 years onwards. Most commonly the service admits residents aged 70 onwards and often exhibiting a greater incidence of age-related dementia and complex needs. Personal support is provided but independence is encouraged wherever possible. A room and ensuite are provided for each resident as well as access to an extensive lifestyle program. The service claims to have successfully achieved long-term solutions to older homeless people who have been determined to be unsuitable for other facilities through behavioural management care strategies.

Corpus Christi Community provides residential aged care to 88 men. The facility currently receives Commonwealth aged care funding for 84 beds and maintains 4 unfunded positions. Currently, aged care services are limited to residential aged care beds. Most residents are 50 years of age or older and have a past history of homelessness, a large proportion suffer from an alcohol related brain damage and/or psychological illness, resulting in a number of associated social and behavioural factors. Corpus Christi operates as a cooperative community, with established values shared by residents and staff. Residents are encouraged to participate in community tasks as much as possible, tasks range from making their own breakfast, making breakfast for other residents who are less able to mowing lawns and gardening. Corpus Christi has a sound volunteer base that assists in resident supervision and care where necessary. Through this cooperative tasking, Corpus Christi is able to maintain lower levels of staff, however intake is selective to people who are willing to

participate in the community lifestyle and whose personal care needs at the site are relatively low.

arbias provides specialised services in the alcohol and substance related brain injury field. This includes:

- Case Management (outreach case management and FFS);
- Specialist Consultation Services;
- Neuropsychological Assessment;
- Recreation Services;
- Attendant Care Services;
- Training and Education Services;
- Specialist Accommodation – accommodation services provide long term and transitional accommodation for people with alcohol and substance related brain injury in a home like setting. Support with daily living and case management are provided to the person depending on their level of need. There are twenty one-bedroom flats available across Melbourne. However, these are only accessible to independent residents with no additional support needs.

66

Paxton House is a 10 bed dry house located in Clifton Hill, Victoria. It provides long term semi-independent living for people, mostly over 50 years old with alcohol or substance related brain injury in a home like setting. The facility is currently working on moving towards a more independent style of living by such strategies as; building the daily skills level of the residents, getting community access programs up and running, promoting client empowerment through resident meetings, and involvement in decision making processes.

Wintringham is a not-for-profit welfare company established in 1989 to provide high quality care to elderly men and women who are homeless or at risk of becoming homeless. Wintringham owns or manages a wide range of housing properties throughout inner urban Melbourne. Services include three low care residential facilities supporting 129 residents and a newly built Ron Conn Nursing Home in Avondale Heights which provides high care support to 60 residents. Wintringham also manages 271 Community Aged Care Packages providing home based care in the southern, northern and western regions of Melbourne, five housing sites which accommodate 140 residents and an extensive Outreach Program. The Outreach Program is funded by both the Commonwealth ACHA program and the State Government Community Connections Program. The organisation also delivers an extensive recreation program which runs across all Wintringham sites. In all Wintringham now provides services to 750 people each night.

The housing is of the highest quality and is targeted at elderly men and women who are either homeless or at risk of becoming homeless. Wintringham provides residents with appropriate levels of support either internally through our linked federally and State funded community care support packages, or through brokered services from other providers. All housing services operate under public housing guidelines. Residential services provide a safe, flexible and caring environment which allows residents to maintain their chosen lifestyles, habits and activities and to be as independent as they choose to be. The right of each person to maintain their chosen lifestyle, habits and activities is respected and rules are kept to an absolute minimum. Residents are permitted to drink alcohol and smoke, provided they do not disturb other residents. Supported accommodation facilities include:

- 1 **McLean Lodge**, in Flemington offers affordable, high quality accommodation and low-level care to 34 men and women aged 50 and over who are financially disadvantaged and homeless or at risk of becoming homeless. One place is reserved for people requiring short-term, respite care. All new residents must be first assessed by a Commonwealth Aged Care Assessment Service. Six houses provide a comfortable living environment set in landscaped surroundings. Each house is shared between two to six residents and has its own lounge and dining area, a fully equipped kitchen and laundry. Residents have their own fully-furnished room and share ensuite shower and toilet facilities. Most rooms face onto a private verandah,

- giving residents extra space to enjoy. There are also three lounges and a dining room for the shared use of residents;
- 2 **Wintringham Hostel, Williamstown** provides quality residential low-level care for 60 older men and women who have been assessed by a Commonwealth Aged Care Assessment Service. Two places are reserved for short-term, respite care and 36 places are reserved for people who are financially disadvantaged. Each resident has a private bed-sitting room and ensuite. All units have their own external entrance and garden area. There are also three lounges and a dining room for the shared use of residents;
 - 3 **Wintringham Hostel, Port Melbourne** offers affordable, high quality accommodation and care to 35 men and women aged 50 years and over who are financially disadvantaged and homeless or at risk of homelessness. Residents are required to be assessed by a Commonwealth Aged Care Assessment Service prior to entry. One place is reserved for people needing short term, respite care. The beautiful buildings, set in landscaped surroundings, have won international acclaim, winning the United Nations World Habitat Award. There are six houses shared between five to seven residents with each house having its own lounge and dining area, a fully equipped kitchen and laundry. Residents have their own fully-furnished bungalow style room with a personal shower and toilet. All rooms face onto a private veranda, giving residents extra space to enjoy;
 - 4 **The Ron Conn Nursing Home** in Avondale Heights was developed to provide a high level of residential aged care specifically designed to house frail, elderly, financially disadvantaged men and women who would otherwise be homeless or at risk of homelessness. The development of this facility has allowed the service to meet the full continuum of care for Wintringham clients, ensuring that they continue to receive appropriate, affordable and culturally relevant care until their final days. Focusing on a person or client centred approach to care rather than promoting an institutional or regimented care regime Wintringham have designed a building that is both functional and beautiful while allowing residents both privacy when required and easy access to the range of social events occurring within the home. The building provides residents with their own room and shared en-suite set around courtyards with central lounge, dining and kitchen areas, access to kitchenette staff at all times. Staff of the facility both understand and support the care needs of older homeless with complex care needs. Over 50% of admissions include residents from a Culturally or Linguistically Diverse Background.

8 Conclusions

Bisset et al's 1999 report recognised that gaps or failure in the service delivery systems may result in a client, whose needs may not be complex in themselves, appear to be in need of high care. Such problems as inaccurate assessment of clients' needs, services that are not able to appropriately manage disruptive behaviours, services that are unable to provide appropriate specialist care, services that are culturally inappropriate and the inability of services to provide long-term support solutions²⁸. It has been reported that culturally diverse people who are experiencing homelessness may be further marginalised as a result of their cultural background especially those of non-English speaking backgrounds and Aboriginal and Torres Strait Islander descent²⁸. The combination of individual needs and acknowledged deficits in the service system often result in a net increase in the complexity of problems associated with daily living¹⁶⁴.

The final report to the Department of Family and Community Services on 'Appropriate responses for homeless people whose needs require a high level and complexity of service provision' identified several factors important to establishing and maintaining specialised care services. They included:

- a capacity for continuity offered by a key worker or team approach;
- the establishment of a long-term relationship with clients, including staying with clients in spite of the circumstances;
- a capacity for an intensive response, based on appropriate staff: client ratios, extended time limits, and continuity of service provision;
- a capacity for development of goals and contracts,
- a harm minimisation philosophy underpinning practice;
- practical and concrete assistance and support into recreation and 'non-welfare' activities and supports;
- community based approach, as distinct from a clinical model²⁸.

68

The difficulty in case management and providing appropriate accommodation for elderly homeless persons with high and complex needs has posed a problem for health care providers, social support agencies and housing agencies for decades, especially since the introduction of social policies involving deinstitutionalization and the promotion of community-based living. The people to whom we refer somehow fall in the jurisdictional cracks created by division and structure of funding for health and social care. These people tend to transiently shuffle between organizations that cannot provide long-term care management solutions. Their mental well-being and chronic health status incrementally deteriorates to such a point that the increased reliance on hospital and emergency services reaches crisis level at which stage institutionalization remains as the only viable option.

All too often these people become part of a cyclic pattern that commences when their self-neglect deteriorates to such a point that they lose the capacity to care for themselves. At this stage they usually enter the hospital service where an assessment is made and a guardian and trustee is appointed. Their care is managed, the alcoholics 'dry out', psychiatric conditions are treated and their cognitive ability improves. Another assessment is performed at which time the person is now deemed capable to care for himself or herself and they are discharged, ready to start the cycle again. The unfortunate consequence of this cyclic pattern of care and neglect is the progressive deterioration in psyche and physical health. There is evidence that older people with multiple needs may be particularly unwilling to use specialist or mainstream services. Outreach services provided on the streets; need to be maintained for this client group, however there remains a difficult balance between human rights and intervening where the client is unable to make a 'rational' decision about their own welfare or poses a risk to others.

A few organisations, most notably in the USA, UK and Australia, have developed services specifically for homeless older people. Despite all efforts, there remains a fragmented and uncoordinated service system approach to homelessness in Australia. Specialised services have restrictions on the longevity of their care, so that the individual may be referred to a new stage of care, regardless of his or her own readiness. Complex funding processes mean that resources are spread over Commonwealth and State and Territory portfolios, non-government organisations and service providers, creating practical obstacles to agencies comprehensively addressing an individual's

complex needs¹⁶⁵. A paradigm shift is required whereby mainstream services need to be more flexible, accessible and creative when supporting those with enduring mental illness particularly in association with older age and homelessness. They need to recognise that a person's mental health needs can and do change over time, and therefore require an ongoing assessment. Interventions should not be short-term, as potential 'change' is often a long-term process and they need to take into account that homeless people may have multiple needs and therefore are not suited to inflexible systems and working practices.

It has been demonstrated above that in Australia, there is a distinct lack in statutory provision for the older homeless population and there continues to be a lack of higher level supportive accommodation, e.g. 24 hour staffed hostel, self-contained flat or bedsit with support, and a lack of registered care. Most rehabilitative projects within the community have an emphasis that can overlook the needs of homeless people, particularly with coexisting complex mental health issues resulting from ARBD.

9

References

- 1 Hogan, W.P. (2004) *Review of Pricing Arrangements in Residential Aged Care: Final Report*. Canberra, Australia.
- 2 St Bartholomew's House (2005) *Quality and Equity in Aged Care*⁷⁹. VAHEC Submission to Commonwealth of Australia.
- 3 O'Connell, J.J. (2004) *Dying in the shadows: The challenge of providing health care for homeless people: Commentary*. *Can. Med. Assoc. J.*, 170 (8): pp 1251-1252.
- 4 Morris, A., Judd, B., Kavanagh, K. & Naidoo, Y. (2004) *Older Homeless People: Pathways into and out of homelessness*. University of New South Wales, Australia.
- 5 Lipmann, B. (2006) *Personal communication*. Wintringham Hostels. Australia.
- 6 Department of Human Services (2004) *Dementia Framework for Victoria 2005 and Beyond – Consultation Paper*, Victorian Dementia Reference Group, Aged Care Branch.
- 7 McIntosh, G. & Phillips, J. (2003) *Caring for the Elderly: An Overview of Aged Care Support and Services in Australia*. Information/E-links, E-Brief: Online 30 April 2003.
<http://www.aph.gov.au/library/intguide/SP/agedcare.htm>
Accessed 03/04/06.
- 8 World Health Organisation – Europe, Health Evidence Network (2005) *How can health care systems effectively deal with the major health care needs of homeless people?*
<http://www.who.dk/eprise/main/WHO/Progs/HEN/Syntheses/homeless>
Accessed 03/04/06.
- 9 O, Connell, J.J. (2005) *Premature Mortality in Homeless Populations: A literature review*. National Health Care for the Homeless Council Inc., Nashville.
<http://www.nhchc.org/PrematureMortalityFinal.pdf>
Accessed 03/04/06.
- 10 Pannell, J. & Palmer, G.(2004) *Coming of age: Opportunities for older homeless people under Supporting People*. The Coalition on Older Homeless in the UK.
<http://www.npi.org.uk/reports/homelessness%20older%20people.pdf>
Accessed 03/04/06.
- 11 Australian Local Government Organisation (2005) *Age-friendly built environments: Opportunities for Local Government submission*.
<http://www.alga.asn.au/policy/healthAgeing/ageing/resources/publications/builtEnv.php>
Accessed 03/04/06.
- 12 The Myer Foundation (2002) *2020: A Vision for Aged Care in Australia*.
http://www.myerfoundation.org.au!/upload_files/attachment/AgedCareBooklet.pdf
Accessed 03/04/06.
- 13 Tasmanian Government (2004) *Response to Senate Community Affairs References Committee Inquiry into Aged Care*.
http://www.aph.gov.au/senate/committee/clac_ctte/aged_care04/submissions/sub200.pdf Accessed 03/04/06.
- 14 Australian Government Department of Health and Aging (2006) *Reducing the number of younger people with disabilities living in nursing homes*.
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/feb2006coago7.htm>
Accessed 03/04/06.

- 15 O'Reilly, K. & Pryor, J. (2002) *Young people with brain injury in nursing homes: Not the best option!* Aust Health Rev 25 (3): pp 46-51.
- 16 Lipmann. B. (2006) *'A Home until Stumps': How have policy changes over the past 20 years affected the elderly homeless?* Australian Federation of Homeless Organisations, 4th National Homelessness Conference, 2006.
- 17 Judd, B et al, (2003), *Housing Options and Independent Living: Sustainable Outcomes for Older People Who are Homeless*, AHURI.
- 18 Commonwealth Department of Family and Community Services (FACS), (2002) *SAAP Monograph: Older SAAP Clients, Monograph Number 2*, Canberra, Australia.
- 19 Australian Institute of Health and Welfare (2005). *Australia's Welfare 2005*. AIHW cat. no. AUS65. Canberra: AIHW.
- 20 Department of Human Services (2003) *Responding to people with multiple and complex needs – Phase 1 report*. Melbourne, Australia.
- 21 Department of Human Services (2003) *Responding to people with multiple and complex needs project – Client Profile data and case studies report*. Melbourne, Australia.
- 22 Lipmann B., (1995) *An investigation into the provision of services for frail, elderly homeless men and women in the United States of America, Britain, Sweden and Denmark*. Melbourne, Australia.
- 23 WHO (2002) *Active Ageing: A Policy Framework*. pp 27 (as cited in Australian Local Government Organisation (2005)).
- 24 Australian Institute of Health and Welfare (2002). *Older Australia at a glance 2002* (3rd edition). AIHW Cat. No. AGE 25. Canberra: AIHW and DOHA.
<http://www.aihw.gov.au/publications/welfare/oago3/index.html>
Accessed 03/04/06.
- 25 Department of Human Services (2001) *Support Responses For Older People With Complex Needs Who Are Homeless: Information Paper*. Victorian Homeless Strategy.
- 26 Hall, F. (2003) *Assertive Outreach and The Hidden Homeless*. HACC, Disability, Allied Health and Social Support in Housing (DASH) Program, Centacare, The Catholic Diocese of Ballarat, Victoria. Paper presented at the 3rd National Homelessness Conference 'Beyond the Divide'. Australian Federation of Homelessness Organisations, Brisbane, 6-8 April 2003.
<http://www.afho.org.au/conference/2003conference/Hall.pdf>
Accessed 03/05/06.
- 27 Department of Human Services (2003) *Summary of Supported Residential Services (SRS) Census: Resident Snapshot*.
http://www.health.vic.gov.au/srs/downloads/resident_snapshot.pdf
Accessed 08/05/06
- 28 Bisset, H., Campbell, S. & Goodall, J. (1999) *Appropriate responses for homeless people whose needs require a high level and complexity of service provision – Final report to the Department of Family and Community Services, ACT Australia*.
<http://www.dhs.vic.gov.au/complexclients/>
Accessed 03/04/06.
- 29 Buckle, Q. (1998) (as cited in Bisset, H., Campbell, S. & Goodall, J. (1999)).
- 30 Bourke, T. (1994) *Homelessness in Australia: Causal factors*. Supported Accommodation Assistance Program, Australian Government Publishing Service. Canberra, Australia.

- 31 Neil, C. & Flopp, R. (1992) *Homelessness in Australia: Causes and consequences*. Australian Housing and Urban Research Institute, Research Monograph 1.
- 32 Chamberlain C., and McKenzie D.(1992) *Understanding Contemporary Homelessness: Issues of Definition and Meaning*. *Aust J Social Issues*, 27(4): pp 274-297.
- 33 Supported Accommodation Assistance Program (2001) *National Data Collection: Annual Report 1999-2000*. Canberra, Australia.
- 34 Purdon Associates Pty Ltd (1991) '*Supported Accommodation Assistance Program: Needs of homeless older people*', Commonwealth Department of Community Services and Health, Canberra.
- 35 Commonwealth of Australia Department of Family and Community Services (2000) *Working towards a National Homeless Strategy – a discussion paper*.
[http://www.facs.gov.au/internet/facsinternet.nsf/vIA/homelessness/\\$file/national_homelessness_strategy.pdf](http://www.facs.gov.au/internet/facsinternet.nsf/vIA/homelessness/$file/national_homelessness_strategy.pdf)
 Accessed 03/04/06.
- 36 Victorian Government (1988) *Gordon House, Ozanam House and The Gill Memorial Home: A Framework for Redevelopment*. Homeless Persons Services Redevelopment Project. Victoria, Australia.
- 37 Commonwealth of Australia Department of Family and Community Services (2003) *Working toward a National Homelessness Strategy – A response to consultations*.
http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/house-nat_homeless_strat.htm
 Accessed 03/04/06.
- 38 Wright-Howie, D. (2003) *Homelessness Strategies in Australia: Will they make a difference?* Council to Homeless Persons, Victoria. Paper presented to the 3rd National Homeless Conference, Aust Federation of Homeless Organisations. April 2003. Brisbane, Australia.
- 39 Department of Human Services (2004) *From hospital to home. Improving care outcomes for older people: A National Action Plan for improving the care of older people across the acute-aged care continuum, 2004-2008*. Metropolitan Health and Aged Care Services Division.
<http://www.health.vic.gov.au/acute-agedcare/national-action-plan.pdf>
 Accessed 03/04/06.
- 40 Northern Residential Mental Health Services Reference Group (2002) *Housing and Support – No Vacancy: Housing Deficit Report November 4, 2002*.
<http://chirs.infoxchange.net.au/cms/items/21017-upload-00001.doc>
 Accessed 03/05/06.
- 41 Thomson Goodall Associates (1992) *It Can Be Done – Health Care for People who are Homeless*. Royal District Nursing Service Homeless Persons Program.
- 42 Department of Human Services (undated) *Support Responses For Older People With Complex Needs Who Are Homeless – Information Paper*. Victorian Homeless Strategy.
[http://hnb.dhs.vic.gov.au/ooH/ooHchfch.nsf/b850691345bdco744a25671c000be005/8834f538c181ede9ca256cecoo24edcd/\\$FILE/backsupportolder.pdf](http://hnb.dhs.vic.gov.au/ooH/ooHchfch.nsf/b850691345bdco744a25671c000be005/8834f538c181ede9ca256cecoo24edcd/$FILE/backsupportolder.pdf)
 Accessed 03/04/06.

- 43 NSW Health (1999) *Inpatient Statistics Collection (as cited in South East Health (2000) Homelessness and Human Services – a Health Service Response*. March 2000 Clinical Services Policy and Planning Unit. NSW).
<http://sesinfo/cspp/Publications/Publications.shtm>
Accessed 03/04/06.
- 44 Health Care for the Homeless Network (2004) *Annual Report on Homeless Deaths. Public Health – Seattle and King County*. Issued October 2005.
<http://www.metrokc.gov/health/hchn/2004-annual-report-HD.pdf>
Accessed 03/04/06.
- 45 Little, G.F. & Watson D.P. (1996) *The homeless in the emergency department: A patient profile*. *J Accident and Emergency Medicine*. 13(6): pp 415-417.
- 46 Blood, I (2003) *The Discharge of Older Homeless People from Hospital Summary. Help the Aged*.
http://www.olderhomelessness.org.uk/documents/id2385_hosdissum.pdf
Accessed 03/04/06.
- 47 Department of Human Services. (2005) *HARP – Chronic Disease Management*. Metropolitan Health and Aged Care Services.
<http://www.health.vic.gov.au/harp-cdm/>
Accessed 03/04/06.
- 48 Australian Bureau of Statistics (2004) *Disability Aging and Carers – Preliminary Report, 2003*.
<http://www.abs.gov.au/Ausstats/abs@.nsf/bo6660592430724fca2568b5007b8619/768ee722e31f6315ca256e8b007f3055!OpenDocument>
Accessed 03/04/06.
- 49 Kermode, M. et al (1998) *Health indicators and risks among people experiencing homelessness in Melbourne, 1995-1996*. *Aust NZ J Public Health*. 22(4): pp 464-470.
- 50 Swanborough, T., Parkes, R. (1994) *Nursing care for people who are homeless*. *Aust Nursing Journal*. 1(7): pp 34-46
- 51 Darnton-Hill, I. et al. (1990) *Sociodemographic and health factors in the well-being of homeless men in Sydney Australia*. *Social Science Medicine*. 31(5): pp 537-544.
- 52 Darton-Hill, I. & Truswell, A. (1990) *Thiamin status of a sample of homeless clinic attenders in Sydney*. *Medical J Aust* 152(1): pp 780-781.
- 53 Trevena, L. Nutbeam, D. & Simpson, J. (2001) *Asking the right questions of disadvantaged and homeless communities: The hole of housing, patters of illness and reporting behaviours in the measurement of health status*. *Aust NZ J Public Health*. 25(4): pp 298-304.
- 54 Martens, W.H. (2001) *A review of physical and mental health in homeless persons*. *Public Health Review*. 29(1): pp 13-33.
- 55 Eggins, B. (2000) *Homeless shelter users in postdeinstitutionalization era*. *Can J Psychiatry* 45(9): pp 844-845.
- 56 Tompkins, C., Wright, N., Sheard, L & Allgar, V. (2003) *Associations between migrancy, health and homelessness: A cross-sectional study*. *Health Soc Care Community*. 11(5): pp 446-452.
- 57 Kershaw, A., Singleton, N. & Meltzer, H. (2003) *Survey of the health and well-being of homeless people in Glasgow*. *Int Review Psychiatry*. 15: pp 141-143.
- 58 Lawrence, C. (1999) *The effects of income inequity on health*. *Australian Health Review* 22(1): pp 98-106.

- 59 Marmot, M., et al. (1991) *Inequities in health twenty years on: The Whitehall II study of British civil servants*. *Lancet*. 337: pp 1387-1393.
- 60 National Health Strategy (1992) *Enough to make you sick*. Research Paper No 1. Canberra, Australia.
- 61 Dixon, J. (1999) *National research and development collaboration on health and socio-economic status for Australia: First discussion paper*. National Centre for Epidemiology and Population Health. Canberra, Australia.
- 62 Barak, Y. & Cohen, A. (2003) *Characterizing the elderly homeless: A 10-year study in Israel*. *Arch Gerontol Geriatr*. 37(2): pp 147-155.
- 63 Stergiopoulos, V. & Herrmann, N. (2003) *Old and homeless: A review and survey of older adults who use shelters in an urban setting*. *Can J Psychiatry*. 48(6): pp 374-380.
- 64 Commonwealth Department of Health and Aged Care. (1999) *Health financing in Australia: The objectives and players*. Research and Statistics Occasional Paper.
<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubs-hfsocc-ocpahfsv1-cnt.htm>
 Accessed 27/03/06.
- 65 Lipmann, B. (2003) *Providing housing and care to elderly homeless men and women in Australia*. *Care Management J* 4(1): pp 23-30.
- 66 Australian Bureau of Statistics (2001) *Mental Health In Australia: A Snapshot, 2001*. No 4824.0.55.001.
<http://www.abs.gov.au/ausstats/abs@.nsf>
 Accessed 27/03/06.
- 67 Lish, J.D., Zimmerman, M., Farber, N.J., & Lush, D. et al. (1995). *Psychiatric screening in geriatric primary care: Should it be for depression alone?* *J Geriatric Psychiatry and Neurology*, 8: pp 141-153.
- 68 Harris, E.C. & Barraclough, B.M. (1994). *Suicide as an outcome for medical disorders*. *Medicine* 73: pp 281-298.
- 69 Henriksson, M.M., Marttunen M.J., Isometsa, E.T., et al. (1995). *Mental disorders in elderly suicides*. *International Psychogeriatrics*. 7: pp 275-286.
- 70 Australian Institute of Health and Welfare (1997) *Demand for Disability Support Services: Size, Cost and Growth*. AIHW.
- 71 Crane, M. (1999) *Understanding Older Homeless People: Their Circumstances, Problems and Needs*. Open University Press, Buckingham.
- 72 Crane M. & Warnes A.M. (2000). *Profiles of London's Single Homeless People. A Report to Bondway, St Mungo's and Thames Reach*. Sheffield Institute for Studies on Ageing, University of Sheffield.
- 73 Department of Health and Ageing. Population Health Division. (2003) *The effects of alcohol on the body*. Fact Sheet 17.
http://www.health.gov.au/pubhlth/publicat/document/metadata/alcfs_intro.htm
 Accessed 27/03/06.
- 74 Miller, N.S. (1997), *'The Principles and Practice of Addictions in Psychiatry'* University of Illinois at Chicago. (as cited in Homeless Link (2000)).

- 75 Victorian Government (2002) *Mental Health Homelessness Program: Mental Health Branch – July 2002*.
<http://www.health.vic.gov.au/mentalhealth/pdrss/mh-homelessness.pdf>
 Accessed 20/04/06.
- 76 State Government of Victoria (2002) *Victorian Homelessness Strategy: Action Plan and Strategic Framework*. Department of Human Services. Melbourne, Australia.
- 77 Australian Institute of Health and Welfare (2004) *The Impact of Dementia on the Health and Aged Care Systems*. AIHW Cat. No. AGE 37. Canberra, Australia.
- 78 Alzheimer’s Australia (2003) *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia 2003*.
<http://www.alzheimers.org.au/content.cfm?infopageid=905>
 Accessed 27/03/06.
- 79 Commonwealth of Australia (2005) *Quality and Equity in Aged Care: Chapter 5 – Funding for Residents with Special Needs* pp 131-150.
http://www.aph.gov.au/senate/committee/clac_ctte/aged_care04/report/
 Accessed 27/03/06.
- 80 Acrod Ltd (2005) *Policy On Ageing And Disability July 2005*. National Industry Association For Disability Services.
<http://www.acrod.org.au/A&DPolicy-Jul05.pdf>
 Accessed 27/03/06.
- 81 McKay, R., & McDonald, R.(2004) *Response to the senate enquiry into aged care – 28th July 2004*. Aged Care Psychiatry Unit. NSW, Australia.
http://www.aph.gov.au/senate/committee/clac_ctte/aged_care04/submissions/sub46.pdf
 Accessed 27/03/06.
- 82 Fortune, N. & Wen, X. (1999). *The definition, incidence and prevalence of acquired brain injury in Australia*. Australian Institute of Health and Welfare. AIHW Cat. No. DIS 15. Canberra, Australia.
<http://www.aihw.gov.au/publications/welfare/dipabia/dipabia.pdf>
 Accessed 27/03/06.
- 83 Victorian Department of Human Services (2001) *Acquired Brain Injury Strategic Plan, 2001*.
- 84 Long, C. J. (no date) *Dementia versus Depression: Problems in Differentiation*. Neuropsychology and Behavioral Neuroscience.
<http://neuro.psyc.memphis.edu/NeuroPsysc/np-dx-demen.htm#pseud>
 Accessed 27/03/06.
- 85 The Victorian Government. Better Health Cannel.(2005) *Acquired Brain Injury – Health And Medical Information For Consumers*.
[http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/\(pages\)/acquired_brain_injury?opendocument](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/(pages)/acquired_brain_injury?opendocument)
 Accessed 27/03/06.
- 86 Benson Yody, B., Schaub, C., Conway, J. et al. (2000) *Applied behavior management and acquired brain injury: Approaches and assessment*. J Head Trauma Rehab 15(4): pp 1041-1060.

- 87 Australian Government Department of Health and Aging.(2005) *National Alcohol Strategy 2005-2009 Consultation Paper*, April 2005.
<http://www.alcohol.gov.au/consultation.pdf>
 Accessed 27/03/06.
- 88 Alcohol Concern – The National Agency on Alcohol Misuse. (2002) *Alcohol Misuse Among Older People, Acquire Report – Alcohol Concerns Quarterly Information And Research Bulletin*, Autumn 2002 Pp I-Vii. UK.
http://www.alcoholconcern.org.uk/files/20030801_134206_older%20people%20factsheet.pdf
 Accessed 27/03/06.
- 89 National Institute on Drug Abuse (2005). *Medical Consequences of Drug Abuse – Neurological Effects*. NIDA. USA.
<http://www.nida.nih.gov/consequences/neurological/>
 Accessed 27/03/06.
- 90 O’Connell, H., Chin, A., Cunningham, C. and Lawlor, B. (2003) *Alcohol use disorders in elderly people – Redefining an age old problem in old age*. *British Medical Journal*. 327: pp 664-667.
- 91 Simpson, M., Williams, B. and Kendrick, A. (1994) *Alcohol and elderly people: An Overview of the Literature for Social Work*. *Ageing and Society*. 14: pp 575-587.
- 92 Wattis, J. P. & Seymour, J. (2001) *Alcohol Abuse in Elderly People: Overview and Summary*. In: ‘*Alcohol and Coffee use in the aging*’. Watson, R.(Editor) CRC Press. London.
- 93 Thomas, V. & Rockwood. K. (2001) *Alcohol abuse, cognitive impairment and mortality among older people* *Journal of the American Geriatric Association*. 49: pp 415-420.
- 94 McCabe, L. (2005) *Alcohol related brain damage: Knowledge and attitudes of frontline care staff*. Department of Applied Social Science, University of Stirling.
<http://www.aerc.org.uk/documents/pdf/finalReports/AERC%20report%20McCabe.pdf>
 Accessed 27/03/06.
- 95 The Medical Council on Alcohol. (2003) *Medical Students’ Handbook: Alcohol And Health*, 3rd Ed, UK.
http://www.medicouncilalcol.demon.co.uk/handbook.hb_harm.htm
 Accessed 27/03/06.
- 96 Cox, S., Anderson, I., McCabe, L. (eds) (2003) *Report of the Expert Group on Alcohol Related Brain Damage June 2003*. Dementia Services Development Centre. University of Stirling. Stirling, Scotland.
- 97 Lipmann, B., Mirabelli, F., Rota-Bartelink, A. (2004). *Homelessness Among Older People: A Comparative Study In Three Countries Of Prevention And Alleviation*, Wintringham, Australia.
- 98 Kay, D., Forster, D. & Newens, A. (2000) *Long-term survival, place of death and death certification in clinically diagnosed pre-senile dementia in Northern England*. *The British Journal of Psychiatry* 177(2): pp 156-162 (as cited in McCabe (2005)).
- 99 Australian Bureau of Statistics (1997) *Australian Demographic Statistics*. Cat.3101.0. Australian Government Publishing Service. Canberra, Australia.
- 100 Rosewarne, R.C., Opie, J.R. & Ward, S.M. (2000) *Dementia-specific care in Australia: An overview and future directions*. *Research and Practice in Alzheimer’s Disease*, Vol 4, Springer Publishing Company (New York).

- 101 Johnson, A. K. & Cnaan, R. A. (1995). *Social work practice with homeless persons: State of the art.* Research in Social Work Practice, 5: pp 340-382.
- 102 Council to Homeless Persons (2004). *Why We Need A National Strategy for the Homeless Elderly.* Australia.
<http://www.chp.org.au/parity/articles/results.chtml>
 Accessed 27/03/06.
- 103 Castaneda, R., Lifshutz, H., Galanter, M., et al.(1992) *Treatment compliance after detoxification among highly disadvantaged alcoholics.* Am J Drug Alcohol Abuse. 18: pp 23-34.
- 104 Richman, A. & Smart, R.G.(1981) *After how many detoxifications is rehabilitation probable?* Drug Alcohol Depend. 7: pp 233-238.
- 105 Cox, G.B., Walker, R.D., Freng, S.A., et al. (1998) *Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates.* J Stud Alcohol. 59: pp 523-532.
- 106 Drake, R.E., Osher, F.C. & Wallach, M.A. (1991) *Homelessness and Dual Diagnosis* American Psychologist. 46 (11): pp 1149-1158.
- 107 Homeless link (2000) *Submission to the health committee on NHS Mental health services: About National Homeless Alliance.* London.
<http://www.homeless.org.uk/db/20000801143556/view>
 Accessed 27/03/06.
- 108 Sane Australia (2005) *Dual Diagnosis.* Better Health Channel.
http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dual_diagnosis?OpenDocument
 Accessed 27/03/06.
- 109 Kodituwakku, P., Kalberg, W. & May, P. (2001) *The Effects of Prenatal Alcohol Exposure on Executive Functioning.* Alcohol Research & Health. 25(3): pp 192-198.
- 110 Barkley, R. (2001). *A theory of ADHD: Inhibitions, self-control and time.* Keynote presentation at the conference ADHD in the Third Millennium: Perspectives for Australia, Sydney.
- 111 Australian Institute of Health and Welfare (1998) *Australia's Health 1998.* AIHW Canberra, Australia.
- 112 Lawrence, C. 1999. *The effects of income inequality on health.* Australian Health Review 1999; 22,1: pp 98-106.
- 113 Syme, S.L. 1998. *Social and economic disparities in health: Thoughts about intervention.* The Milbank Quarterly. 76, 3: pp 493-503.
- 114 Walker, C., Peterson, CL, Millen, N. 2003. *Chronic illness and socio-economic status: An investigation.* The International Journal of Medicine – Medicine Online.
<http://www.priory.com/SES.htm>
 Accessed 27/03/06.
- 115 Hecker, K. (2002) *Salvation Army services to older clients.* Parity – Meeting the needs of older people. 15(10): pp 29-30.
- 116 Hodder, T., Teesson, M. & Burich, N. (1998) *Down and out in Sydney: Prevalence of mental disorders, disability and health among homeless people in inner Sydney.* Sydney City Mission, Sydney, NSW Australia.
- 117 Russel, C. et al (2002) *Housing histories of marginalised men growing old in the inner city.* Parity – Meeting the needs of older people. 15(10): pp 15-17.

- 118 Kermodé M, et al.(1998) *Health indicators and risks among people experiencing homelessness in Melbourne, 1995-1996*. Aust N Z J Public Health. 22(4): pp 464-470.
- 119 McMurray-Avila, M. (2001). *Organizing health services for homeless people: A practical guide*, 2nd edition.: National Health Care for the Homeless Council. Nashville, USA.
- 120 Department of Human Services (2004) *Victoria Drug Policy and Services: An overview*. Department of Human Services Drugs Policy and Services Branch Victorian Government.
http://www.health.vic.gov.au/drugservices/downloads/drugpolserv_overview.pdf
Accessed 27/03/06.
- 121 Brodaty, H., Draper, B.M.& Low, B. (2003) *Behavioural and psychological symptoms of dementia: A seven-tiered model of service delivery*. MJA. 178(5): pp 231-234.
- 122 McCabe, M.P. et al (2004) *Aging Well, Aging Productively: Stakeholder Submission*. Australian Government, National Health and Medical Research Council.
http://www.nhmrc.gov.au/publications/_files/sub8.pdf
Accessed 27/03/06.
- 123 Cnaan, R., Blankert, L., Messinger, K. & Gardner, J. (1988) *Psychosocial Rehabilitation: Toward a Definition*. Psychosocial Rehabilitation Journal 11(4): pp 61-77.
- 124 Finnema, E., Droes, R.M., Ribbe, M. & van Tilburg, W. (2000) *A review of psychosocial models in psychogeriatrics: Implications for care and research*. Alzheimer Dis Assoc Disord. 14(2): pp 68-80.
- 125 Department of Human Services (2004) *Acquired brain injury and mental illness: Issues Paper*. Victoria, Australia.
<http://www.health.vic.gov.au/mentalhealth>
Accessed 27/03/06.
- 126 Greeley, J. & McDonald (1992). *Alcohol and Human Behaviour – abridged from The Effects of Alcohol on Cognitive, psychomotor, and Affective Functioning: Report and Recommendations Prepared by an Expert Working Group for the Royal Commission into Aboriginal Deaths in Custody (1989) – Australian Institute of Criminology – Australian Government*.
<http://www.aic.gov.au/publications/other/dic1992/14.pdf>
Accessed 27/03/06.
- 127 Jacobs, K. & Arthurson, K. (2003). *Developing effective housing management policies to address problems of anti-social behaviour – Final Report*. AHURI. Australian Housing and Urban Research Institute – Southern Research Centre.
- 128 Darcy, M., Randolph, B.& Stringfellow, J. (2000) *Social and Behavioural Issues in Housing Estates: An Overview of Research Questions and Policy Issues*, University of Western Sydney, Australia.
- 129 Saunders, P. & Tsumori, K. (2002) *Poverty in Australia: Beyond the Rhetoric*, CIS Monograph 57, Centre for Independent Studies. Sydney, Australia.
- 130 Keene, J. (2001) *Clients with Complex Needs*. Interprofessional Practice. Blackwell Science Ltd. UK.
- 131 Victorian Department of Human Services (2000) *Supporting the needs of Individuals with High Complex Behaviours*. DisAbility Services Division, Melbourne, Australia.

- 132 Australian Government Department of Family and Community Services (2003) *People who are assisted by SAAP services and require a high level and complexity of service provision: An enhanced assessment and measurement framework*. FaCS Supported Accommodation Assistance Program. Thomson Goodall Associates Pty Ltd.
[http://www.facs.gov.au/internet/facsinternet.nsf/vIA/saap/\\$File/SAAP_Report_appendix_literature_review.rtf](http://www.facs.gov.au/internet/facsinternet.nsf/vIA/saap/$File/SAAP_Report_appendix_literature_review.rtf)
 Accessed 27/03/06.
- 133 Teesson, M., Hodder, T. & Buhrich, N. (2003) *Alcohol and other drug disorders among homeless people in Australia*. *Substance Use and Misuse*. 38 (3-6): pp 463-475.
- 134 Buhrich, N., Hodder, T. & Teesson, M. (2000) *Lifetime prevalence of trauma among homeless people in Sydney*. *Australian and NZ Journal of Psychiatry*. 34(6): pp 963-966.
- 135 Buhrich, N., Hodder, T. & Teesson, M. (2000) *Prevalence of cognitive impairment among homeless people in inner Sydney*. *Psychiatr Serv*. 51(4): pp 520-521.
- 136 Ash, D., Galletly, A., Haynes, J. & Braben, P. (2003) *Violence, self-harm, victimization and homelessness in patients admitted to an acute inpatient unit in South Australia*. *Int J Soc Psychiatry* 49(2): pp 112-118.
- 137 Dumaine, M.L. (2003) *Meta-analysis of interventions with co-occurring disorders of severe mental illness and substance abuse: Implications for social work practice*. *Research on Social Work Practice* 13 (2): pp 142-165.
- 138 Johnston, S. et al (1998) *Intensive case management: A cost-effectiveness analysis*. *Aust and NZ J Psychiatry*. 32(4): pp 551-559
- 139 Morse, G.A. et al (1992) *Experimental comparison of the effects of three treatment programs for homeless mentally ill people*. *Hospital and Community Psychiatry*. 43(10): pp 1005-1010.
- 140 Rosenheck, R., Resnick, S. & Morrissey, J. (2003) *Closing service system gaps for homeless clients with dual diagnosis: Intergrated teams and interagency cooperation*. *J Mental Health Policy Econ*. 6(2): pp 77-87.
- 141 **arbias** (2005) *Alcohol Related Brain Injury: Looking forward*. General Information Publication.
- 142 Wintringham (2006) *Wintringham Resident Assessment Package*. Interpreted By Brumen, S. Wintringham Clinical Care Co-Ordinator. Wintringham, Australia.
- 143 Mearns, J. & Lees-Haley, P.R. (1993) *Discriminating neuropsychological sequelae of head injury from alcohol-abuse-induced deficits: A review and analysis*. *J Clin Psychol* 49(5): pp 714-720.
- 144 **arbias** Services Overview – Specialists in alcohol and substance related brain injury.
http://www.arbias.org.au/activities/services/services_overview.html
 Accessed 27/03/06.
- 145 City of Port Phillip (2005) *Responding to crisis and building community – A Local Government perspective of mental health and service responses*. Submission to the senate Select Committee on Mental Health.
- 146 Department of Human Services (2000) *Support responses to people with acquired brain injury who are homeless: Information Paper*. Victorian Homeless Strategy.
- 147 Promoting excellence in End-of-Life Care (2006) *Innovative Models and Approaches for Palliative Care*. University of Montana, USA.
<http://www.promotingexcellence.org/>
 Accessed 15/05/06.

- 148 Barton, R. (1999) *Psychosocial Rehabilitation Services in Community Support Systems: A Review of Outcomes and Policy Recommendations*. American Psychiatric Association. *Psychiatr Serv.* 50: pp 525-534.
<http://ps.psychiatryonline.org/cgi/content/full/50/4/525>
 Accessed 15/05/06.
- 149 Purdon Associates Pty Ltd (1991) *Supported Accommodation Assistance Program: Needs of homeless older people*. Commonwealth Department of Community Services and Health, Canberra, Australia.
- 150 Carling, P.J., Randolph, F., Ridgway, P., & Blanch, A. (1987). *Housing and community integration for people with psychiatric disabilities*. Burlington, VT: Center for Community Change Through Housing and Support.UK.
- 151 Brown, M.A., Ridgway, P., Anthony, W.A., & Rogers, E.S. (1991). *Comparison of outcomes for clients seeking and assigned to supported housing services*. *Hospital and Community Psychiatry* 42(11): pp 1150-1153.
- 152 Watson, L., Tarpey, M., Alexander, K. and Humphreys, C. (2003) *Supporting People: Real change? Planning housing and support for marginal groups*. York: Joseph Rowntree Foundation (as cited in Watson, L. Harker, M. (2003) *Literature review – Mental health and housing*. Social Exclusion Unit. UK).
<http://www.socialexclusion.gov.uk/downloaddoc.asp?id=207>
 Accessed 27/03/06.
- 153 Watson, L & Tarpey M (1998) *Pick and Mix: Developing flexible housing choices in community care*. Chartered Institute of Housing/Joseph Rowntree Foundation. UK.
- 154 Culhane, D, Metraux, S & Hadley, T (2001) *The New York agreement cost study: The impact of supportive housing on service use for homeless mentally ill individuals New York*. Fannie Mae Foundation.
- 155 Watson, L. & Harker, M. (2003) *Literature review – Mental health and housing*. Social Exclusion Unit. UK.
- 156 Lyon, J. (2006) CEO, The William Simpson's Home. *Personal communication* 19th April 2006.
- 157 Czerwinski, S.J. (2000) *Homelessness: Consolidating HUD's McKinney Programs*. United States General Accounting Office. United States.
<http://www.gao.gov/archive/2000/rc00187t.pdf>
 Accessed 15/05/06.
- 158 Burt, M.R., Hedderson, J., Zweig, J., et al (2004) *Strategies for Reducing Chronic Street Homelessness: Final Report*. US Dept of Housing and Urban Development Office of Policy Development and Research.
<http://www.huduser.org/Publications/PDF/ChronicStrtHomeless.pdf>
 Accessed 15/05/06.
- 159 Barrow, S., Soto Rodríguez, G., Córdova, P. (2004) *Final report on the evaluation of The Closer To Home Initiative*. Corporation For Supportive Housing. USA
http://documents.csh.org/documents/policy/cth_final.pdf#part1
 Accessed 15/05/06.
- 160 Interfaith Housing Development Corp. of Chicago (2004) *Pathfinders and Partners*.
<http://www.ihdc.org/>
 Accessed 15/05/06.

- 161 Mercy Housing Lakefront (2005) *More than a roof*.
<http://www.lakefrontsro.org/buildings.html>
Accessed 15/05/06.
- 162 South Australian Council of Social Service (2003) *Submission to the Social Development Committee of The South Australian Parliament for The Inquiry into Supported Accommodation*. May 2003.
<http://www.sacoss.org.au/pubs/supa.pdf>
Accessed 15/05/06.
- 163 The Richmond Fellowship Victoria. (2005).
<http://www.rfv.org.au/ServicesPrograms/Yandina%20Program.html>
Accessed 15/05/06.
- 164 Memmott, P. (2002) *Responses to Indigenous people living in public spaces*. *Parity*. 15(1):11-13.
- 165 Parker, S., Limbers, L. & McKeon, E. (2002) *Homelessness and Accommodation Models for People Living with Mental Health Problems Homelessness and mental illness: Mapping the way home*. Mental Health Coordinating Council.
<http://www.mhcc.org.au/projects/homelessness.htm>
Accessed 15/05/06.

Wintringham

Wintringham

ABN 97 007 293 478

Head Office

136 Mt Alexander Road

PO Box 193

Flemington Victoria 3031

T 03 9376 1122

F 03 9376 8138

E admin@wintringham.org.au

I www.wintringham.org.au