POVERTY AND COMMUNITY CARE FOR THE AGED: AN INNER CITY RESPONSE

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Brotherhood of St Laurence
Working for an Australia free of poverty

INTRODUCTION

The Community Aged Care Services mentioned in this article all come under the Brotherhood of St Laurence, which is a major Melbourne-based welfare organization associated with the Anglican Church. Its mission is the eradication of poverty with its consequent hardship and lack of opportunity, and the improvement of the quality of lives of people on low income.

The services under discussion are all located on the same precinct in Fitzroy, in inner city Melbourne, and include a day centre which provides a wide range of services such as nursing, podiatry, income support, meals and recreation to an average of 70 people each day; nineteen independent housing units; a rooming house which houses 12 people; 60 housing linked community aged care packages and a 40 bed residential aged care facility

These services are integrated not just because they happen to be next to one another, but mainly because people can move easily between them. For example a number of people living in the independent housing units or rooming house receive services through the community aged care package program and also through attending the Coolibah Day Centre.

MARGINALISED CLIENTS

All the clients for our program come under the heading "marginalised" and by this I mean our client not only have low incomes but also have serious deficiencies in accommodation, diet, social supports and friendships, and health. In particular our client group have a low self-esteem. The clients have been put down so often in their lives that they feel they are of little value and often believe that no one could be really interested in them.

This last point is important as from our experience we have found that often the hardest thing facing a marginalised person is not the lack of material goods such as shelter, food, etc., but being seen as having no worth, being devalued as a person. This feeling they are of little worth leads to a loss of dignity as a person and living a "dehumanised" existence with few friends and little social contact. Consequently we see one of the main aims of our services is to assist such people to recreate their belief in themselves and to consistently affirm them as being worthwhile.

Our model of operation is based on maintaining or building up their strengths and providing support and resources to enable our clients to maintain a reasonable lifestyle, and remain independent for as long as possible. Clearly it is essential for workers dealing with marginalised people to be non-judgmental and to often put aside their own value

POVERTY AND INNER CITY COMMUNITY CARE: AN INTEGRATED SERVICE RESPONSE

Introduction

In the paper we are giving to-day we will be focussing on how we use our integrated Community Aged Care Services to assist severely marginalised people, that is, people who are on low incomes, are socially isolated and have some type of disability or condition which precludes them from accessing many mainstream programs. We will be then discussing the inner city catchment area for the programs and describing some of the main issues facing people on low incomes living in this area. Finally we will be outlining some of the strategies we use to assist our clients and then giving a case example to show how these strategies work in practice.

Description of Integrated Services

The Community Aged Care Services we are going to discuss all come under the Brotherhood of St Laurence. The Brotherhood of St Laurence is a major Melbourne-based welfare organisation associated with the Anglican Church. Its mission is the eradication of poverty with its consequent hardship and lack of opportunity, and the improvement of the quality of lives of people on low income. Its aim is to see an Australia free of poverty. It has been operating for nearly 70 years and offers a wide range of services including employment programs, services for families and children, housing services, services for newly arrived migrants, residential care services and community care services for older people and for people with disabilities.

The actual services under discussion are all located on the same precinct in Fitzroy in inner Melbourne and all have the same aim which is to enable marginalised older people to have a dignified lifestyle, and to remain living as independently as possible in their local community area. These services are the Coolibah Day Centre which provides a wide range of services such as nursing, podiatry, income support, meals and recreation to an average of 70 people each day. The Centre is open every day of the week, excluding Saturday. Ten independent housing units. A rooming house which currently houses 12 people, but will house another 15 people when the renovations are finished, which should be early next year. This rooming house, unlike other rooming houses in the area, has an en-suite in each room and is divided into 3 houses with each house having its own fully self contained kitchen and laundry. We also have thirty housing linked aged care packages managed from the site and a 40 bed residential low care facility which recently underwent a $5m upgrading. In addition, a community health centre, which is not operated by the Brotherhood of St Laurence, is also located on the precinct.

These services are integrated not just because they happen to be next to one another, but mainly because people can move easily between them. For example a number of people living in the independent housing units or rooming house receive services through the community aged care package program and also through attending the Coolibah Day Centre. I will speak later about the actual details of how these services actually integrate in practice.

Catchment Area

The clients for our services primarily come from two inner city municipalities in Melbourne and they are the City of Yarra and the City of Moreland. These municipalities cover suburbs such as Richmond, Collingwood, Fitzroy and Brunswick. As with virtually all inner areas of large cities these suburbs are undergoing vast changes. Rising land values in the inner city has meant large economic growth and development, and this has often come at the cost of destroying strong and viable social systems and infrastructure.

Rooming houses and private hotels previously providing low cost accommodation for elderly people have been sold and converted to high cost hotels, apartments or private residences. In the City of Yarra alone over the past 7 years there has been a loss of over 300 rooms in private rooming houses, which is over 50% of the total rooms in private rooming houses in the municipality. In the same period there has been little change in public housing stock in the area. This has meant that in the last few years over 300 mainly aged marginalised people have lost their home.

One result of this decline in affordable housing is that elderly people are being forced to live in squats or in unregistered rooming houses or rented premises which are often just rooms or sheds at the back of shops or houses. These rooms are usually in a poor state of repair, have no heating or cooling, no refrigerators, no access to cooking or washing (personal or laundry) and external toilets which are difficult to access.

With so many rooming house proprietors looking at selling or converting their premises to other uses it is not surprising that they are not willing to spend money to upgrade or even maintain their facilities. Consequently, even registered rooming houses often provide only the barest minimum in facilities and many are only marginally better than unregistered rooming houses.

As well as rooming houses elderly people on low incomes in the area live in public housing, and many of these are on high rise estates over 20 stories high. One of the major problems with these estates, outside of the unsuitability of the infrastructure itself, is the lack of safety. Security guards on the estates have not alleviated the threat of violence that forces many older people to remain in their rooms for much of the time, and that often limits visits by support workers, such as home care or nursing, because the safety of the workers cannot be guaranteed. This situation is also prevalent in many rooming houses. Because of their vulnerability this is a particular concern for frail aged people and many live in an atmosphere of suspicion and distrust.

MARGINALISED CLIENTS

All the clients for our program come under the heading "marginalised" and by this I mean our clients have serious deficiencies in the following main areas of their lives:
Accommodation: As mentioned before many of our clients live in sub-standard accommodation which is usually unstable or temporary.
Income: All of our clients are on low incomes - mainly disability or old age pension. This is their only source of income. Their only assets would be some clothes and a little furniture. None of them has much money in their savings accounts.

Diet: Many of them have a poor and inadequate diet. The meals they receive at the Coolibah Day Centre or through the community packages program would constitute most of the food they would have for the day and certainly their only substantial meal. A number of our clients have no proper cooking facilities and, outside of the meals supplied through the packages and the Day Centre, they would rely on cheap and unhealthy take-away food.
Social Supports: Virtually all of the clients live by themselves and social isolation is a major problem. Many of them have split from their families and no longer have contact with them. Very few, if any, have close friends. Most of them have no-one to assist them if they facing any particular problems.
Health: As would be expected the general health of the clients is very poor. Diabetes, high blood pressure, cardiac problems, respiratory problems, obesity, liver problems, poor eyesight, poor hearing, the list goes on. Many of these problems are a result of lifestyle and substance abuse – mainly alcohol and nicotine.
Disabilities and Disorders: Virtually all of our clients have a disability or other condition which precludes them from, or limits their opportunities to participate in, regular community activities. Mental illness, behavioural problems and intellectual disability are common to many of our clients as well as a physical disability. Also a number of our clients have some form of substance abuse particularly alcohol and nicotine, although one interestingly is addicted to coca-cola and this is the only fluid intake she has. Gambling is also a huge problem with the TAB and poker machines.
Self-Esteem: Again virtually all our clients lack self-confidence. They have been put down so often in their lives that they feel they are of little value and often believe that no-one could be really interested in them.

This last point is important as from our experience we have found that often the hardest thing facing a marginalised person is not the lack of material goods such as shelter, food, etc., but being seen as having no worth, being devalued as a person. This feeling they are of little worth leads to a loss of dignity as a person and living a "dehumanised" existence with few friends and little social contact. Consequently we see one of the main aim of our services is to assist such people to recreate their belief in themselves and to consistently affirm them as being worthwhile.

It may sound as if we are painting a picture of clients who are beyond assistance, but many of them have great strengths. Speaking generally, they have survived what to many of us would seem an horrendous life and have overcome many great personal difficulties and setbacks. As was mentioned, they usually have low levels of self-esteem, but they can be fiercely independent and are not afraid of standing up for their rights and seeking to improve their lives if they are given the proper support and resources. It is obvious that many of them have great resilience, are resourceful and have a strong determination to remain in their local communities.

Most of the clients have a strong sense of place and identify strongly with the local area in which they live. Indeed a number of the clients have lived in this local area all their lives. They have a good knowledge of the services and facilities in the area, and feel comfortable in the places they know. Consequently our aim is ensure people remain connected to the local area and utilise local services which are known to them. In a sense this is “ageing in place”.

Our model of operation is based on maintaining or building up these strengths and providing support and resources to enable our clients to maintain a reasonable lifestyle, and remain

independent for as long as possible. Clearly it is essential for workers dealing with marginalised people to be non-judgmental and to often put aside their own value system. It is so easy to say it is their own fault that they are marginalised (As some of our politicians are keen to state). But in fact many of our clients have a disability or condition, such as a psychiatric or intellectual disability, which has never been diagnosed or properly treated and which has greatly limited their opportunities in life. We believe one of the great benefits of working with marginalised people is that it causes you to question your own set of values and priorities in life.

Strategies Used to Assist Clients

Integrated Services

The integration of our services occurs in a number of ways:

- Through our assessment process so that people who are assessed as eligible for any of our services then become automatically eligible for our other services, except of course where an ACAT assessment is required. A number of our clients on community aged care packages live in our rooming house or independent living units and attend the Coolibah Centre.

- Through staff at one service providing assistance at another service. For example, staff at Coolibah provide support to residents in the accommodation services during the day and staff at the residential care facility provide after-hours support to these residents. The residents at the rooming house each has a call button which can be used to directly page the overnight staff at the residential care facility who respond to the call.

- Through easily utilising a number of services. Even frail aged people with mobility aids can easily travel from one service to another as there are no strong boundaries between the services, physical or otherwise. Even residents at the residential care facility attend the Day Centre and socialise with their friends including having a meal if they choose.

- Through the meal service as all meals for both the residential care facility and day centre are produced at the one kitchen which is located at the low care facility. However the kitchen operates autonomously with the chef reporting directly to a senior manager and so it is not under the direct management of either the day centre or low care facility.

Partnerships

One of the main strategies we use to assist our clients is through forming strong partnerships with other key care providers. For example, in tackling the accommodation issue we work closely with housing agencies such as transitional housing, community housing, the local council and the Office of Housing as well as the private sector to obtain reasonable housing for our clients. This partnership is strengthened through network meetings of key organisations involved in housing which are held on a regular basis.

Similarly in providing health care for our clients we work closely with specialised services who are familiar with our client group. These include the Royal District Nursing Services'

Homeless Persons' Program, allied health staff from the local Community Health Centre, local general practitioners, mental health team, acute and post-acute care and hospital at home services. An example of this is that our low care facility has reached agreement with a local major hospital for the use of 2 unfunded beds in the facility for the hospital to fund as post acute care accommodation for people who live by themselves or who have no carer. In this agreement the hospital provides all allied health and nursing care and the facility provides all the other services. This agreement means that supported accommodation is available for people who are ready to be discharged from hospital but not ready for independent living.

We have also formed partnerships with local traders and companies, and have reached agreement with one large local insurance company for them to operate a breakfast program on every second Sunday morning at the Coolibah Day Centre for marginalised elderly people. The insurance company provides the labour, who are all volunteers from their workforce, and all costs for the food. At present we are getting an average of over 30 people attending each breakfast.

Trust relationships

In most organisations service delivery to marginalised people has changed from the charitable hand-out approach to a developmental model emphasizing personal independence and responsibility which often uses a case management technique. In utilising this latter model we need to be aware that professional relationships is not the answer to overcoming a person's social isolation. As Jo Thomas stated in an article in the magazine Parity "No model of social work can replace the family or the support of friends or provide a sense of belonging" (Social Connectedness, Vol. 14, Issue 5, Pp 12-13)

However, many marginalised people, often because of a long history of abuse and dysfunctional relationships, are so isolated from mainstream community life that they need a professional relationship to begin to understand and experience trust so that they can commence to once again build up their support networks.

The partnerships with other organisations mentioned earlier only work when there is trust between the partners and it is the same with our clients. In order to assist our clients we have to build a trust relationship. Usually when dealing with other professional agencies there is already existing a strong platform for trust as you may be aware of the other agency's reputation, calibre of staff, track record and so on. But this is not the case when starting off with marginalised clients. The clients have been hurt badly in their lives and they do not readily trust others and do not believe they are concerned for them. Also, as mentioned, our clients have very low levels of self-esteem and cannot believe that others may be genuinely interested in their welfare.

Consequently, while trust may seem a simple matter it is often very difficult to attain with our clients, and can require a great deal of time and resources. Despite this, we believe it is essential as it is our experience that the extent to which a client will be involved in, and benefit from, a program usually depends upon the amount of trust the client has in the person providing the program.

To illustrate how these strategies of integrated services, partnerships and trust relationships with clients work in practice I would like to present a case study of one of our client whom I shall call Toby.

Case Example - Toby

Toby is a victim of severe Post Traumatic Stress Disorder arising out of his experiences with the British Army in the Second World War. This was never properly treated and Toby suffered from personality disorder, alcoholism and sleep disturbance. Toby's behaviour alternated between complete withdrawal and aggressive violence. Toby and his family migrated to Australia but his behaviour continued to deteriorate and eventually his wife divorced him and he became completely estranged from his daughter and his sibling.

Toby also had double incontinence and it was this that brought Toby to the attention of the RDNS Homeless Persons Program and then via an ACAT assessment to our housing linked aged care packages program. At this stage Toby was living in a primitive single room rented bungalow at the back of a private residence in Fitzroy with no facilities except access to an outside toilet

It was a long and slow process developing a relationship with Toby to the point where he was trusting enough to begin to accept services. Initially there was the problem of tracking Toby down, that is identifying his "hang outs", such as outside a particular hotel, and then meeting him there and talking with him. These discussions were very general and non-threatening and no demands were made of Toby. It was very much a process of engagement with Toby. Then it was a matter of occasionally providing Toby with things such as cigarettes, a trip to the barber, some new clothes etc as requested by Toby. At the same time as the care manager was building up a relationship with Toby we were working with the home care service providers to ensure they could provide a home carer who would be capable of building a rapport with Toby. Eventually, after a period of some 4-5 weeks of seeing Toby on a regular basis of a couple of times a week the trust had developed to a stage where Toby agreed to go on the Community Care Packages Program.

Once on the program Toby was shown our rooming house and Toby agreed to move to this accommodation. Toby was given a high priority on the waiting list and after a new months a vacancy occurred and Toby moved into the rooming house. At the same time Toby was introduced to the Coolibah Day Centre and he agreed to attend the Centre. At first Toby only attended for the meal service, where he was provided with a healthy fresh cooked meal daily, whereas previously his diet consisted almost entirely of sandwiches or fast food. However, as he began to get to know the staff he started to spend more time at the centre so that now he attends each day for a number of hours and participates in other programs at the centre.

Also, the Home Carer from one of our contracted agencies has built up a strong rapport with Toby and assists Toby with personal care as well as withdrawing Toby's weekly allowance from the State Trustees.

Toby now has good quality accommodation and is provided with meals and health care. He is still somewhat withdrawn but now quite often initiates social contact with other clients at Coolibah and at the rooming house.

After encouragement and support from all staff involved who worked together to assist Toby, and in particular his care manager and home carer, Toby contacted his daughter and has now been reunited. Following this reunion Toby made a decision to contact his brother in Canada and has done this via email, and now wishes to contact his sister who lives in England. A reunion in England is in the process of being organised.

Toby's case is a particular examples of how our services, based on a integrated model, in partnership with other services, can assist severely marginalised people to develop trust and a belief that other people do care for them. It is our experience that once this occurs our clients do benefit from the services offered and do develop a higher quality of life.

It is also important to point out that this relationship between the professional staff and Toby is based on equality, that is the staff and client have equal standing in the relationship. In this way client independence is encouraged and an example of this is the way Toby initiated the process of contacting his brother in Canada following the reunion with his daughter.

Conclusion

In this presentation we described how our services on the same precinct in Fitzroy operate in an integrated way to assist margninalised people. We then outlined some of the characteristics of our target group and the problems faced by our clients, and in particular the need for suitable accommodation. We followed this by presenting some strategies we use to address these issues, in particularly partnerships, service integration and building trust relationships with the clients and fostering their independence. Finally we presented a detailed client case study to illustrate how these strategies work in practice.

We hope the presentation has stimulated your thinking in regard to providing care for marginalised older people and we thank you for listening.

We would be happy to answer any questions you may have.