Submission to the Royal Commission into Aged Care Quality and Safety

Recommendations from the inter-agency Aged Care Reference Group to address deep and persistent disadvantage

Jesuit Social Services
Building a Just Society

Catholic Social Services Victoria
...building a more just and compassionate society

VincentCare
Engage. Enable. Empower.

Brotherhood of St Laurence
Working for an Australia free of poverty

Recommendations

1 Enable earlier access to aged care services for people who are prematurely aged

2 Introduce Interim Home Care Packages to provide immediate, flexible supports for older people who are homeless or at risk of becoming homeless

3 Broaden the types of services that can be funded under Home Care, including case management for older people experiencing deep and persistent disadvantage

4 Introduce a new supplement (in line with the tightly defined Homelessness Supplement), targeted towards specialist service providers, that recognises the additional resources required to provide care for people experiencing deep and persistent disadvantage

5 Ensure any new funding model, such as the Australian National Aged Care Classification (AN-ACC), adequately incentivises services for people experiencing deep and persistent disadvantage

6 Support the Aged Care Quality and Safety Commission to understand and define the distinctive service offering and approach needed for people experiencing deep and persistent disadvantage, including greater risk, acceptance of harm minimisation and complex social and personal care strategies.

Introduction

All older people in Australia should enjoy the same high standards of care. Unfortunately, this is not the case for many older people who experience **deep and persistent disadvantage**.

This category of deep and persistent disadvantage describes any older person suffering from the effects of poverty, trauma and/or social isolation, homelessness, and anyone with reduced capacity to live independently or without informal support/s from family, friends or carers.

We estimate that there are over 18,000 older people in Australia[1] experiencing this type of disadvantage who cannot readily access aged care or who are not welcome in many services. These older people have much to offer, but they also have special aged care needs stemming from a lifetime of disadvantage.

[1] This Reference Group has drawn this figure from available homelessness and poverty datasets. We note that there is no direct way to compare available data. Information on deep and persistent disadvantage is scarce. However, these datasets can allow us to calculate an approximate figure of the total number of older people in Australia experiencing the issues we outline in this submission.

In Australia, the rate of older persons experiencing homelessness increased from 26 persons per 10,000 people in 2011 to 29 in 2016 (ABS 2016). Data from the Australian Institute of Health and Welfare shows that time spent in homelessness services has increased significantly, from 18 to 27 days (AIHW 2019), suggesting that older people are presenting with more complex issues that take longer to resolve. It may also indicate that people are experiencing greater difficulty securing housing after crises. A significant number of older people are a step away from crisis. According to the Australian Council of Social Service 11.6% of people aged over 65 live in poverty (where the definition is 50% of median incomes) (ACOSS 2020). For older renters the poverty rate is even higher at 43.4%.

Using this data, we can estimate that anywhere between 60,000 and 400,000 older people may experience disadvantage (as defined as homelessness or poverty). Our figure is considerably lower as we are primarily concerned with the intersection of different types of disadvantage and their impacts.

Who are we?

We are a group of providers, advocates and researchers proudly committed to supporting all older people to live their best lives and age with dignity and respect. This submission is the result of consultations with a broad range of organisations, including the Brotherhood of St Laurence, Catholic Social Services Victoria, Housing for the Aged Action Group (HAAG), Jesuit Social Services, Prague House, Sacred Heart Mission, St Mary's House of Welcome and VincentCare. We seek to work with the Royal Commission and the government to ensure that this growing cohort, who experience inequity because of poor access, poor understanding and poor experiences within the aged care sector, receives the services and supports that they need.

We specialise in service delivery to the most disadvantaged older people in Australia, employing specialist practice approaches, including a commitment to harm minimisation and social inclusion. Our organisations understand that the model of care required for disadvantaged individuals differs greatly from that of the general population. We engage with and support individuals and groups experiencing deep and persistent disadvantage as part of our mission to help those in need achieve the best possible outcomes and live with agency, dignity and respect.

Who are our clients?

Our clients are older people disadvantaged as a result of:

- complex, often lifelong, histories of significant disadvantage, including trauma, poverty, homelessness or insecure accommodation (including both private rentals and social housing), institutionalisation, mental health concerns, disability, substance abuse and/or substance abuse disorders, or a combination of these issues
- engagement with the justice system, including older inmates and prison leavers
- social and/or cultural dislocation, including refugees and new migrants
- family violence and elder abuse (both victims and perpetrators)
- child abuse, sexual abuse and/or out of home care
- premature ageing or complex healthcare needs
- non-participation and/or exclusion from society, communities and services
- very little or no support from friends or family members.

These factors lead to deep and persistent disadvantage, which impacts people's social mobility and connections, living skills, emotional regulation, resources, health and ability to engage with services. This results in a group of people who have complex and multiple needs that cumulatively impact their capacity to access services and to engage with long-term solutions to meet those needs. This group can also be 'invisible' to society. Illustrative case studies are profiled in **Appendix A**.

People with histories of disadvantage are also more vulnerable to premature ageing and related conditions. In our experience, this cohort presents with needs comparable to the Aboriginal and Torres Strait Islander community (who are eligible for aged care services from the age of 45). Although there is already some recognition of premature ageing for older people experiencing homelessness, eligibility issues across this diverse cohort are not well recognised or addressed.

What is needed?

We are pleased by the work done to date by the Royal Commission and note that the Commission has heard evidence about the diversity of people receiving aged care. We are, however, writing as a group concerned to ensure that people experiencing deep and prolonged disadvantage are considered in the Final Report and recommendations.

There are six areas in particular where we consider that mainstream service offerings and funding do not best support this cohort, and we invite the Royal Commission to consider the following issues and potential solutions.

1 Redefine aged-based access to services

People experiencing disadvantage often experience age-related conditions at a younger age as a result of their histories. We recommend eligibility criteria for aged care services for this cohort be in line with those for Indigenous Australians, where people aged 45 and over can access services. We acknowledge that premature ageing is well understood for people experiencing homelessness, where people aged 50 and over can access services. Yet, many older people who are prematurely aged still cannot access age-appropriate services unless they are in crisis.

2 Introduce Interim packages to support individuals who are homeless or at risk of homelessness

Our clients may be in precarious situations, including homelessness, insecure or inappropriate accommodation and leaving prison. These circumstances require an immediate response to avoid significant poor outcomes where people's needs are not met. In our experience, people cannot afford to wait for an Aged Care Assessment Team (ACAT), while Transition Care is often inappropriate, or unavailable unless people have had a hospital stay.

Additionally, once an individual identifies a service, if there is not a quick assessment or referral, they will often not re-engage or return to the service for follow-up appointments. For people facing homelessness or at risk of homelessness, receiving proactive supports at, or before, crisis can slow or avert the deterioration of their health and social condition and reduce their needs in the long run.

Examples of people at risk of homelessness include people (aged over 45) who are:

- leaving a violent partner or experiencing elder abuse
- re-entering society after a period of incarceration
- leaving an institution, such as a mental health facility or drug and alcohol service
- living in insecure or inappropriate accommodation (including private rentals or social housing)
- for whatever reason, experiencing poverty and at high risk of losing their home.

We propose that a new **Interim Home Care Packages Program** would best support older people experiencing deep and persistent disadvantage while they are waiting for assessment and/or services. This program would enable selected providers to support at-risk older people to access appropriate housing and wrap-around services and address their aged care needs. Availability of holistic supports would also reduce use of residential aged care before it is absolutely necessary. Interim Packages should remain in place until the person receives an appropriate Home Care

Package receives a Commonwealth Home Support Programme (CHSP) funded service, or is determined to be ineligible.

The duration and amount of additional funding provided under any new program aimed at the most disadvantaged could be consistent with the Short Term Restorative Care (STRC) Program.

Making Interim Home Care Packages available through a limited set of specialist providers (and for a defined cohort of consumers) would:

- ensure that the program is appropriately targeted and limit its cost
- be consistent with the government's policy approach to other people at significant risk.

3 Broaden the types of services that can be funded through a Home Care Package including support for higher levels of case management for people who experience deep and persistent disadvantage

Older people experiencing deep and persistent disadvantage often require a higher level of case management. This is because people may:

- have no in/formal supports (including family, friends and/or carers)
- have complex healthcare and personal needs
- have lower levels of acuity
- are less likely to engage with services because of distrust, previous experiences and/or feelings they are not welcome or understood (exacerbated by the fact that general/mainstream services are not equipped to identify and/or triage the types of services this group needs).

The services this group requires are different to the general aged care population. Examples of the types of unfunded services involved for this group include:

- organising and liaising around appointments (in all aspects of a person's life)
- transporting people to appointments
- coordinating all visits, case conferences and appointments
- overseeing medication compliance and/or connections with drug and alcohol services
- seeking out and negotiating accommodation solutions
- establishing trusting relationships between providers and clients
- assisting people with emotional regulation and community engagement; and
- supporting people rebuild relationships and re-unify with family and society.

The supports this cohort needs depend on the specific combination of their personal history and how they present. Often these services will need to continue even during long stays in hospital or drug and alcohol rehabilitation centres. Accordingly, the available service offerings need to be different and flexible.

For example, Neil[2] tries to organise an appointment at a medical service; Neil now lives by himself in social housing but has a long history of sleeping rough, underpinned by drug and alcohol abuse. When he arrives, due to his appearance and presentation, he is immediately treated differently by reception staff. Neil has also arrived late because of relying on public transport and confusing the appointment time. Neil becomes so frustrated by the delay and his perceived poor treatment that his behaviours of concern (like anger and verbal outbursts) are triggered. This scenario, which illustrates the types of tasks a case manager undertakes that are specific to people experiencing disadvantage, could be handled differently by specialist service staff.

Many mainstream services do some of these tasks, but overall such services are not profitable or marketable; nor are they readily definable or attractive to deliver.[3] As a result, specialist services predominantly cater to this cohort. Mission-driven organisations step into this gap and support people to manage in a similar way a person's next of kin would (although providers often cannot rely on a person's Home Care Package funds to support this work). Yet, offering these types of services is more expensive and challenging. Our staff require:

- skills in assertive outreach
- training in managing mental health and trauma (e.g. social work skills)
- extra supervision (given the vulnerability of clients)
- support and other systems and processes to mitigate carer fatigue and staff burnout.

While the services are more challenging to deliver, beneficial outcomes are significant. This type of care, delivered well, supports individuals to:

- achieve and maintain stable accommodation
- avoid incarceration or reincarceration
- attend medical appointments, for better health outcomes and management
- avoid further deterioration of health or social outcomes
- manage addictions and/or mental health concerns.

Addressing these needs has a significant impact on the whole of a person's life; it is not just about enabling individuals to stay in their home longer but about enabling them to live their best lives and avoid further deterioration.

[2] All case studies and examples in this submission are composites, drawn from experiences common to all members of this Reference Group, to avoid the risk of identifying individuals. This decision best respects our clients and their privacy.

[3] The Reference Group notes that where case management services are funded from existing Home Care Packages there can also be inequitable outcomes, as these types of intensive, tailored supports are higher cost and can therefore reduce the resources available for other important supports (such as drug and alcohol counselling, occupational therapy, accommodation, and so on). We therefore note that funding for case management should either be block-funded or provided on top of existing packages for this cohort.

4 Introduce a new provider supplement that recognises the additional resources required to provide care for people experiencing deep and persistent disadvantage

The government currently recognises the additional costs and different service models of providers delivering care to people with a history of homelessness through the Homelessness Supplement. The supplement supports specialist providers delivering care where more than half of the residents meet the viability expansion component and homelessness assessment criteria.

We believe a new, tightly defined supplement should be introduced to support specialist services providing care to people experiencing deep and persistent disadvantage (as outlined above). This approach recognises:

- that this cohort has diverse and distinctive care needs
- that these consumers are often not welcome in mainstream aged care services or may find it difficult to negotiate and secure a place there
- that delivery of care to this cohort can be higher risk and requires a higher risk tolerance. For example, many of our clients smoke, do not have strong emotional regulation or otherwise require care to be delivered in a fundamentally different way, that is more focused on harm minimisation and social connection than other aged care services.

5 Ensure that any new funding model adequately incentivises providers to deliver services to people experiencing deep and persistent disadvantage

We understand that a new funding model is currently being trialled in residential care: the Australian National Aged Care Classification (AN-ACC).

AN-ACC is proposed to have a higher fixed payment for services that deliver supports to people experiencing homelessness (and we recommend the expansion of subsidies as described above). However, we are keen to ensure that any new funding model does not act as a disincentive for mainstream aged care services to accept clients experiencing deep and persistent disadvantage and provide appropriate care.

Additionally, we recognise that specialist services, while the most appropriate place for the cohorts we work with, will not be available to all those who need them and/or in all locations. We therefore want to ensure that any new funding model properly incentivises and supports mainstream aged care providers. These providers also need to be able to accept and provide suitable care for clients that may not otherwise be attractive, for reasons including their low financial means, history of trauma/abuse, social isolation and challenging behaviours.

Many of our clients are high functioning in activities of daily living (that is, they are relatively physically able, mobile and are less impacted by age-related cognitive decline). Despite this, they have higher than average care needs, because of complex personal histories, anti-social behaviours, acquired brain injury (ABI), multiple comorbidities which impact on their physical health, poor emotional regulation, low trust in others (especially in positions of authority), and/or the fact that they may be triggered by a wide range of events or actions.

We hope new funding is contingent on provision of appropriate care and supports for this group.

6 Support the Aged Care Quality and Safety Commission to understand the unique service offering and approach needed for people experiencing deep and persistent disadvantage including higher risk tolerance and acceptance of harm minimisation

Service providers working with people experiencing deep and persistent disadvantage require a greater tolerance for risk than mainstream providers. Many such specialist providers focus on harm minimisation (rather than risk avoidance), behavioural support and social programs to address the complex, seemingly non-compliant behaviours typical of this cohort.

We would like to see a greater acceptance of harm minimisation strategies in accreditation and quality reviews by assessors, and further education and guidance for the assessment workforce about the special considerations of service delivery to this group of clients. The Commonwealth government's Aged Care Diversity Framework provides a solid foundation, but more can be done to recognise the diverse needs of older people experiencing or at risk of homelessness, and the impacts of a life lived in poverty.

Additionally, we strongly believe there is a need to define the care delivered by 'specialist providers' within the quality standards. Providers are currently able to claim they are a 'specialist service' without demonstrating a specialist service offer. This further disadvantages clients and those providers that do provide a tailored, flexible model of care. Criteria for a specialist provider, and how such specialist care is defined within the quality standards framework, are therefore important components underpinning our recommendations.

Contacts

This Reference Group stands ready to assist the Royal Commission further. For additional information please find a list of key contacts for the organisations represented in this Group:

Amber Mills
Senior Research Fellow, Inclusive Ageing
Research and Policy Centre
Brotherhood of St Laurence
M: 0411 313 498
E: Amber.Mills@bsl.org.au

Fiona York
Executive Officer
Housing for the Aged Action Group
P: (03) 9654 7389
M: 0449 554 142
E: Fiona.York@oldertenants.org.au

James Finnis
Policy Advisor, Inclusive Communities
Research and Policy Centre
Brotherhood of St Laurence
M: 0451 176 904
E: James.Finnis@bsl.org.au

Joshua Lourensz
Executive Director
Catholic Social Services Victoria
P: (03) 9287 5569
E: joshua.lourensz@css.org.au

Malcolm Shimmins
Acting GM, Marketised Services
VincentCare Victoria
P: (03) 9611 9200
M: 0427 325 585
E: malcolm.shimmins@vincentcare.org.au

Ralph Hampson
Associate Professor, Director Strategic Engagement
Department of Social Work, School of Health Sciences
The University of Melbourne
M: 0425 172 983
E: ralph.hampson@unimelb.edu.au

Robina Bradley
Chief Executive Officer, Company Secretary
St Mary's House of Welcome
P: (03) 9417 6497
M: 0419 505 975
E: robina.bradley@smhow.org.au

Sally Parnell
Executive Director Programs, Chief Operating Officer
Jesuit Social Services
P: (03) 9421 7606
E: Sally.Parnell@jss.org.au

Stephen Schmidtke
Executive Director Client Services
Sacred Heart Mission
P: (03) 9536 8476
M: 0412 230 041
E: sschmidtke@sacredheartmission.org

Tina Melrose
Manager
Prague House
St Vincent's Hospital Melbourne
P: (03) 9231 8600
E: Tina.MELROSE@svha.org.au

Appendix A: Case studies

Meet Bob …

Bob is a chronic smoker who was imprisoned for many years due to poverty-driven theft in the middle of his life. He currently resides in a boarding house and experiences outbursts as a result of mental health concerns he has developed, particularly following his release from prison. These outbursts can be confronting for many people and Bob is particularly isolated, with no informal supports. Bob recently had a serious health event and is requiring clinical and social supports. Given his insecure housing and limited education, he finds it difficult to keep and attend medical appointments or determine where to access aged care support. He lacks technical capability to navigate My Aged Care. Bob is hesitant to engage with service providers directly as he does not understand the costs to him and is concerned that he won't be understood or that his mental health issues will be a barrier to him receiving care.

What could it look like for Bob?

Bob was identified by community outreach as at significant risk and in need of aged care. Engaging with services, Bob was provided with an interim package and case manager who supports him and has the necessary skills and training to understand him and his history. The case manager is able to assist Bob in accessing and attending medical appointments, and to provide reassurance and support to Bob about receiving home nursing care. Bob could benefit from an ongoing relationship with an organisation that not only provides home care services but also connects him with other people.

Meet Elise…

Elise experienced homelessness in her late 50s following the breakdown of her marriage as a consequence of domestic abuse. Prior to this, Elise had experienced trauma as a child and was moved through the foster system. Elise is currently in public housing, but has tended to move around, staying with others for a sense of safety. Sometimes Elise finds herself with nowhere to sleep for the night. Elise misses a lot of her personal appointments and is difficult to contact as she does not have a consistent phone number. Elise is now in her mid-60s and uses a four-wheeled walker because of multiple chronic health conditions which are exacerbated by her housing situation and constant travelling. Elise knows she's struggling and that she can't live on her own anymore, but she's also scared of entering permanent residential care given her experience in the foster system and concerns about not being safe.

What it could look like for Elise?

To help Elise retain her independence, ABC Care found her a residential service that supported her periods away and which held a place for her to ultimately return to for clinical care and accommodation. Her freedom to come and go as she pleased empowered her but also meant she kept on top of her clinical care needs and got access to other supports. She enjoys living in a community of people with similar experiences who understand her. Elise now spends less time away from the residential service as she feels reassured and less anxious. The staff also get to know her regular patterns of travel and are able to locate her and encourage her return.

Appendix B: Summary of issues and solutions

We propose that there be greater flexibility and increased funding to address certain issues specific to the problems faced by people experiencing significant disadvantage.

We acknowledge the work done in relation to the Homelessness Action Plan and Diversity Action Plan. The proposals we identify below are consistent with these.

Topic	Problem	Proposed solution
Access	Our clients often age prematurely as a result of their disadvantage and have one or more age-related conditions. While these people are not aged 65+, they require an aged care service	Earlier access: People facing deep and persistent disadvantage who are prematurely aged should be given access to aged care services from the age of 45 (in line with Aboriginal and Torres Strait Islander populations)
Access	If a service cannot provide a quick assessment or referral, those experiencing deep and persistent disadvantage will often not re-engage or return to the service for follow-up appointments. This is a serious problem for the period when supports are unfunded and people are waiting for a package. For people experiencing homelessness or who are at risk of homelessness, receiving more proactive supports will slow or avert the deterioration of their health and social conditions and reduce their needs in the long run	Interim packages: Interim Home Care Packages could provide immediate relief, services and/or supports to an individual at risk of homelessness or experiencing homelessness. This would provide vulnerable clients who engage with the aged care system with sufficient supports at a time of significant trauma and risk. Interim Packages would also enable case management to identify the best longer-term care options
Services	Given the complexity and layered disadvantage many of these individuals face, they require a broader set of services (e.g. behavioural, financial assistance, housing security, social services). Provision of supports also varies considerably, as the needs of this cohort are more complex	Flexibility in home care packages: Providers working with this cohort need to be able to deliver greater care co-ordination services and for this to be recognised and supported through the Home Care and CHSP programs. This is important as case management for these clients involves substantially more complicated work than is often required for other older people
Funding	There are small margins (and in some cases no funding) for the types of services required by individuals experiencing deep and persistent disadvantage. This limits the capacity of both mainstream and specialist services to meets their complex needs	Changed funding and supplements: A new supplement in residential care (in line with the tightly defined eligibility criteria of the Homelessness Supplement) would recognise this group and address the inequalities they face. Where specialist services are unavailable for severely disadvantaged clients, changes to aged care funding must support mainstream services with these clients to provide appropriate care
Capacity	As a result of the behaviours of this cohort, service providers need a greater risk tolerance than the generalist providers, focusing on harm minimisation (rather than risk avoidance), behavioural support and other social programs	Support for specialist services: Assessors need to be authorised to accept harm minimisation in accreditation and quality reviews, and further education and guidance is needed for the assessment workforce to understand the special considerations of providing services to people experiencing deep and persistent disadvantage