Submission to the Royal Commission into Aged Care Quality and Safety

September 2019

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Introduction

Sacred Heart Mission applauds the Commonwealth Government on the undertaking of the Royal Commission into Aged Care Quality and Safety. We urge the Royal Commission to recognise the specific needs of ageing people with histories of homelessness and trauma, break down barriers to access to the aged care services system, and consider how best to provide specialist aged care services for those who require it.

Our submission will focus on how the aged care system can be improved to meet the needs of people who have experienced homelessness and chronic disadvantage, and highlight our experience delivering best practice and innovative models for people who have complex needs.

Recommendations to the Royal Commission

Recommendation 1: That a significant focus is placed on ensuring access to safe, affordable long-term housing using the Housing First principles, and significant national investment into housing supply, with growth targets to prevent and reduce homelessness now and into the future.

Recommendation 2: That the Assistance with Care and Housing (ACH) program be maintained and expanded so that people over 50 at risk of or experiencing homelessness have access and can sustain affordable, safe and long term-housing and support, to prevent early entry into residential aged care.

Recommendation 3: Improve the links between the NDIS and My Aged Care and remove requirements that someone under the age of 65 must be proven ineligible for the NDIS prior to referral to My Aged Care.

Recommendation 4: That ACAS services become more flexible to recognise when individuals require aged care services as a result of complex factors such as homelessness, with a consistent approach across regions.

Recommendation 5: That state-funded programs, such as Home and Community Care – Program for Younger People (HACC PYP), are continued to maintain functionality and support particularly for people with age-related conditions or premature ageing who are under the age of 65.

Recommendation 6: That Trauma-Informed Care training be implemented in aged care services, who support clients with complex needs, for client-facing and administrative staff.

Recommendation 7: That consideration is made to developing safe and appropriate specialist care models for older people who have problematic issues with alcohol and other drugs, to assist them to reduce their substance use, in both residential and community settings.

Recommendation 8: That aged care services adopt a harm minimisation approach to alcohol and other drugs, and support clients to maintain autonomy as they age.

Recommendation 9: That amendments are made to security of tenure provisions within the *Aged Care Act 1997* that balance resident and staff safety with the ability for providers to exit residents who are causing severe harm to others into other supported residential settings.

Recommendation 10: That all staff who work with older people are trained in recognising and addressing poor mental health and wellbeing.

Recommendation 11: That residential care settings must provide active and appropriate lifestyle and social inclusion activities to support mental health and wellbeing.

Recommendation 12: That aged care services embed inclusive practices within their organisations that recognise the diverse characteristics and life experiences of older Australians.

Recommendation 13: That consideration is made into investment for supported accommodation facilities that provide care placements for older people with complex mental illness who require ongoing support.

Organisational Background

Sacred Heart Mission (SHM) has been delivering services and programs for people experiencing long-term disadvantage and exclusion for over 35 years. SHM is committed to programs that build people's strengths, capabilities and confidence to participate fully in community life. This is strongly reflected in SHM's Service Model which emphasises the development of innovative programs that facilitate social and economic participation so that individuals can develop independence and ultimately achieve their potential.

Every day about 400 people attend SHM's two engagement hubs. A significant majority of those people experience long-term homelessness and are living with acute mental health issues. Many of these people are aged or are ageing prematurely due to their entrenched disadvantage over many years. As a result, SHM has developed a structured and effective assertive engagement approach to build relationships with people who are excluded from mainstream and specialist services and isolated from the broader community. A persistent, patient and proactive approach is the cornerstone of SHM's practice expertise. SHM further developed this approach to incorporate a therapeutic practice framework that focuses on acknowledging underlying trauma and an emphasis on building social connections away from the homeless subculture.

Today we are one of Victoria's leading agencies working with people who are experiencing deep, persistent disadvantage and social exclusion, particularly people experiencing long term homelessness. SHM provides a broad range of services to adults and older adults, many of whom are aged over 50 and have aged prematurely compared to their chronological age. These fall into three main areas of service delivery, with our programs that have a stronger focus on ageing clients highlighted.

Engagement Hubs include Sacred Heart Central and the Women's House which provide a safe space that is welcoming and supportive. The engagement hubs provide access to the necessities of life - healthy food, a shower, laundry facilities and medical assistance through our GP clinic. The hubs also facilitate access to our case management services and referral to specialist services.

Individualised Planned Support incorporates outcomes focused; time-limited case management responses tailored to the individual. In many cases this will involve resolving a crisis situation, such as addressing immediate homelessness and improving safety and wellbeing. Case Management services are provided at Sacred Heart Central, Women's House, Homefront and thorough the Wellbeing and Activities Program. Intensive Case Management is provided through the Women's House, GreenLight Supportive Housing Program and the Journey to Social Inclusion (J2SI) program.

Ongoing Support provides specialist service responses for vulnerable members of the community, many of whom require a high level of support for an indefinite period. This includes:

- **Sacred Heart Local** – in-home support program delivering Home Care Packages (HCPs) and the Commonwealth Home Support Program (CHSP), to approximately 170 clients, as well as being an NDIS provider.
- **Rooming House Plus Program** – self-contained and long-term supported accommodation for 67 single adults with on-site support services available, including case management, a social inclusion program, and additional supports such as cleaning, meals provision and medication management. Building a sense of community is central to RHPP and residents are strongly supported through the social inclusion program to be involved in activities in the broader community.

- **Bethlehem Community** – Medium to long-term independent accommodation for women with case management support and social inclusion activities. Outreach support is provided to women in community housing, as well as former residents now in private rental. Located in Reservoir and Thomastown.
- **Sacred Heart Community** – a home for people with histories of homelessness, mental illness and disadvantage who require 24-hour care and support as they age. The complexities associated with these histories require a very different approach to mainstream residential aged care service provision.

These program models are described in further detail later in the submission. For more information about SHM, please see our website – www.sacredheartmission.org.

Need for affordable housing across Australia

It is well established that homelessness in Australia is increasing and will continue to do so without significant investment in social and affordable housing nation-wide. Homelessness is a complex issue and affects people across all age brackets within society. At SHM, it is clear that a lack of investment in public housing for many decades, and complex pathways for community members to navigate between various systems – such as mental health, justice, hospitals and income support, means that people are falling through the gaps into homelessness, including aged people. Homelessness also contributes to premature ageing and increased health needs, which increases the pressure on the aged care and health systems, that we know are growing with an ageing population.

Embedded in SHM's models of service delivery are the Housing First principles - a recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent or supported, permanent housing. It is accompanied by the provision of tailored and individualised supports. Though housing is not a primary focus of the Royal Commission, it is important to recognise that the issues discussed in this submission can be prevented into the future with significant national investment into housing supply, with growth targets, and the use of Housing First principles when responding to homelessness.

Recommendation 1: That a significant focus is placed on ensuring access to safe, affordable long-term housing using the Housing First principles, and significant national investment into housing supply, with growth targets to prevent and reduce homelessness now and into the future.

Discussion – Ageing, Aged Care and Homelessness

At SHM, we work with adults across the life course; many of our clients are aged or are ageing. It is important to recognise that extensive periods of homelessness, will result in the majority of people we see having experienced significant trauma, and present with significant health vulnerabilities, emotional, and psychological needs far greater than the average ageing Australian. We work with people who experience a range of complex issues such as:

- Histories of homelessness
- Histories of significant trauma exposure

- Experience of family violence
- Involvement in the justice system
- Social exclusion, living alone with no family network or limited informal supports
- Long-term unemployment
- Chronic health conditions
- Substance dependence
- Mental health illness and psychosocial conditions (e.g. hoarding, anxiety)
- Physical and intellectual disability including Acquired Brain Injury (ABI).

Premature ageing and homelessness

SHM works with people who have experienced chronic homelessness, which has significant impacts, particularly premature ageing. As a result of many years of rough sleeping and tenuous accommodation, people are prematurely aged as result of living a life without their core needs of health and safe and secure housing being met for extensive periods of time. Many also have significant health vulnerabilities, chronic conditions, as a result of a lack of intervention or mismanagement over an extensive period (such as diabetes, heart problems, and liver disease caused by long-term alcohol misuse). In addition, years of isolation and sleeping rough can make it difficult for older people to trust professional staff.

A program that recognises these challenges is the ACH program, funded by the Commonwealth Government. This program arose through the recognition that people who are prematurely aged due to homelessness have different needs that cannot be met by mainstream services, as they are below the age qualification for entry into aged care services, which is generally 65 years.

SHM receives ACH program funding to provide targeted advocacy and support to women and men aged 50 and over who come to our Engagement Hubs. ACH staff support people by linking them into services they require, be they health or housing related. Some ACH clients can live independently with assistance, but for this to occur there must be appropriate, affordable, safe and available housing which is frequently not the case, with growing waiting lists for social housing and lack of affordable supply in the private rental market. As a result, people are forced into sub-standard boarding or rooming houses and other insecure or inappropriate housing options that do not meet their needs. This shortfall in housing supply is likely to continue to be an issue for older people into the future unless there is a national strategy and growth targets for significant investment.

Recommendation 2: That the Assistance with Care and Housing (ACH) program be maintained and expanded so that people over 50 at risk of or experiencing homelessness have access and can sustain affordable, safe and long term-housing and support, to prevent early entry into residential aged care.

Challenges with age qualifications in accessing aged care services

In our experience, the legislated minimum age of 65 to access mainstream aged care services is not reflective of the complex needs of people who have experienced homelessness. For people in these circumstances, being accepted into ‘aged care’ is

complex and challenging, with clients needing to prove that they have exhausted all other avenues of support (such as the disability support system) prior to being considered eligible for aged care services. Staff across a number of SHM programs have indicated that since the introduction of My Aged Care and the NDIS, it has become much more difficult for someone under the age of 65 to access a Home Care Package, even if there is demonstrable need and evidence to support this.

In theory, the introduction of the NDIS should mean that entry into aged care can be delayed for people with a permanent and significant disability, where previously aged care services were accessed early due to a severe lack of alternative options. However, this does not recognise that premature ageing, and age-related conditions are not always the result of a disability, or that that disability may not meet the NDIS requirements of '*permanent and significant'*. There are persistent concerns about access to appropriate support for clients who are ageing and have age related conditions but do not meet the eligibility criteria for the NDIS. In these situations, people are stuck between two national funding models, unable to navigate either system, leaving them at risk of falling through the system gaps.

In our experience, referrals to My Aged Care for people under the age of 65 will not be accepted unless the person has already been deemed ineligible for the NDIS and a letter to this effect is submitted with the My Aged Care referral. This means that individuals may be without essential support for extensive periods while this is occurring, and their needs are not being met. It is also disempowering for clients to be told they must apply for the NDIS when they do not meet the eligibility criteria, prior to being able to access aged care services.

The links between the NDIS and My Aged Care need to be improved in reducing barriers for people under 65 with complex needs to access the most appropriate support for their situations, regardless of age. It is essential that people are not left without support due to the complexities of funding systems that do not liaise with each other.

It is evident from discussions across the community services sector that organisations and consumers are struggling with the application processes for My Aged Care more broadly. Organisations like SHM who specifically work with marginalised populations are particularly concerned by this issue, due to the inability and capacity to self-advocate and navigate this complex system.

As previously mentioned, the people SHM supports have histories of complex trauma and homelessness, are socially isolated, have minimal financial resources and have very limited ability to self-advocate. Therefore, we need to provide significant support to people to complete applications and when required to appeal decisions in order to ensure people get access services. Much of this work is unfunded, and staff have found this process extremely frustrating, and an unproductive use of time and energy that could be better used to provide direct client support.

Recommendation 3: Improve the links between the NDIS and My Aged Care and remove requirements that someone under the age of 65 must be proven ineligible for the NDIS prior to referral to My Aged Care.

An added barrier to services is the responsiveness of the Aged Care Assessment Service (ACAS) to our client cohort, which varies across the different regions that SHM operates. We

seek to build strong relationships with all ACAS services, but we have had very different experiences in obtaining assessments for people under the age of 65. The ACAS that operates within northern Melbourne where our Bethlehem Community service is located, is extremely reluctant to undertake assessments for anyone under the age of 65 and requires an overwhelming amount of evidence is required prior to their willingness to undertake the assessment.

However, in contrast, the ACAS that services clients living in and around our main site of St Kilda is more flexible for our client cohort and recognises where the need for support is due to ageing, even if they are under 65, and is willing to provide an Aged Care Assessment in this context. This enables us to provide suitable care for our clients, whether that be an HCP, CHSP support or 24-hour residential care as appropriate.

Recommendation 4: That ACAS services become more flexible to recognise when individuals require aged care services as a result of complex factors such as homelessness, with a consistent approach across regions.

The Home and Community Care – Program for Younger People (HACC PYP) model, funded by the Victorian Department of Health and Human Services is a program that provides daily living supports to people under 65 (or 50 if they are Aboriginal or Torres Strait Islander), who are not eligible for the NDIS. HACC PYP is an important program for the targeted cohort, as it fills the service gap for people who require daily living supports but are not eligible for aged care or the NDIS.

However, due to the national aged care and disability reforms that have occurred over several years, this program has faced funding uncertainty, adding to the complexity for providers and clients and meaning that it is unclear how to access supports under HACC PYP. In this context, we support endeavours to strengthen and improve the program and ensure it is effectively targeted. We would not support a recommendation by the Commission that HACC PYP (and comparable programs that exist in other states) should be decommissioned.

Recommendation 5: That state-funded programs, such as Home and Community Care – Program for Younger People (HACC PYP), are continued to maintain functionality and support particularly for people with age-related conditions or premature ageing who are under the age of 65.

Impact of trauma on homelessness, ageing and mental illness

At SHM, we work with people whose capacity to participate fully in community life is affected by trauma, deep, persistent disadvantage and social exclusion. Trauma can be both a cause and consequence of homelessness. Between 91% to 100% of people experiencing homelessness had experienced at least one major trauma in their lives.[1] In comparison, only 57% of the general population have experienced at least one major trauma in their lives.[2]

[1] O'Donnell, M, Varker, T & Phelps, A (2012). *Literature Review: The Nature of the Relationship between Traumatic Events in People's Lives and Homelessness*. Australian Centre for Posttraumatic Mental Health, University of Melbourne.
[2] Ibid.

People experiencing homelessness also had higher rates of exposure to trauma in childhood, in comparison to the general population.[3] For example, almost all evaluation participants in SHM's Journey to Social Inclusion (J2SI) pilot program (87%) had experienced childhood trauma in one form or another, and the average age which they first experienced a traumatic event was just under 13 years of age.[4]

Trauma can have long-lasting effects on all aspects of someone's life, including how someone thinks, feels and behaves. Trauma increases the chance of anxiety, depression, substance misuse, employment problems and suicide. The symptoms of trauma may include poor impulse control, anxiety, anger, depression or substance use. A trauma survivor may need the ongoing support of mental health professionals and medication.

Trauma, homelessness and mental illness are intrinsically linked - the majority of people who experience homelessness also experience at least one psychiatric disorder, and the prevalence of these disorders is much higher than in the broader community.[5] There is also evidence that some people become mentally ill as a result of experiencing chronic homelessness. Repeated exposure to trauma while homeless and its long-term impacts cannot be understated, and these are felt across the life-course as people age. Furthermore, people with histories of trauma and mental illness are often at increased risk for losing housing or never gaining adequate stable housing. This is the vicious cycle of trauma, homelessness and mental illness that SHM sees every day. The cycle can be broken with time, community and professional support, and stable housing.

SHM is a trauma-informed organisation, which means that all aspects of service delivery are organised around the recognition and acknowledgement of trauma and its prevalence. At a minimum, trauma-informed care services aim to provide an increased sense of safety and strive to avoid any re-traumatisation of their clients. We do this by building strong relationships with our clients, as well as establishing boundaries and role expectations. All SHM staff engage in trauma-informed care training to ensure it is embedded into our practice. This is also important for staff who do not work with clients directly – as it builds an understanding of why we do what we do, and of cohesion across the Mission, so all staff are working towards the same goals and outcomes, even within different aspects of the organisation.

In the 21st century, there is far greater knowledge and understanding of the importance of positive mental health and wellbeing than in previous decades. We live in an era where obtaining professional support, practicing self-care and talking about challenges faced are becoming normalised, but this is not something many older people are used to as this was largely frowned upon in the past. As a result, many older people have never received support for mental health, grief, loss and so on, and have carried trauma with them throughout their lives. It is important to recognise this when working with ageing clients.

Recommendation 6: That Trauma-Informed Care training be implemented in aged care services, who support clients with complex needs, for client-facing and administrative staff.

[3] Ibid.
[4] Johnson, G, Parkinson, S, Tseng, Y & Kuehnle, D (2011), *Long-term homelessness: Understanding the challenge - 12 months outcomes from the Journey to Social Inclusion pilot program*. Sacred Heart Mission, St Kilda.
[5] O'Donnell et al. 2012.

Harm minimisation, substance dependence and aged care

For people who are ageing while actively misusing alcohol and other drugs – illicit or prescription – there are additional layers in accessing aged care services, particularly residential aged care. Many people who access drug and alcohol treatment, such as maintenance opioid substitution therapy (i.e.: methadone), are ageing and are experiencing age-related health problems for the first time (Australian Institute of Health and Wellbeing, 2014).

Most aged care services are not specialised in managing substance use issues. Similarly, drug and alcohol services have not previously been expected to manage age related health problems due to the overall younger age of clients. This means that older people can fall through the gaps (NSW Health 2015). For people who are socially isolated and not engaged with services, they may consume alcohol or substances in their homes without causing a disturbance and are not easily identifiable as being at risk. Although falls and other accidents do occur and cause emergency presentations for this group, the cause is often attributed to age and impaired mobility, rather than impairment from drug or alcohol use and goes unnoticed (NSW Health 2015).

There is a growing need for appropriate supported accommodation and support options for older people with substance use issues that is not currently being well addressed (NSW Health 2015). For older people who cannot live independently, they may require higher level care in a residential setting, but most aged care facilities simply cannot accommodate people who experience addiction, and as such, they are likely to be turned away from most services.

Recommendation 7: That consideration is made to developing safe and appropriate specialist care models for older people who have problematic issues with alcohol and other drugs, to assist them to reduce their substance use, in both residential and community settings.

Many SHM clients have a long history of alcohol and drug misuse and substance dependence, which often contributes to their increased medical needs (such as cirrhosis of the liver, alcoholic dementia, increased risk of cancers etc). Problematic alcohol and drug use can be both a cause and a consequence of the experience of homelessness, and is frequently linked to trauma, as these substances can be used as an outlet to manage the impact of trauma.

At SHM, we generally operate using the harm minimisation approach, which is important when supporting people who misuse substances. It is more effective and empowering to support people to reduce or minimise use, and regain control, rather than expecting they will be able to abstain completely, and to be able to do so in a non-judgemental way. For our ageing clients, substance misuse is often a long-term pattern of behaviour influenced by trauma. We assist people to live a comfortable life, build social inclusion and respect their choices and decisions.

We cannot control what occurs outside of our properties, and do not place controlled measures on a client's private space, as this is infantilising to our clients. Rather, we focus on managing risks for the safety of our client group within the shared spaces in our facilities. For example, residents of Sacred Heart Community are not permitted to be drunk in public areas but can drink in their private rooms if they wish. We also hold a "Happy Hour" in the

communal area, once a week. This approach means that residents maintain the autonomy to consume alcohol, while balancing their own safety and that of others.

Recommendation 8: That aged care services adopt a harm minimisation approach to alcohol and other drugs, and support clients to maintain autonomy as they age.

However, we have found that we are unable to effectively support people who are active users of illicit drugs, particularly crystal methamphetamine (ice). Heavy and frequent use of ice can lead to hallucinations and aggressive or violent behaviour, which has significant negative impacts on other residents, staff and visitors. There is a need for specialised aged care services for people who are ageing with substance dependence, as this small but significant and growing cohort needs a safe place to live where their needs can be met.

Security of tenure provisions under the Aged Care Act 1997

The security of tenure provisions found in the *Aged Care Act 1997* are intended to provide aged care residents with high levels of certainty over their care and restricts the ability for a provider to ask a resident to leave their care, with few exceptions. Though this legislation has been designed to protect residents, in our experience it is too restrictive for providers in managing difficult situations that do arise with regards to harmful behaviour of residents.

As an aged care provider, we are obliged to act reasonably in the provision of a safe and secure environment for our residents and our employees, as well as providing appropriate levels of care for our residents. For example, in extreme situations we have been forced to discharge residents who were consuming substances, mainly ice and alcohol, that caused aggressive and violent behaviour. These types of issues cause huge disruption to the operation of the service and risk the safety of all parties – residents, staff and visitors.

The *Aged Care Act 1997* also states that *even if* there are grounds to provide a resident with 14-day notice to vacate, providers are unable to force a resident to leave "until suitable alternative accommodation is available that meets [the care recipient's] long-term needs." Though we attempt to find residents an alternative home, this is almost impossible – it is highly unlikely that another aged care provider will agree to take on someone in these circumstances who has extremely difficult behaviours, let alone be able to manage them.

As SHM provides specialist care at Sacred Heart Community, we recognise that the situations we experience are markedly different to what happens in other residential aged care settings. Most of our residents are with us because there is nowhere else they can safely live in the first place, particularly if they are under the age of 65. They have come from periods of rough sleeping or insecure accommodation, rooming houses, psychiatric wards and so on. Many are also under state guardianship and have no family for us to discharge them to – and we cannot discharge someone into homelessness. This puts providers in an extremely difficult situation where there are no good solutions – exiting residents is a last resort, but we cannot have people in our care who are behaving in a way that causes significant harms to others. The *Aged Care Act 1997* does not provide adequate measures to deal with these unique situations.

Recommendation 9: That amendments are made to security of tenure provisions within the *Aged Care Act 1997* that balance resident and staff safety with the ability for providers to exit residents who are causing severe harm to others into other supported residential settings.

Importance of social inclusion for ageing communities

As Australians are living longer, it is essential that our society supports older Australians in healthy ageing, and to remain included in their communities. As a result of the ageing process and physical and emotional changes that occur, older people risk becoming socially excluded from their communities and a reduction in their health and wellbeing.

We have recognised that our Sacred Heart Local clients who live in their own homes can be socially isolated and need assistance with everyday tasks, such as changing a light bulb or watering their plants or need someone to check in on them and provide a friendly face that is important for mental health and wellbeing and to maintain social connections. In response, we developed the "Five Minute Volunteer" program, which is extremely flexible and provides volunteering opportunities for people who cannot commit to longer or regular shifts that drive the success of our Meals Program and Op-Shops. Volunteers visit or telephone their clients regularly and engage in activities together that they both enjoy – and this is a beneficial experience for the clients and the volunteers. One of our volunteers commented on their relationship with their client:

> *"I believe we genuinely enjoy each other's company. We have a lot of shared interests and I learn something new each visit – a true education for me."*

This program is currently funded through philanthropic funding, and previously by local government. With this flexible model, more people can access volunteering opportunities, and we can support people who are socially isolated as they age; but are not necessarily in receipt of formal Commonwealth aged care funding.

It is essential that older people are supported to live fulfilling lives in their communities as they age, and activities should be adapted to meet the needs of reduced functionality. Resilience and strong support networks, as well as appropriate care settings, are essential to manage and address poor wellbeing for older people.

There must be a recognition within aged care services that being confronted with the need to adapt in this way (which may occur quite suddenly, such as after a fall or illness, or over a longer period) is extremely challenging. Many older people do not want to accept in-home support, or to move to residential aged care as they see this as a loss of independence. Many struggle to adjust to their lives in a new place or with new supports in place. For a person who recognises that they are unable to care for a partner or other family member anymore, this is also confronting, and people in this position often feel a sense of grief, loss and guilt, and that they are 'abandoning' their loved ones.

Such circumstances often lead to poor health and wellbeing, for both people in receipt of aged care and carers. It is important that direct and indirect staff working in aged care are trained in understanding and recognising this and intervene when appropriate to prevent poor outcomes for their clients. For example, services can offer formal counselling and emotional supports to service users (the aged person and their loved ones) and provide social inclusion activities so that connection to community is maintained and supported.

Recommendation 10: That all staff who work with older people are trained in recognising and addressing poor mental health and wellbeing.

At SHM, our ageing clients have experienced extreme social exclusion and economic disadvantage for extensive periods of time. Most of our clients live with complex mental illness, which is still highly stigmatised within society. In order to address these issues for our clients, SHM delivers social inclusion activities to complement existing formalised case management services and enhance outcomes for the individuals.

At RHPP and Sacred Heart Community, we employ Social Inclusion/Lifestyle Coordinators, who have developed evolving social inclusion programs that residents can participate in, to the extent they desire. The lifestyle programs have been developed with input from residents and are reflective of their interests.

Examples of social inclusion activities include:

- Monthly calendars and community meetings, special events and discussion groups
- Bus outings/walking – to cafes, market, public library etc.
- Visits from medical professionals, health and wellbeing sessions, nutrition, ability to use the on-site gym (RHPP), cycling and walking group activities, laughter yoga, mindfulness.
- Learning about gardening and setting up an aquarium (RHPP), animal therapy (Sacred Heart Community)
- Art therapy (including opportunities to show work at external exhibitions), creative writing, storytelling, knitting circle.
- Music group (which performs at SHM events), drama group, sing-a-longs, piano concerts
- Film/television show screenings, table games, quizzes, active games,
- Education and training – cooking, computer courses, barista training, English as a Second Language, managing mental illness. Some residents have been supported to undertake vocational or tertiary courses
- Support for residents to obtain paid employment and volunteer work
- Life skills training – travel, managing tax affairs, voting, accessing Centrelink
- Access to the Community Visitors Scheme that supports volunteer visits, providing friendship and companionship to older people
- Attending mass at Sacred Heart Church
- Special events and celebrations – Christmas, Easter, NAIDOC Week, etc.

These activities recognise the importance of social connections, physical activity and mental health and wellbeing, particularly for those experiencing extreme disadvantage. Residents are supported to attend wider community activities in line with their personal goals, and build their independence, social networks and resilience, and prevents or reduces the severity of periods of mental ill-health.

Recommendation 11: That residential care settings must provide active and appropriate lifestyle and social inclusion activities to support mental health and wellbeing.

Diversity and inclusion in aged care services

The Aged Care Diversity Framework that was released in 2017 was a positive step in building inclusive aged care services. As a service provider, we continue to evaluate our practice to ensure we are an inclusive organisation. We support the use of the Action Plans that were developed under the Aged Care Diversity Framework for the following groups, to address specific barriers and challenges faced by:

- Aboriginal and Torres Strait Islander communities
- Lesbian, Gay, Bisexual, Trans* and Intersex (LGBTI) communities
- Culturally and linguistically diverse (CALD) communities

The Diversity Framework and Action Plans recognise that some older people and their carers face additional barriers and challenges in accessing aged care services as a result of being part of a group or multiple groups that have exclusion, discrimination and stigma during their lives.

In particular, the Aged Care system currently supports Aboriginal and Torres Strait Islander Australians to access aged care services over the age of 50. This recognises the life expectancy gaps between Aboriginal and Torres Strait Islander Australians and the general population of Australia that are still profound despite efforts to address them. As such, it is essential that the Aged Care system continues to support Aboriginal and Torres Strait Islander Australians from a younger age, and this should be maintained alongside efforts to reduce life expectancy and health gaps.

People experiencing, or at risk of homelessness who are also members of one or more of these groups are further marginalised by their experiences and require appropriate and inclusive responses. At SHM, we have a number of 'working groups' that undertake projects and activities to build diversity and inclusive practice within the organisation. The work on diversity in aged care that has been undertaken by the Commonwealth is crucial in ensuring that all older people experience a high quality and equitable aged care system. The existing frameworks should be strengthened, evaluated and improved over time, and be embedded within aged care services.

Recommendation 12: That aged care services embed inclusive practices within their organisations that recognise the diverse characteristics and life experiences of older Australians.

Support models and case studies of SHM programs

At SHM, we support people to recover from trauma and support their recovery journey – no matter where they are in the process. SHM has a long history of supporting people who are ageing with complex needs, including chronic and degenerative illnesses, mental illness and psychosocial disability, as well as chronic homelessness and disadvantage. This section includes detailed descriptions of our programs and support models.

The Rooming House Plus Program (RHPP)

The people who live at RHPP have a range of complex needs including mental illness, substance use, and histories of long-term homelessness and trauma. Of the 67 current residents at RHPP:

- The oldest resident is 75, and the youngest is 28
- 8 residents are aged over 65 years (12%), with a further 24 residents (36%) aged between 50 and 60 years old

Of the 8 residents aged over 65 years, one resident is approved for the CHSP, and 3 have approved HCPs, but only two are using their HCP at present. Of the remaining four residents aged over 65, RHPP staff believe three out of four would benefit from an ACAS assessment. Unfortunately, the residents themselves are highly resistant to this process, mainly due to their experiences of trauma, mental illness and a lack of trust in professional staff. RHPP has also encouraged some residents to consider relocating to Sacred Heart Community, our residential aged care property, as they can receive more appropriate care for their needs. Two former RHPP residents have successfully relocated to Sacred Heart Community. One of our success stories is Frank*, whose story is included as a case study below:

Client Case Study – Frank[6]

Frank is 71 and came to Sacred Heart Community in 2014. After a successful career as a radio announcer, he became isolated and depressed after the death of both of his parents. He had no other living siblings. He soon found himself homeless.

He said: 'I was at Queens Road [RHPP] for about eight years, but the majority of the people there are much younger than me. At the other rooming houses I'd lived in, there was drug use and violence. I was not well, so my friend Rob* got me into Queens Rd.'

But Frank struggled at Queens Rd as his care needs increased. He became severely depressed and could no longer physically take care of himself. He was admitted to Baringa by the Alfred Hospital's Community Psychiatry team. Through his friend, Rob, as well as our Parish Priest and other SHM staff at Queen's Road, it was suggested that he might like to move to Sacred Heart Community. He arrived at Sacred Heart Community very frail and thin. He couldn't shower, dress or eat and, according to the Manager at Sacred Heart Community, was a very sad man.

Frank said, 'When I used to stay in my room, I was very depressed. Now I'm up and about and get involved in everything. There are lots of things to look forward to. Every Tuesday we have an excursion. I've made new friends; I go to the Vineyard Café each week. I enjoy the mind and body program and the quizzes. I love the sing-alongs. I love reading, especially non-fiction books on WW1 and WW2 and biographies. Dickens is one of my favourites. We go down to the St Kilda library every week and I take out new books.

I love staying here. I feel secure. I'm not worrying. I feel like it's home. The staff here genuinely care. They are very gentle and kind and love their work. I could go and talk to them anytime.'

However, many RHPP residents are unwilling to move to Sacred Heart Community, as they do not want to leave their homes and their communities, are concerned about not feeling welcomed and feel this would lead to a loss of independence. For those who do not accept formal assistance through an HCP or CHSP there is an increased risk of falls and hospitalisations, and inability to live independently. However, people's dignity, choice and control are of utmost importance, and it is inappropriate and unfair to force them to relocate

[6] Trifiletti, G (2017). My Community My Way (internal document), Sacred Heart Mission, St Kilda.

or receive in-home support against their wishes. In these situations, we do our best to support residents to remain independent as best we can and respect their decisions to live their lives the way they want to, including as they age.

Sacred Heart Community - Residential “aged care” for people with complex needs

SHM operates Sacred Heart Community, a home for people with histories of homelessness and disadvantage who require 24-hour care and support as they age. The program is funded as residential aged care, yet our resident profile is markedly different from that of mainstream residential aged care facilities, in that:

- 95% of our residents have a history of homelessness
- We have 68% men in our community, almost the opposite to the general aged care population where women make up 70%
- Nearly 75% of our residents are under 72 years of age on admission
- 10% are over 80 years old (compared to 80% in the general aged care population)
- 25% are younger than 64 years old, in comparison to 1 in 25 aged under 65 in the general population
- Our residents’ average length of stay is 6.2 years, more than twice the average of general aged care (2.7 years).
- Our residents have almost twice the number of diagnosed mental health conditions per resident than the combined Victorian data (1.9 compared to 1 incident per resident)
- Significantly less occurrences of developing dementia (17% vs 51% in the Victorian data)
- 14 times the occurrence of psychoses (42% vs 3%), and
- 66 times the occurrence of other mental and behavioural presentations (66% vs 1%).[7]

The model of care at Sacred Heart Community is unique and recognises that our residents are different to other ageing people, due to their experiences of homelessness and long-term disadvantage. Key features of our model are highlighted below:

Pre-admission interview

All prospective residents are interviewed prior to entry into the program, to ensure that they understand what it will be like for them, and to ensure that they will fit in to the existing community and be happy living in a structured environment (for example, sharing mealtimes with other residents). We also conduct comprehensive trauma assessments to ensure that we have a deep understanding of what each person has been through and can respond to their needs. Prospective residents are encouraged to ‘come and try’ living at Sacred Heart Community (which may or may not be as part of a formal respite arrangement) and can decide not to stay with us if they do not feel it is for them.

Emotional Support Therapist role

We employ an Emotional Support Therapist, who offers a safe and supportive space for residents to open up and tell their stories over a period of time. As a response to trauma and fragmentation within their lives, many residents have learned to ‘shut down’ emotionally to protect themselves from further harm and mask their lack of confidence and self-esteem. Residents have identified that it is extremely empowering to have the opportunity to tell their stories, and for many it is the first time they have felt safe enough to do this.

[7] Ibid.

Workforce

The staff at Sacred Heart Community receive significant internal training to support them in their roles. We employ experienced Registered Nurses, as well as Enrolled Nurses and Personal Care Attendants (PCAs). All our staff come to us as experienced professionals, as the challenges they face in working in the environment and with our residents requires skills gained through experience. We further train and support our staff to work with people who have experienced significant trauma, and coordinate responses collectively to support residents, and manage challenging behaviours in a respectful way. Other roles include our Lifestyle Coordinator and Assistants, who develop and manage our comprehensive lifestyle and social inclusion program for residents.

End of life care

We focus on creating a 'home for life', which means that residents live at Sacred Heart Community can remain with us for the remainder of their lives. We provide end of life care, including in-home palliative care, pastoral care and emotional supports to residents who are nearing the end of their lives. We support our staff, residents and volunteers before, during and after there is a death within the community. Many of our residents do not have biological families or have been estranged from them for many years. The Parish Priest and Pastoral Care Worker assists families and ensures that each resident is celebrated with an inclusive, loving service at the end of their life based on their wishes (for example, a religious or secular celebration). Part of this process is the memorial quilt, made using cloth handprints of residents and staff, which is placed over the coffin during the service. The quilt hangs within the home, as a reminder of the community environment. An annual memorial service is also held for previous residents who have passed away, which is an emotional, but meaningful and respectful occasion of remembrance. Our resident Frank* summed this up well:

> *"You can spend the rest of your life here. You won't die alone, and you will be surrounded by loving people"*

We received the Palliative Care Award from Bethlehem Hospital in 2017, and a Better Practice Commendation Award in 2018 from the Aged Care Quality Agency, which highlight our success in providing holistic and trauma-informed care to our residents.

Experience with supporting residents with complex mental illness

Many 'mainstream' residential aged care facilities cannot accommodate people with complex mental illness. There are several factors that contribute to this, including, but not limited to:

- The need for greater time to work with residents and build trust with staff to achieve positive outcomes than is commonplace in most residential aged care
- Stigma around mental illness and associated behaviours, and how residents relate to each other
- Potential disruption for other residents when mental illness is not well managed, and how this is experienced in a community home environment
- Experience of staff in understanding and working with aged people who have mental illness

In contrast, Sacred Heart Community is an environment where older people with complex mental health needs can live a supported and fulfilling life and their health and wellbeing is well managed with support tailored specifically for their needs. One of our residents, William* is an example of someone who has thrived since moving to Sacred Heart Community:

Client Case Study - William[8]:

William* is 60 years old and has been at Sacred Heart Community for nearly three years. He developed severe schizophrenia in his late teens, following his discovery of his mother, a Holocaust survivor, who had suicided at home. He turned to alcohol and drugs and was admitted to many hospital psychiatric units, including locked wards.

Before moving to Sacred Heart Community, William struggled to live independently: he couldn't manage his personal hygiene and his schizophrenia medication. He had lived in various supported accommodation facilities and was at grave risk of becoming homeless. He had become floridly schizophrenic and mainstream aged care could not meet his needs.

His sister, Grace*, a doctor and his sole carer for many years looked desperately for somewhere for him to live. As Grace observes: 'The problem with defining care as 'Aged Care' is that someone like William doesn't fit into existing categories or services, despite being at great risk of homelessness, and having a much shorter life expectancy due to his illness."

Though initially William did not want to be at SHM, he is now very happy here and feels that it is his home. Grace is confident that William will live at Sacred Heart Community for the remainder of his life.

She says: "Before coming here, William's life was completely unstable. Now, he has a clean room, and clothes. He is safe, fed, his medication is administered to him and he doesn't go 'off the rails'. He's the most stable he's ever been. He's contented. He has meals in the common area and walks to the local shop. He is so different now. There is a contentment about him. He is not isolated. Now I know my brother is cared for."

Unfortunately, William's history of previous inappropriate placements prior to living at Sacred Heart Community is not unique. Some of our residents have received poor care for their mental health needs in the past, and others were previously refused care at other services due to their mental illness. In part, this is due to the significant and persistent stigma surrounding complex mental illness, and particularly of disorders that present with symptoms of psychosis. As such, there is a clear need for specialised services that support aged people with higher mental health needs, as well as other challenges. However, mainstream aged care services should seek to improve their practice in working with people who have complex mental illness, to ensure consumers have choice when it comes to deciding where they should live.

Recommendation 13: That consideration is made into investment for supported accommodation facilities that provide care placements for older people with complex mental illness who require ongoing support.

[8]Ibid.

Conclusion

Sacred Heart Mission is confident that the Royal Commission into Aged Care Quality and Safety will be able to recommend changes to the system that are transformative and will make significant improvements to the current aged care system for future generations of Australians. We urge the Royal Commission in its recommendations to highlight that long-term transformative change for Australia's ageing population will occur with significant and rapid investment in safe, affordable and appropriate housing. This will reduce the impact of premature ageing, chronic health conditions and mental illness within society and support people to age well into the future.

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*Note: All names have been changed.