Wintringham

Substance abuse among older homeless people: To break a continuing cycle.

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Currently Australia has a well developed aged care 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. Despite the richness of services available, 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 their needs. Relatively little is known about the incidence of alcoholism and substance misuse in older people, including misuse of over-the-counter medication. Although there is a general perception that this kind of abuse is uncommon in older generations, it is more likely that the incidence is hidden. While it has been well documented that alcohol use and misuse generally declines with age, the use of prescription and over-the-counter drugs increases in later life. The frequency and effects of substance abuse, particularly of illicit drugs among older people has not been thoroughly investigated. Changes in attitude in subsequent generations mean that alcohol consumption amongst older people, and possibly use of illicit drugs, is likely to increase as these groups age. We have already begun to see evidence of this change with survivors of heavy drug use from the 'flower' generation (the 1960s and 1970s) beginning to enter aged care services and presenting with a number of drug related ailments.

There are three major sources of ethical dilemma associated with the care and management of individuals with drug and alcohol related brain impairment (ARBI). The first involves the balancing and individual's right to autonomy with an acceptable level of protection for themselves and others[i]. 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 strategies especially for long-term drinkers with severe ARBI and associated health and behavioural issues. For these individuals withdrawal from drugs and alcohol can be a dangerous and sometimes life-threatening experience. In many ways the level of care required by people with ARBI and complex care needs is similar to those provided to elderly people living with dementia. Age-related dementia can be associated with varying levels of cognitive impairment and challenging behaviours which, at the extreme end of the spectrum, can result in the requirement of dementia-specific accommodation and facilities. These types of facilities could also suit the accommodative needs of people with other conditions such as long-term homelessness, those with acquired brain injury (ABI), ARBI and even sufferers of such conditions as Huntington Disease. All of these conditions can result in dementia-like symptoms and a complexity of behaviours and care

needs that require higher levels of support. However, due to strict eligibility criteria these people often end up in shelters or inappropriate accommodation settings.

When the absence of appropriate service supports necessitates premature admission into "mainstream" residential care and if that person is lucky enough to secure a place, often such a facility severely restricts their life choices resulting in an overlay of behaviours that further alienate the person from future community options. The behavioural characteristics commonly associated with alcohol related brain injury have been shown to differ from that of age-related dementias particularly with regard to social skills and social interactions resulting in a completely different set of complex care needs. When these needs are inappropriately addressed, a continuing cycle of escalating behavioural disturbance, evictions, restrictive interventions and frequently, premature death may result.

If a residential care placement is not found, very 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 then deemed capable of caring for themselves 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 the person's psyche and physical health.

The gap in the provision of specialised long-term supported accommodation for these people, particularly older homeless people with acquired brain injury resulting from alcohol related brain damage must be addressed in future policy and program development. Wintringham is a welfare company that provides aged care services specifically targeted at elderly homeless men and women (50 years and older) in Melbourne, and by the nature of its clients, goes some way to addressing this need; however, there still exists a need for a purpose-designed specialized 'model of residential care' specifically aimed at providing long-term care solutions for older people with more severe or advanced ABI and ARBI.

It is Wintringham's philosophy that (elderly) people with alcohol addictions or other substance abuse problems must be provided with the opportunity to live in comfortable housing in dignified surroundings. Clients of Wintringham are not prohibited from drinking in or at the premises. While Wintringham staff will certainly facilitate the pursuit of treatment options, this is not necessarily our aim. The Wintringham rationale is simple – to afford each individual the right to live their final years with dignity and respect. In order to facilitate this we provide homeless people with alcohol-related problems with a pleasant and non-punitive home environment in which to live. These people would otherwise be living on the streets or in hostel-type accommodation where abstinence from alcohol is mandatory. Our aim is not focussed on 'recovery' per se, but rather on strategies designed to manage levels of consumption within parameters of safety while still maintaining the individual's freedom of choice. This approach is somewhat aberrant in the fields of aged care and homelessness[ii].

A recent review of international literature reveals that, the United Kingdom, Canada and United States, have produced some documentation reporting on residential aged-care service delivery models for older people with a history of homelessness and/or ABI[iii]. However when it comes to the care of individuals with severe, or advanced ABI, reports originating from these countries acknowledge a general lack of specialized long-term care options. Scotland is among a few countries that have begun to initiate projects designed to meet this need, however all are in the early stages of design and implementation. Currently in Australia, the care needs of these individuals have been serviced by a limited number of service providers in an adhoc, uncoordinated approach with varying and limited levels of success. There is no evidence of the existence of a purpose-designed long-term residential model of care for older sufferers of advanced ARBI in Australia. In the future, Wintringham, in collaboration with *arbias,* aims to investigate, design and trial a validated model of care incorporating intensive, specialized support services specifically directed at addressing this need and is currently in the process of attempting to secure funds to support this endeavor.

In a Government funded review of the aged care industry, Professor Warren Hogan observed that the elderly homeless population, albeit small, are one of the most difficult groups to place in residential care[iv]. 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 or managing alcohol and/or drug dependency and medical and dental issues[v]. It has been well documented that people who are homeless have higher rates of illness, drug dependence and injury than the general population. Homeless people are generally reluctant to seek treatment for health problems until a condition reaches the severity for 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 the necessary care support and appropriate 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 impairment.

In a study undertaken by Wintringham in 2003, 13% of 125 newly referred older homeless clients (aged over 50 years) reported having problems with illicit drugs. All respondents who reported drug issues were aged between 50-59 years, most of whom had not sought professional assistance for their addiction. Forty-three percent of the study's participants reported having issues with alcohol[vi]. Alcohol 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 class[vii]. 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 than the socially disadvantaged and that alcohol abuse among the older population is grossly under reported[viii,ix]. This may be due to such factors as a lack of acknowledgment or understanding 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, many people with ARBI experience premature aging and require additional support at ages younger than 65. They commonly have issues associated with 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.

Wintringham's philosophy is that our clients are primarily regarded as being 'aged' and only secondly as being 'homeless and financially disadvantaged' has had a huge bearing on our ability to attract funds to provide appropriate care and support to our clients. Although we work within the aged care system, we have always argued that we are a housing provider into which we deliver appropriate and individual aged care services. Wintringham's belief in providing its clients with an increased range of options has led us to continually widen the range of care and housing choices available to homeless people, leading to the recent opening of The Ron Conn Nursing Home. 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.

The specialised nature of Wintringham's work, has given us a great understanding of the special needs of those who are socially and financially disadvantaged, many of whom suffer alcohol-related brain damage, chronic illness or unresolved psychiatric issues. We believe that treating each person as an individual and planning care on this basis provides the best and most effective methods of meeting resident's physical and emotional support needs. With the support of *arbias*'s specialist services, individual alcohol and cigarette programs are developed to help residents manage these addictions. With future projections of significant increases in the aging population and no evidence of a decrease in the incidence of alcohol and drug abuse within the community, there will be an increasing demand on service providers to appropriately address the needs of older people with complex behavioural issues. Systemic change resulting in the development of policy and funding structures to support new strategies designed specifically to address this problem are desperately needed. We believe that we are one of a few providers who can meet the needs of older people with complex behavioural issues, particularly relating to alcohol abuse.

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