



VincentCare
Victoria

**RESPONSE TO THE PRODUCTIVITY
COMMISSION INQUIRY INTO CARING
FOR OLDER AUSTRALIANS
DRAFT REPORT**

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Executive Summary

VincentCare Victoria welcomes the report of the Productivity Commission into the needs of older Australians. This is an area of social policy and service provision which is in great need of comprehensive review, particularly in the light of projected future demand on the system. The recognition of special needs groups is welcome, as this will enable diverse needs to be reflected in the 'suite' of options for care in later life.

As an organisation with a primary concern for those who are experiencing disadvantage, we are not seeking to respond to the broader issues within the Productivity Commission Report. **This response focuses on the needs and situation of those who are, because of disadvantage, particularly homelessness, not adequately catered for in the current aged care system.**

VincentCare welcomes the proposal of the Commission to establish a more effectively targeted definition of social disadvantage. The anomaly created by pension eligibility resulting in being considered financially disadvantaged in the aged care system (and home ownership not being taken into account in determining pension eligibility), means that many who have the capacity to contribute to accommodation and care costs are considered financially disadvantaged. VincentCare supports the Commission's view that these arrangements 'crowd out' the targeting of subsidies for those in greatest need.

However, concern must be expressed that the largely market driven model proposed by the Commission is unlikely to meet the needs of very disadvantaged older Australians. The danger of market driven systems is that they may result in well-resourced and planned services for some sections of the aged population, while not catering for the socially and economically disadvantaged. **VincentCare therefore advocates for specific provisions – in policy, funding levels where necessary, ancillary supports, and service expertise – to meet the needs of the most disadvantaged and vulnerable people within the aged care system.**

As a service provider VincentCare is very concerned about levels of funding that do not take into account the needs of many of our disadvantaged residents related to difficult behavioural issues and / or a lack of informal support networks. These **inadequate levels of funding threaten the viability of facilities committed to the care of the most disadvantaged older Australians** (Noting that the previous system (RCS) provided higher levels of funding for complex needs), and may well limit the access of those with additional needs to other services as they are seen as 'too costly to care for'.

There is a need for the Aged care system to **encourage and support innovation so that models of housing and support provide socially inclusive care responsive to the additional needs of very disadvantaged older people.** To support this innovation and maintain a financially viable sector requires realistic capital and recurrent funding.

The ability of very disadvantaged older Australians to access the aged care system at an appropriate age is also a concern. Many of the VincentCare client group are prematurely aged as a result of the life experiences of homelessness, illness or substance abuse. As the overall system is under more pressure, these people are less able to obtain assessments and therefore access to the aged care system.

The Commission has proposed that after five years supply restriction in both residential and community care be removed to meet future demand. VincentCare would propose that the **restrictions on Community Care packages be lifted immediately** and that residential bed licences be increased gradually. While all Australians would benefit from immediate release of ongoing

pressure on the residential system (including on acute and rehabilitation hospital beds) more people would be able to stay in their homes, and a critical level of need can be met by the urgent expansion of Community Aged Care Packages targeted to disadvantaged older Australians.

The proposed Aged Care Gateway is potentially a more user friendly access point; however there are many issues which must be considered if it is to improve access for those with complex and additional needs. Will pathways be created between the Gateways and the homelessness, substance abuse and mental health service systems? Will assessments take account of complex and less visible needs? Will the Gateways create another bureaucracy for our client groups? – a particular concern as our client groups are generally reluctant to engage with bureaucracies and what role will technology play within the gateway and the extent to our clients will be ensured access?

Finally we recommend the implementation of a **specific strategy for the most disadvantaged Australians, in recognition of -**

- **Their particular support needs and associated costs of providing services,**
- **Their lack of resources to compete within a largely market based system,**
- **The unlikelihood of mainstream services accommodating or responding to residents having significant behavioural concerns, or needs related to substance abuse, mental illness or previous experience of homelessness,**
- **The need for further innovative models of care and support for this client group.**

We look forward to presenting our response to the Productivity Commission Public Hearings in Melbourne on 23 March 2011 and would be pleased at that time to elaborate on any aspect of this written response.

Summary of Recommendations:

1. *The Limits of the Proposed Market Driven Approach*

1.1 That specific strategies are developed to meet the needs of the very disadvantaged, whose needs are unlikely to be met by the proposed market driven approach.

2. *Appropriate Models of Care for those with Additional Needs*

2.1 The Commission's proposal for supported accommodation quotas is revised, and a more integrated means of assuring places for disadvantaged older Australians is developed.

2.2 That the eligibility for 'disadvantaged' status be tightened to ensure priority for the very disadvantaged older Australians.

3. *CACPs*

3.1 That the supply restriction on Community Aged Care Packages be immediately removed.

3.2 That increases in Community Aged Care Packages targeted to disadvantaged older Australians be increased as a matter of urgency.

4. *Levels of Funding*

4.1 That the ACFI funding system is *urgently* reviewed to take account of the impact of residents' behavioural issues and lack of informal support, so as to ensure the financial viability of organisations committed to the care and support of very disadvantaged older Australians.

4.2 That block funding be utilised to adequately support organisations specialising in innovative responses to the complex and challenging behaviours of elder disadvantage.

5. *Eligibility and Assessment:*

5.1 That eligibility for assessment is *mandated* and *prioritised* for those under 65 where there is evidence of premature ageing.

5.2 That ACAS referral processes incorporate recognition of homelessness or extreme disadvantage as a possible contributing factor to the need for aged care services.

5.3 That this expanded eligibility be communicated widely among both aged care and non-aged care providers, so that potential referral sources are aware of this mandated eligibility.

6. *Proposed Seniors Gateway:*

6.1 That the proposed regional Aged Care Gateways providers be required to demonstrate their capacity to engage with, assess and assist the most disadvantaged older Australians, including those who have experienced homelessness, mental illness and substance abuse.

6.2 That, if required, a specialist Aged Care Gateway be established to meet the needs of the above client group.

7. *Informal Support Networks*

7.1 That assessments and funding levels take into account the additional staff time required when residents have complex co morbidities and do not have informal support networks.

VincentCare Victoria

VincentCare Victoria was established by the Society of St Vincent de Paul in Victoria in 2003, to accept responsibility for the Society's services for disadvantaged and vulnerable people including those who are homeless, mentally and physically disabled, aged and suffering from forms of substance abuse. VincentCare works within the mission of the St Vincent de Paul Society Victoria providing an extensive range of structured social services, often in partnership with government programs.

VincentCare's responsibility is to:

Provide quality services for the homeless, the aged, people with a disability, and men and women struggling with complex needs including substance abuse and mental health needs; and advocate for vulnerable and disadvantaged people, respect their dignity and rights and understand their needs so as to provide them with support and encouragement and enable greater self-dependence.

VincentCare Aged Care Services:

VincentCare operates seven aged care facilities including residential care, ageing in place and a day therapy centre.

VincentCare is committed to the provision of quality facilities and care for people as they age and is very conscious of an ageing population that will demand more from these services in the coming years.

As part of our current Strategic Planning process, in response to its Mission, the organisation has affirmed its commitment to:

- Providing care for the disadvantaged as a priority in its delivery of aged care services.
- The provision of a wider range of services that support people within their present communities wherever possible.
- Dementia being an increasing challenge that requires caring and innovative responses.

VincentCare recognises and practices a commitment to social justice and to the more disadvantaged, by allocating a substantial number of beds to homeless and marginalised members of the community.

The **key outcomes** VincentCare is aiming to achieve for socially disadvantaged older people are:

- ✓ enriched lives
- ✓ capacity to exercise choice in matters of health and well being
- ✓ stable and appropriate accommodation
- ✓ positive relationships
- ✓ community connections
- ✓ maximise independence
- ✓ opportunities for participation

From this perspective as a service provider and organisation with a primary concern for the most disadvantaged ¹older Australians, VincentCare Victoria makes the following comments in response to the Commission's Draft Report.

¹ In referring to the 'very disadvantaged' in this response VincentCare recognises that concept of disadvantage is multi-dimensional. It can be:

- **Structural**, arising from inequalities in our society that advantage some and significantly limit others
- **Geographical**, with some communities unable to access or provide opportunities when compared to others that are able to access an array of resources; and
- **Individual**, with a person's circumstance and personal characteristics often constraining, limiting or excluding his/her access to resources and opportunities such as access to education and employment.

Isolation, exclusion and lack of connection are the defining characteristics for VincentCare in describing the concept of disadvantage.

1. The limits of the Proposed Market Driven Approach - Implementation of a specific strategy for the most disadvantaged older Australians

As canvassed earlier in this paper, VincentCare recommends that the specific needs and situation of the most disadvantaged, particularly those Australians who have experienced homelessness, calls for a specific strategy.

It is suggested that the draft report does not sufficiently consider this group, and the following specific implementation steps are put forward by VincentCare for consideration:

1. Urgently address anomalies in the ACFI system, to ensure the viability of providers who predominately accommodate very disadvantaged residents;
2. Immediately increase the availability of CACPs, so as to:
 - Enable organisations to get support to people living in a range of accommodation settings, noting in particular the growth of the over 55 age group in the numbers of people who are homeless; and
 - Relieve pressure on the residential aged care system, and acute and rehabilitation hospital beds.
3. Establish a specialist response within the Aged Care Gateway, and increase funding for case management, to enable services which assist very disadvantaged older Australians to navigate through the system.
4. Provide block funding to specialist providers to develop innovative responses to the complex needs of very disadvantaged older Australians.

Recommendation:

- 1.1 That specific strategies be developed to meet the needs of the very disadvantaged, whose needs are unlikely to be met by a market driven approach.**

2. Appropriate Models of Care for those with Additional Needs

VincentCare is very concerned by the Commission's proposal to establish supported accommodation quotas within regions, and the related proposal to allow trading of these places between providers. This is not a proposal that is likely to lead to the best outcomes for very disadvantaged Australians, for a number of reasons:

- Unless the targeting of supported places is considerably tightened (i.e. The proposal of the Commission to change eligibility so that home ownership is taken into account, is accepted by government), these quotas are unlikely to meet the quantum of demand;
- We are of the strong view that the very disadvantaged client group, particularly those who have experienced homelessness, mental illness or substance abuse, have specific needs unlikely to be met in mainstream settings, and in any case are unlikely to be accepted where they are 'competing' against more easily cared for applicants;

- The 'trading' of places is unlikely to lead to the establishment of appropriate settings, particularly in rural and isolated areas;
- Any system of quotas will require close monitoring, as the current regional supported resident ratio for aged care providers to accept disadvantaged residents is often not monitored and adhered to;
- The very disadvantaged are unlikely to fare well in any market system where quality can be traded for price, and there is a need to ensure there is a safety net for those who face multiple disadvantages in their life, which are reflected in the aged care system;
- The crucial role played by the not for profit sector in developing innovation and meeting the needs of the very disadvantaged in this sector should be recognised and supported.

We are of the view that a more appropriate means of ensuring that disadvantaged older Australians receive appropriate housing and support is to encourage specialist providers in innovation through block funding and/or realistic funding of capital and recurrent costs, of models of housing and support which:

- Take into account the lifestyle pathways and stages of disadvantaged older Australians;
- Are within settings which enable social inclusion;
- Are able to meet the complex social, emotional and physical needs of residents.

This reflects the Australian government's White Paper on Homelessness which flagged the need for innovation in services for the older population of homeless people.²

The aged care and support needs of many people who fall into the homeless or disadvantaged category do not always easily fit into existing care programs such as HACC, CACPs or residential care. They require a much broader mix of accommodation and support options. It is important that government funding enable opportunities to explore innovative models which are better tailored to particular populations or communities. Where specialist agencies have capacity to respond to respond flexibly and innovatively to an individual's needs, far better outcomes can be achieved. VincentCare is committed to seeing provision of holistic care to specialist groups of older people.

There is value in exploring the continuum of care for people who are clients of agencies such as VincentCare in the early to middle years of their lives and how they could then transition into services designed to meet their needs in their older years. The benefit of this approach is that agencies such as ours are attuned to working flexibly with clients who are chronically disadvantaged, in a person-centred way. Other innovative programs worth exploring further include the Home Share Program where vulnerable Victorians who need help with household tasks are matched with younger people looking for accommodation in home environment.

VincentCare sees great opportunity in a supported Independent Living Units model, or other high quality and appropriate housing, where frail and socially isolated people can be supported to remain living independently with a range of services provided to them in their homes.

² The Road Home – the Australian Government White Paper on Homelessness
<http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/whitepaper>

Recommendations:

- 2.1 That the Commission’s proposal for supported accommodation quotas is revised, and a more integrated means of assuring places for disadvantaged older Australians is developed.**
- 2.2 That the eligibility for ‘disadvantaged’ status be tightened to ensure priority for the very disadvantaged older Australians.**

3. CACPs - Expansion of Community Aged Care Packages

The Commission has proposed that after five years supply restriction in both residential and community care be removed to meet future demand. VincentCare would propose that the restrictions on Community Care packages be lifted immediately and that residential bed licences be increased gradually. All Australians would benefit from immediate release of ongoing pressure on the system (including on acute and rehabilitation hospital beds).

In addition to relieving pressure on the overall residential system, by enabling more people to stay in their homes, a critical level of need can be met by the urgent expansion of Community Aged Care Packages targeted to disadvantaged older Australians.

VincentCare has found that CACP and HACC are beneficial in supporting those who are homeless or disadvantaged. But CACPs are extremely limited and difficult to secure. The success of VincentCare’s CACP programs specialising in working with significantly disadvantaged people at risk of homelessness reinforces the considerable capacity of a package to turn around the life of an older person who is in need of a range of community supports in order to remain living in the home.

Those within the homeless population aged over 50 are more likely than other age groups to be sleeping rough (in cars, tents, squats or the street). People in this age group are also over-represented in boarding houses, and among marginal residents in caravan parks. 42% of marginal residents in caravan parks, and one-quarter of people in boarding houses are aged over fifty five. ³

CACPs would enable tailored support to be provided to these people, who often receive little assistance until they have reached a high level of need.

Recommendations:

- 3.1 That the supply restriction on Community Aged Care Packages be immediately removed.**
- 3.2 That increases in Community Aged Care Packages targeted to disadvantaged older Australians be implemented as a matter of urgency.**

³ Homelessness Australia Fact Sheet ‘Homelessness and Older Australians 2010’
<http://www.homelessnessaustralia.org.au/site/issues.php>

4. Levels of Funding

We welcome the recognition that some components of the ACFI may be set too low. These funding levels have a crucial impact on our clients, particularly those people who have experienced homelessness or have mental health or substance abuse issues. The proposal that Department of Health and Ageing conduct a public benchmarking study of pricing of care and support services in consultation with the industry and other stakeholders within the next two years, while sound, does not sufficiently reflect the urgency of the situation for VincentCare and other organisations whose commitment and service provision are focussed on the very disadvantaged aged.

A large proportion of VincentCare clients have additional needs, which require additional support hours. This affects the viability of our services; because of the additional costs of care this client cohort would also have significant difficulty in accessing mainstream services. The ACFI does not recognise the very substantial costs associated with the care of those who have significant additional needs associated with previous experience of homelessness, mental health or substance abuse problems.

This largely results from the failure of ACFI to recognise the impact of the 'behavioural domain' on the staff time, and therefore costs of providing care for residents. It is important to note that this funding inequity has a dual impact on disadvantaged older Australians – firstly, it limits their access to mainstream services, as they are seen as a financially less attractive option; and secondly, it threatens the financial viability of those organisations committed to the care of disadvantaged residents.

The funding shortfalls are significantly less than under the previous RCS system.

The following case studies illustrate these additional needs and related costs:

CASE STUDY

Resident: 54 year old male

Primary Health Issues: Chronic Alcohol Abuse

Past History: Schizophrenia

Epilepsy

L CVA (Severe haemorrhage) 1990

Peripheral Neuropathy

Tobacco Abuse

Pancreatitis 2000

Current History: Intermittent acute psychoses

Tobacco withdrawal

Depression, (related to self-blame when occasionally consumes alcohol)

Intermittent agitation, (often on weekends – boredom, unable to occupy self)

Social History: Admitted to hostel in 2002 as unable to care for self in the community

Brother is not in regular contact and works 5 days per week

Under RCS, this resident is assessed for a RCS 6 rate of \$36.38 per day.

Under ACFI, this resident is classified as Nil/Med/Nil which is \$14.11 per day. This is a shortfall of @22.27 per day or over \$8,000 per annum and is a 60% reduction.

CASE STUDY

Resident: 78 year old male

Primary Health Issues Alcohol abuse

Past History: Intracerebraes encephalopathy

Cerebrovascular disease

Myocardial infarction

Malnutrition

Current History Stress/urinary incontinence

Abnormalities of gait & mobility

Mild cognitive impairment

Social History: Admitted Jan/10

Unable to care for self in the community

Has no family. Previously lived in rooming house.

Under RCS, this resident is assessed for a RCS 6 rate of \$113.55 per day.

Under ACFI this resident is classified as Nil/Med/Nil which is \$57.29 per day. This is a shortfall of \$56.26 per day or over \$20,000 per annum.

Recommendations:

- 4.1** That the ACFI funding system is *urgently* reviewed to take account of the impact of residents' behavioural issues and lack of informal support, so as to ensure the financial viability of organisations committed to the care and support of very disadvantaged older Australians.
- 4.2** That block funding be utilised to adequately support organisations specialising in innovative responses to the complex and challenging behaviours of elder disadvantage.

5. Eligibility & Assessment

The premature ageing of some groups in the community is mentioned within the Draft Report (such as that experienced by members of the Aboriginal community). However, no specific reference is made to age related eligibility for Aged Care assessments. Premature ageing of homeless people has been recognised in the aged care system for several decades with those over 50 being regarded as eligible for aged care services.

Many people we support through our programs present with signs of age-related conditions even though they may be as young as their late forties. Our recent experiences indicate that most ACAS' are reluctant to carry out an aged care assessment if a person is less than 65 years of age, regardless of whether they present with concerning age-related symptoms. This is a concerning trend, which is effectively preventing homeless people accessing aged care services. We believe it is essential for ACAS teams to perform an assessment where a health, community or aged care provider believes it is warranted.

The experience of our staff has been that for a long time it was possible to get assessments at 50 for those who had experienced long term homelessness or other disadvantages resulting in premature ageing, but recently it had become increasingly difficult. Given the pressure within the system there is the perception that Aged Care and Assessment Teams are essentially rationing intake by limiting

assessments of those in younger age groups from the disadvantaged population. In some cases we are very concerned about ACAS teams requiring individuals to trial other forms of often inappropriate accommodation such as SRS, or rooming houses prior to any assessment. Setting up an older person up to fail is costly both to the individual and to the broader community.

Recommendations:

- 5.1 That eligibility for assessment is mandated and prioritised for those under 65 where there is evidence of premature ageing.**
- 5.2 That ACAS referral processes incorporate recognition of homelessness or extreme disadvantage as a possible contributing factor to the need for aged care services.**
- 5.3 That this expanded eligibility be communicated widely among both aged care and non-aged care providers, so that potential referral sources are aware of this mandated eligibility.**

6. The Proposed Seniors Gateway

The Aged Care Gateway, as the front end of the system, providing information, assessment and care coordination/ case management is potentially a more coherent and user friendly 'face' to the aged care system.

However, from the perspective of our client group it is essential that these agencies have the expertise and capacity to work effectively with people who have experienced homelessness, mental illness, substance abuse or have other additional needs. There are a number of key issues which will need to be addressed if the proposed Aged Care Gateway is to improve responses to those older Australians who are very disadvantaged –

- Ensuring access to the gateway is simple (and non-bureaucratic),
- Establishing pathways between homelessness, mental health and substance abuse service systems,
- Skilling staff to recognise the (not always visible) needs of the very disadvantaged.

Publicity materials and assessment and other tools must not inadvertently exclude people who are marginalised, and must understand their needs and consequent service requirements. In particular, it should be noted that our client group is often reluctant to approach or engage with bureaucracies. There is a need for a specialist capacity within the regional Gateway, so that staff are resourced about the most appropriate ways to engage with our client group. Alternatively, it may be more appropriate to establish a specialist Aged Care Gateway, with specific capacity to engage with (both through service providers, and where necessarily directly) the very disadvantaged older Australians.

Recommendations:

- 6.1 That the proposed regional Aged Care Gateways providers be required to demonstrate their capacity to engage with, assess and assist the most disadvantaged older Australians, including those who have experienced homelessness, mental illness and substance abuse.**
- 6.2 That, if required, a specialist Aged Care Gateway be established to meet the needs of the above client group.**

7. Informal Support Networks

While the recognition of those who provide informal support, and incorporation of their needs in assessments is welcome, there is an equal need to recognise the impact of the **lack of** informal support networks. For many of those within our client group, their life experiences and additional needs, have resulted in isolation from family and lack of friendship networks able to assist in times of difficulty. The practical result is that, for example, there are no people able to assist with medical and other appointments and shopping, and little opportunity to participate in outings in the wider community -the person is reliant on service staff to meet these needs. In order to meet these needs providers working in this area routinely use paid staff, despite the lack of funding, as these are essential aspects in provision of care in resident's life

The following case study illustrates the situation of older people with no support networks and the level of unfunded support that is provided by aged care services:

CASE STUDY

Resident – 66 years old

Primary Health Issues – Severe Depression

Past History – Acute Delirium
Wernicked Korsocoff
Dementia
Depression
Heavy smoker and drinker

Current History – Intermittent Acute Psychoses
Intermittent agitation, restlessness, verbal, disruptive and physical abuse.

Social History – Admitted to hostel 2004 because of inability to care for self in the community. Has children, ex-wife, brothers and sisters who have had no contact with resident for the past 15 years.

Self-Care Deficits – On going intoxication whilst living in Public Housing.
Poor Nutrition Status

Resident walks independently, but needs constant prompts with personal hygiene and is non-compliant with these tasks most of the time. He will go without a shower, shave or change of clothes for up to a fortnight. Needs reminders daily to come for meals, he can lack the motivation to eat at all, mostly consuming 1 or 2 meals a day. The resident has very little money for basic living expenses let alone for 'niceties' like his cigarettes or beer, therefore staff control his allocation of 10 cigarettes a day. A slab of beer is purchased by staff with the doctor's approval. This can be used as an incentive for the resident to come for a meal or a shower; however it is not always successful. Restricting these choices from the resident brings disempowerment and promotes isolation and tears away at his self-esteem. Staff and others associated with the facility often purchase 'niceties' for his enjoyment which include purchase of personal items to enhance his self-esteem for example, a footy jumper. Whilst an

amount of money is contributed by State Trustee staff and contractors top up the resident's trust account to be used purely as he chooses.

A volunteer attends monthly to take the resident out for lunch and a movie of his choice paid by the donations of staff and contractors. This volunteer is a staff member from a previous facility who has an established trust and rapport with the resident and the resident is very responsive to them. The volunteer at times has assisted the facility with his personal hygiene, again in his own time.

Appointments to hospitals and radiologist are accompanied by staff either in paid time or on their own time. He is taken out to the football to watch his beloved St Kilda, any expense is catered by the staff: entry fee, pie, beer and footy record etc.

Staff provide emotional support as he always withdraws into his bedroom; so he can feel that he is in control of self. He is unable to go out independently, by his own admission, "would not return and probably end up dead from excessive alcohol consumption". Attends occasional bus activity of his choosing, enhancing a sense of self satisfaction in decision making.

The resident is referred and supported intermittently by Broadmeadows Psychiatric team in unison with GP and staff to facilitate medication review in maintaining a degree of stability with his mental state. Psychologist from G P Melbourne Practitioners visits monthly for 1:1 to provide external independent support as a listener. From these visits staff are provided with education, in assisting and collaborating information to meet the resident's needs.

His anger and bitterness towards the past and what could have contributed to his present behaviour. Due to the ongoing support and persistence of staff and his special volunteer a rapport has been established and acknowledged by the resident showing protectiveness of staff when a display of verbal abuse from a co resident is evident.

A resident's physiology interacts with behaviour, emotion and cognition. As carers working with residents who have complex and often challenging needs we have a responsibility to view the resident's needs holistically, giving consideration to the interconnectedness of all areas of life and how they impact on the individual. Providers working with older socially disadvantaged with complex needs must be adequately resourced to assist in problem solving, enable coping skills, and to educate, advocate, negotiate and collaborate. We are the safety net - providing information and resources that enhance and empower residents, in an effort to improve self-esteem, motivation and sociability.

The ACFI is a funding instrument that measures key care needs, however it does not incorporate these holistic needs of a person.

Recommendation:

- 7.1 That assessments and funding levels take into account the additional staff time required when residents have complex co morbidities and do not have informal support networks.**

Conclusion

The provision of housing and support to very marginalised and disadvantaged older Australians is a commitment that VincentCare and a number of other not for profit organisations have committed their resources and expertise to over many years. It is complex work, as the needs of those who have experienced homelessness, illness and substance abuse, are themselves complex, and rarely fit into the models of support designed for other members of the community. But as the community is accepting its responsibility for the projected needs of the mainstream aged care population, it must also accept the challenges of designing (and funding) a socially inclusive system of care for all older Australians. Specialist agencies such as VincentCare have demonstrated their commitment to this task, and now require the financial and systemic support of government as we move into the future, where the needs of all older Australians will increase.