Homelessness and Dementia in Australia: A Literature Review

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Summary

The area of homelessness and dementia is one of the Australian Government's key priorities areas. The Victoria and Tasmania Dementia Training Study Centre (DTSC) has responsibility for exploring the issues related to dementia in homeless populations. The basis on which the Vic/Tas DTSC undertook this literature review was to explore the issues relating to dementia in homeless populations with a particular focus on the dementia education needs of health professionals working with homeless people. A preliminary search yielded limited information on the topic and therefore a more in-depth examination of the literature was warranted.

It is evident from the most recent 'Dementia in Australia' report from the Australian Institute of Health and Welfare (AIHW) that rates of dementia are increasing with the ageing population. The healthcare workforce will be increasingly challenged to provide appropriate care and support for the increasing number of persons with dementia (AIHW 2012).

The limited evidence there is on rates of cognitive impairment in homeless older people shows higher rates than in the general population (Buhrich, Hodder & Teesson, 2000). Those organisations which provide services for homeless people not only face the challenges associated with supporting homeless older persons but also recognising and understanding the needs of persons with dementia who come into contact with their service/s.

The literature search produced research studies internationally and locally and the majority were published prior to 2010. The limited research since 2010 specific to Australia was mostly studies conducted for organisations working with older homeless populations such as Wintringham Specialist Aged Care Service (WSACS), Catholic Healthcare and Hanover. Of importance for this literature review is that very few recent studies have focussed on cognitive impairment in the older homeless population and even less have examined dementia. Research is needed to understand the needs of both older homeless people with dementia and those organisations who work closely with them.

Search Strategy

The search was conducted by the La Trobe University Library Service on 3rd July 2014, with the search criteria limited to 2004-2014, English, Australian and international. The search terms were: 'cognitive impairment', 'dementia', 'care needs' and 'illness of homeless people'. The databases searched are listed below and they were searched in the Title and Abstract fields. Two searches were done in each database, one for 'dementia' and 'homeless' and another for 'illness' and 'homeless', then these were combined into one large dataset. There were 344 references found once duplicates had been removed. Of these, 35 were deemed directly relevant for the purposes of this review.

Social Services Abstracts (Proquest)	241
AgeLine (EBSCO)	24
Family (Informit)	84
Health and Society (Informit)	73

Actual search words are included in the table below with concept 1: dementia (plus variations) and concept 2: homeless (plus variations).

Concept 1	Concept 2
Alzheimer* disease Cognition Cognitive abilit* Cognitive decline Cognitive deficienc * Cognitive deficit* Cognition disorder* Cognitive dysfunction Cognitive impairment* Dementia Executive dysfunction Executive function* Memory disorder* Memory loss Care needs (care and need*) (Healthcare and need*) Chronic disease* Illness* Terminal disease*	Homeless* Homelessness Homeless people The homeless

While the formal search strategy enabled access to international and national research on older homeless people, it was known that some research would not be found through this method, in particular, government services which assist older homeless people. An exploration of the Australian Government website detailed funded programs such as Home and Community Care (HACC), the Supported Accommodation Assistance Program (SAAP) and Assistance for Care and Housing for the Aged Program (ACHA) through which service providers assist older homeless people. This in turn led to websites of the Community Connections Program (CCP) and the Homeless Persons Project (HPP) and thus to other websites of specific homeless persons services such as Hanover and Wintringham Specialist Aged Care Service (WSACS) where research papers were available. Other research included in this literature review prior to 2004 such as Buhrich et al (2000) were cited in the reference lists of research publications found through the literature search strategy.

Introduction

The literature search produced scant research on homelessness and cognitive impairment / dementia in Australia. Studies that do exist are on average more than 10 years old. One prevalence study on homelessness and cognitive impairment in an inner Sydney population in 2000 showed almost a six-fold increase in cognitive impairment in the homeless population to that of the general adult population (10% compared with 1.7% respectively) (Buhrich et al, 2000). In the homeless population those with cognitive impairment were significantly older than those without and this was

also evident in a study conducted in Los Angeles. However, the authors ruled out 'senile dementia' as an explanation for the cognitive impairment because most of the people were under 65 years of age and 'pre-senile dementia' was rare (Koegel et al (1988) cited in Buhrich et al, 2000).

Results from a preliminary report on a study into cognitive impairment in older homeless people in inner-city Sydney (Rogoz, Burke, Price & Hickie, 2008) found that 67% of this population showed evidence of cognitive impairment. The authors used AIHW research to estimate dementia rates in older homeless people in inner-city Sydney to be 6%.

Lipmann (2009) cited research conducted by Coopers and Lybrand (1985) which found up to half of night shelter persons were elderly. What drives people into night shelters is predominantly the loss of housing and one of the contributing factors is having a mental illness (Lipmann, 2009). Morris, Judd & Kavanagh (2008) claim that along with increasing homelessness and inadequate housing options there is also a shortage of policy initiatives. A research study, based in rural Bendigo, cited in Rota-Bartelink (2008) examined the quality of housing among patients of an area mental health service. Approximately 10 per cent of patients were identified as homeless and almost half had insecure housing, that is housing which is unaffordable, not safe and / or inappropriate for their needs. Almost 1 in 5 of the participants had housing which their case managers considered had a '*substantial negative impact on their mental illness'* (Rota-Bartelink, 2008, p. 16).

According to Lipmann (2009) the very nature of homelessness means lack of access to many of the supports that most people take for granted. Older people can often be left out of support services because of sometimes fierce independence and a reluctance to push their 'rights' – they become invisible. Homeless persons do not come to the attention of aged care services and to some extent, remain invisible. Older persons have the same human rights whether homeless or not and should be able to access appropriate support services (Lipmann, 2009).

Lipmann (2009), also states that whilst there is considerable government funding directed to dementia research and support services for persons with dementia, there is little going towards homeless people with dementia and relates this to the stigma associated with homelessness and the fact that homeless people do not engage with services. Dementia is most often identified by a person's local General Practitioner (GP), usually initiated by a family member, carer or friend. The lack of engagement between older homeless persons and aged care services is at the core of the problem. Funds and resources tend to flow to mainstream aged care services and Lipmann has argued for funds to be directed towards welfare organisations which provide services to older homeless people (Lipmann, 2009, p. 285).

In 2009, following recommendations arising from the Australian Government's Green Paper on Homelessness – 'Which Way Home, and the White Paper on Homelessness – 'The Road Home' the Aged Care Act (1997) was amended to make homelessness a priority and homeless people a special needs group. Recognition and funding has since flowed to this sector as further described within this review. However, according to a recent pilot study of the impacts of gender and location on older homeless Victorians, Batterham, Mallett, Yates, Kolar & Westmore (2013) found the nature of the older homeless population (i.e. transient; rough sleeping; low-income; barriers to service access such as: where to go for help, filling out forms, service consistency), meant that significant numbers of people do not receive the assistance they need. Again, as other researchers have found, Batterham et al (2013) concluded the most significant factor in remaining homeless was the lack of affordable housing. This pilot study did not report on cognitive impairment in older homeless,

people but it can be assumed that the majority of problems older homeless people encounter, will be magnified for those with cognitive impairment.

Prevalence / incidence of dementia in homeless people

Kovess (2002) cited a finding by Herrman (1989) which reported a lifetime prevalence of severe cognitive disorder (dementia) in homeless persons in Australia of 3-3.5% (p. 226). Teeson & Buhrich (1993), cited in Buhrich et al (2000), using the Mini Mental State Examination (MMSE) found severe cognitive impairment in 1 in 4 (25%) of the residents at a hostel for homeless men in inner Sydney.

Given the high prevalence of severe cognitive impairment and the fact that no women were included in the 1993 study (Teeson & Buhrich, 1993), Buhrich et al (2000) conducted a broader study of homeless people in inner Sydney. They used the MMSE and found cognitive impairment among homeless people in their sample to be 10 percent. Of the 204 subjects (155 men and 49 women), 10 percent (20 people) had some form of cognitive impairment. Of the 14 men with cognitive impairment, 35% had severe cognitive impairment. Of the 6 women with cognitive impairment none had severe cognitive impairment but they all had mild impairment. *'The prevalence of cognitive impairment among the homeless subjects in this sample was 10 percent …. the prevalence of cognitive impairment in the general adult population is 1.7 percent….'* (Buhrich et al, p. 521). The homeless people in this study with cognitive impairment were significantly older than those without (Buhrich et al 2000).

Buhrich et al (2000) cited prevalence rates of severe cognitive impairment amongst homeless people in other countries as follows: *'…8.9 % amongst homeless men in Munich, 7.8 percent among homeless men and women in Baltimore, and 6 percent among homeless men and women in Madrid.'* (p. 520).

Buhrich et al (2000) suggest one of the reasons for the higher rate of cognitive impairment compared to the general population may be related to the duration of homelessness and cite research among homeless men in London which found duration of homelessness was related to a deterioration in intelligence quotient (IQ). However, this reason does not explain the disease state of severe cognitive impairment (dementia). These findings show that providing shelter alone is not sufficient to keep homeless older people with cognitive impairment out of homelessness as the cognitive impairment makes it difficult for them to move out of temporary accommodation and / or makes them indifferent about their circumstances. Homeless people with cognitive impairment need care and support beyond shelter to keep them free from homelessness (Buhrich et al, 2000).

A small study by Wintringham Specialist Aged Care Service concerning the mental and physical health of their residents was completed in 2008 (Brumen, 2008). They found that *'Mental illness makes up the largest incidence of conditions amongst the Wintringham residents in the study'. The next most predominant health condition was musculoskeletal, followed by cardiac conditions, EHOH abuse, respiratory disease, Acquired Brain Injury and stroke/CVA/TIA. The third prevailing group of diagnosis includes dementia, gastrointestinal conditions, epilepsy/seizures, diabetes and cognitive impairment.* (Brumen, 2008, p. 34-35) The report in *Parity* by Susan Brumen, the Clinical Care Manager at Wintringham does not include a percentage breakdown of the various mental and physical conditions, nor how dementia was determined, so it is not clear how this result compares with prevalence rates of severe cognitive impairment in other studies. Importantly, there were a considerable number of residents with cognitive impairment and Brumen states that numerous

resources are required to appropriately manage the health and social needs of their residents. In 2008 WSACS was involved with the Wicking Project designed to develop a successful long-term model of residential care for persons with dementia resulting from a severe acquired brain injury and the associated complex behaviours. The results of the Wicking Project are discussed in *Models of Care for Older Homeless People.*

A preliminary report on a study in the inner-city of Sydney (Rogoz et al, 2008) found that 67% of participating homeless older people showed evidence of cognitive impairment. It was not clear from this report how cognitive impairment was determined and the authors did not provide a definition of 'severe cognitive impairment' so the term 'dementia' was assumed from the broader category of severe cognitive impairment. The researchers referred to a number of studies that used the DSM-IV axis I psychiatric diagnosis and for the purposes of this review, that will be assumed. The researchers also wanted to understand if a focussed treatment plan would make a difference to their medical and/or physical morbidity, over a 6-12 month period. (Rogoz et al, 2008, p. 22) Their preliminary results showed that the older homeless population have significant rates of cognitive impairment and the needs of this population are '*….best addressed by the formation of a dedicated multidisciplinary team of mental health professionals skilled in finding, screening, assessing and co-ordinating the management of the high rates of mental health problems, mental illness, physical illness and cognitive impairment in this elderly homeless population.* (Rogoz et al, 2008, p. 23).

Although many of these studies are older than 5 years, we know that rates of homelessness and dementia are increasing (Homelessness Australia, 2013; AIHW, 2012). In summary, the evidence points to the fact that staff caring for older homeless people in Australia are dealing with a population group which has significant rates of cognitive impairment including many people with severe cognitive impairment (dementia).

Current research is needed to understand dementia in the homeless older population and to understand the educational / training / resource needs of health professionals working within those support services (mainstream or otherwise) who engage with homeless older persons.

The literature subsequently includes structural reasons for older persons homelessness in Australia followed by the nature of the support provided to older homeless people within the aged care industry in Australia. As there is more literature on the topic of older homeless people with cognitive impairment, not specifically dementia, we have assumed that the care provided to older homeless people with cognitive impairment will be similar to the care provided to older homeless people living with dementia, albeit the latter group will need more specialised support or treatment. Specifically, in the literature review is an understanding of how older homeless people with cognitive impairment access care; what support and care was provided and evidence of care needs met; what problems existed in providing care, and what were the best models of care in Australia.

Structural problems in Caring for Older Homeless People

Housing

Suitable housing for older homeless people is paramount if authorities are serious in addressing the problem of older homeless people (Morris et al, 2008; Rogoz et al, 2008). Many studies have been conducted showing that a major issue in addressing older persons homelessness is appropriate, affordable and stable housing (Kovess, 2002; Van Wormer, 2005; Morris et al, 2008; Ploeg, Hayward, Woodward & Johnston, 2008; Batterham et al, 2013). A number of case studies on older homeless

people have shown that the main reason for becoming homeless is the loss of adequate, affordable housing, in many cases underpinned by poverty (Morris et al, 2008; Lipmann, 2009). Other reasons include problems with other residents, drug and alcohol abuse and mental illness. (Johnson & Chamberlain, 2011) There is a large body of underutilised local and international research showing that among other issues such as family breakdown and low income a shortage of appropriate and affordable housing as well as poverty significantly influence the size and demographic profile of the homeless population in western countries (Johnson et al, 2011; Batterham et al, 2013).

Dalton & Probyn (2008) found that as poverty can be a pathway to homelessness with older homeless people unable to access mainstream funding through the aged care system, they also do not 'fit into the system'. Indeed, as homelessness prematurely ages people, those who are physically 'old' but chronologically too young for the aged care system do not have access to this highly structured government financial support (Dalton et al, 2008). Poverty, physical and mental co-morbidities as a result of ageing as well as the inherent dangers and challenges of living on the streets has all sorts of implications in terms of the health and wellbeing of older homeless people according to O'Connell, Roncarati, Reilly, Kane, Morrison, Swain, Allen & Jones, (2004).

A number of researchers have found problems within the homeless population can only be effectively addressed in an environment of stable housing. It is difficult to provide care and resources to people who are living on the streets (Crane & Warnes, 2008; Ploeg et al, 2008; Barrett, Fogel, Garrett & Young, 2011). O'Connell et al (2004) claim that a further complication is that diagnosing dementia is difficult on the streets as evaluation of the person necessitates access to a battery of tests and a chronological history of patterns of behaviour. Refusal by older homeless people to be evaluated and subsequent issues of competency and the legalities around this create further barriers to service engagement (O'Connell, 2004) As mentioned previously, Buhrich et al (2000) found that older homeless people with cognitive impairment needed more than secure housing; they needed additional care and support. Van Wormer (2005) also concluded that not only do older homeless people need assistance in gaining housing but also in order to remain in housing. Further, due to the intensive nature of working with older homeless people, experienced staff in housing and aged care services understood the process of housing assistance and support to be a lengthy one of trial and error (Siegmann, 2009).

Services

Other challenges to effectively reducing the older homeless population in Australia have to do with the very nature of this group of people: they are incredibly independent, disengaged with services, lack insight into their physical and mental frailties, and require a lot of time and effort to build a relationship of trust (O'Connell et al, 2004; Lipmann, 2009).

O'Connell et al (2004), in their study of older homeless people (followed 30 individuals 60 years or older for four years) supported by the Boston Health Care for the Homeless Program (BHCHP) found that appropriate ongoing care can be provided if multidisciplinary teams of health professionals engage in outreach strategies on a consistent basis. The BHCHP is an outreach program conducted by a multidisciplinary team of health professionals providing care to the homeless in places they feel comfortable, that is, on the streets. In a preliminary report Rogoz et al (2008) reported on the cognitive impairment in older homeless people in inner-city Sydney and found high rates of significant cognitive impairment and concluded that improving access and delivery of services to the homeless older with cognitive impairment requires dedicated multidisciplinary teams of health

professionals skilled in outreach, assessment and management of the numerous conditions afflicting the older homeless . Many studies have found that providing appropriate outreach services to this extremely difficult to engage population can be effective as long as there are multidisciplinary teams of skilled and specialised health professionals able to build trust over time and remain engaged with the older homeless population (Green, 2005; Yang, Garis & McClure, 2006; Crane et al, 2008).

Prior to the 2009 amendments to the Aged Care Act 1997(ACA) the aged care system was structured such that services were accessed and delivered through mainstream portals such as the Aged Care Assessment Service (ACAS), GPs , the primary care system, the hospital system and through family members. The nature of homelessness meant that service access and delivery were beyond the means of older homeless people. Often the person came to the attention of the health services through accessing the acute care services when they were picked up on the streets suffering a severe health condition that, had it been treated earlier, may have been resolved without further congesting the emergency department in a hospital (Lipmann, 2009). Barrett et al (2011) reporting on older homeless people in Florida, USA, claimed there was an increasing need to understand and work on the different ways older homeless people gain access to services. They found there were a number of ways that access to services could occur and that more work needed to be done on the pathways to services and the outcomes of interventions. Greater collaboration amongst services and agencies caring for older homeless people was needed to ensure best practice.

Jeskie (2008) from the Catholic Healthcare Association in Australia claimed that more needed to be built into the aged care system in terms of appropriate funding models for older homeless people. The funding that existed at this time (2008-2009) did not include the recognition of the specialist care that older homeless people required. Partnerships involved the state health groups assisting with funding for aged care providers by offering beds through the aged care system as 'mental health' beds but in reality an 'elderly homeless' beds. The ACHA, at the time, was the only federally funded program that provided housing, care and support specifically for older homeless people. Even though there was not a great deal of funds for this program the ACHA agencies were instrumental in assisting thousands of older homeless people to find secure housing (Morris et al, 2008).

According to the literature, it was during this period in 2008 that homeless persons' advocates had an opportunity to contribute to the Australian Federal Government's Green Paper on Homelessness. Bryan Lipmann, Chief Executive Officer of WSACS, amongst others, lobbied the Australian Government to make 'homelessness' a special needs group. His argument was that to get the appropriate policy settings in place that will drive aged care reforms in this area and create access to the funding stream of the aged care industry, older homeless people needed to be considered in the ACA as a special needs group. (Lipmann, 2009) Importantly, the Australian Government responded to submissions to the Government's Green, and subsequently White Paper that enshrined a number of legislative changes, in effect not only recognising homeless people as a special needs group under the ACA but also developing a number of programs to support older homeless people with housing and care.

The literature findings established that older homeless people require intensive supportive services on an ongoing basis provided by multidisciplinary teams of people and engagement with someone whom they trust.

A brief summary of the Australian government's support to the older homeless population over the past 20 years is now provided.

Australian Government Funded Aged Care Support for Older Homeless People: 1993-2013

Many of the references cited in this literature review refer to the various programs funded by the Australian Government. It is important to understand the historical context of homelessness services and the more recent focus on this special needs group by the Australian Government since the ACA was amended in 2009.

The Federal Government, in recognition of the overwhelming research and lobbying on behalf of homelessness advocacy groups, released the Green Paper on Homelessness. Government housing assistance for the homeless provided up to that point had been through the SAAP which, despite aiming to provide accommodation and support services, was really just a crisis accommodation service to homeless people (Department of Social Services (DSS), 2014).

Overall, responses from the consultation process as a result of the Green Paper suggested the White Paper develop a new, whole of Government approach that would:

- *Demonstrate national leadership;*
- *Focus strongly on prevention and early intervention to stop people becoming homeless;*
- *Provide support for homeless Australians that leads to increased economic and social participation;*
- *Encourage closer collaboration between homeless and mainstream services used by people vulnerable to homelessness;*
- *Increase access to safe affordable housing linked to appropriate support services; and*
- *Recognise the complexity of homelessness and address the needs of different groups within the homeless population including families with children, young people, Indigenous people, older adults, people with mental health and/or drug and substance abuse issues, and women and children experiencing domestic or family violence.* (DSS, 2014)

The White Paper on Homelessness was released in December 2008 and set the strategic agenda for reducing homelessness through to 2020. Specifically, the goals of the White Paper were to reduce the homelessness population by 50% and offer supported accommodation to homeless persons sleeping on the streets by 2020. Future strategies for funding and support included preventative services; fully integrated services so that sustainable housing is achieved with social and economic participation of homeless people and movement through crisis accommodation into stable housing quickly including continuity of care to ensure homelessness does not recur (DSS, 2014).

The ACA was amended in 2009 to include homelessness as a special needs group. Under the amendment older homeless people's special and unique needs were, and continue to be, recognised. Specifically, the amendment allowed allocation of funding for community and residential care packages and capital funding for specialist facilities for older homeless people. These measures were in response to the White Paper (DSS, 2014).

An alternative and better focussed model for older homeless people than the SAAP was the ACHA. Established in 1993, the ACHA operated outside the ACA and aimed to provide housing and support to incapacitated, low income older people who were living in insecure housing, at risk of

homelessness or who were homeless. The program helped them to remain in the community by facilitating access to housing linked to community care (Melville, 2008). Recurrent funding is provided to organisations that support older homeless people linking them to mainstream housing and care services (DSS, 2014).

According to their website updated November 2010, the Australian Government stated that they also focussed on working strategically and collaboratively across relevant Government Departments and with the Homeless Delivery Review Board to develop integrated ways of addressing homelessness. The Aged Care Funding Instrument (ACFI) was also being reviewed in order to better reflect special needs groups including homelessness.

A further measure arising from the White Paper was the National Partnerships Agreement on Homelessness (NPAH) between the Australian State and Territory Governments. The agreement aimed to prevent and intervene early to stop people becoming homeless; break the cycle of homelessness and improve and expand the service response to homelessness. Specific to the older homeless population it was agreed that State and Territory governments would work towards providing:

- support services and accommodation to assist older people who are homeless or at risk of homelessness, and
- outreach programs to connect rough sleepers to long-term housing and health services.

The NPAH commenced in January 2009 for a period of 4 years. A transitional arrangement occurred between 2012 and 2013 (DSS, 2014).

In 2013 the Australian Government Department of Families, Housing and Community Services funded a program called 'Housing Assistance and Homelessness Prevention Program'. The aim of the program was to provide access to affordable and safe housing and fund initiatives to prevent homelessness. Homelessness services funded under this program respond to people who are homeless, or at risk of homelessness, and their families. These include a community based early intervention program, a strategic framework to improve collaboration and linkages between existing services, and specialist services. This initiative is particularly for families and younger people at risk of, or experiencing homelessness. There appears to be no specific mention of older homeless people. However, according to the Government website, this initiative is in keeping with the White Paper (DSS, 2014).

The ACHA program continues to offer housing and support services to homeless people or people at risk of becoming homeless. The program is accessed through a number of services such as Catholic Community Services. The Federally funded HACC program has a number of strategies including some community outreach programs that the Royal District Nursing Service (RDNS) offers such as the HPP and the CCP at the Merri Outreach Support Service (MOSS). The HPP is an outreach service using a team of specialist community health nurses and works with other services to arrange healthcare for homeless persons. The CCP offered by MOSS is an outreach program in part funded by the State Government in Victoria to locate, engage and connect with appropriate services for older homeless people. There are approximately 16 service providers in Victoria. Other States and Territories have various homeless support services that are funded under the ACHA and HACC programs, including, but not limited to, CCP.

Recent government funding includes support for community care to help older people who are not in sustainable housing or who are homeless. As well, the Residential Aged Care Homeless Supplement better supports aged care homes that specialise in caring for people with a history of, or at risk of, homelessness. While not specifically for homeless people with dementia, those assisted by these initiatives will include people with dementia. Further information is available at http://www.myagedcare.gov.au/aged-care-services/assistance-care-and-housing-aged

Models of Care for Older Homeless People

According to Barrett et al (2011) there are a considerable number of challenges to meeting the care needs of older homeless people. Unfortunately due to the lack of engagement with services until an acute episode where urgent hospitalisation is required, preventative care delivered within the community poses enormous challenges (Barrett et al, 2011). A number of studies have found that effective models of care include outreach on an ongoing basis. In this way the many acute and chronic conditions that older homeless people suffer can be managed to minimise disability. Acute conditions can be detected in an earlier stage and chronic conditions can be better managed to prevent exacerbation (O'Connell et al, 2004; Green, 2005; Yang et al 2006; Crane et al, 2008; Rogoz et al, 2008). However, this approach involves high costs, is very time consuming and requires the specialist skills of multidisciplinary teams (Crane et al, 2008). Barrett et al (2011) underscores the importance of further research in the area of health service requirements to meet the care needs of older homeless people: *'Policy prevention, intervention, and research efforts should continue to focus on the health service needs and receipt of care among homeless persons, as well as affordability of services……* (Barrett et al, 2011, p. 348*).*

Kim, Ford, Howard & Bradford, (2010) undertook research on older homeless men in North Carolina, USA, and concluded that the current system of sporadic crisis-driven care is not the answer services require in caring for this group of older homeless people. Rather, as a preventative approach, long term continuity of care is needed. Continuity of care can be provided in different ways. Two successful models of continuity of care are those of WSACS and the Mercy Arms CCP. Both care approaches have developed through a social justice framework which places importance on dignity, personhood and individual self-worth, and empowerment.

WSACS in partnership with the Wicking Project have evaluated the effectiveness of a model of residential care in older homeless people with acquired brain injuries including dementia. *'Acquired brain injuries can cause symptoms similar to psychosis and dementia, as well as significant problems with impulse control, social skills and self-awareness'* (Lipmann, 2013, p. 7). Their model of care involved intensive recreation, individualised behaviour modification programs built within a social justice framework of building community, building confidence and skills and enabling individual purpose and belonging. They concluded this model of care showed the potential to deliver effective care that was cost effective and able to transition older homeless people from an acute (hospital) setting, crisis driven approach to care, into a long-term continuity of care approach in a residential aged care facility (Rota-Bartelink, 2012).

The CCP reviewed by Morris et al (2008) was started by Mercy Arms Community Care in 2003. The day program aimed to help clients to connect with others socially and to assist them with their daily living and improve their self-worth. Assistance with housing was also part of the service provided. All the participants found that the program had positively impacted on their lives. Specifically the program gave them the opportunity to socialise and become part of a community. Mercy Arms

Community Care at the time of the review in 2008 had become part of the Catholic Healthcare Community Service (Morris et al, 2008).

In 2014 the Catholic Community Services is one of the providers of the ACHA designed to assist disadvantaged older persons with their housing needs. Catholic Community Services also provide two homelessness packages to support older homeless people or those at risk of being homeless to live in the community: Homeless Community Aged Care (HCACP) that provides ongoing community care and monitoring to those aged 65 and older or Aboriginal and Torres Strait Islander Peoples aged 50 and older, previously homeless or at risk of homelessness and Community Options Program (COPS) Homeless with the aim of the program to assist clients to live independently in the community (Catholic Community Services, NSW/ACT) . Many of the specialist aged care services mentioned such as WSACS offer specific Government funded housing support and assistance packages to their homeless clients. However, as evidenced by the literature and more recently found by Batterham et al (2013), there remain significant barriers to older homeless people accessing services, securing affordable housing and the provision of continuity of care.

Some of the services which support older homeless people such as WSACS, have given personal examples of the experiences of some of their clients. Trish Dalton from the HPP at the RDNS and co-author Zoe Probyn from the CCP at the MOSS (both HACC funded) presented 'Joe's' story. which described numerous difficulties along the pathway to supportive housing and care for Joe. These were apparent in Joe's family trying to access services, the delivery of services and the co-ordination of services. At each checkpoint along the pathway problems meant that Joe was not properly housed for many months. Dalton et al (2008) emphasized that services needed to be as visible and as accessible as possible and that innovative ways of delivering these services needed to be explored. Joe's example not only highlighted the problem of access and collaboration but also, as other studies into intervention programs for older homeless people have found, the importance of offering a seamless service which co-ordinates, integrates and shares information between and within services. (Proehl, 2007; Ploeg et al 2008; Siegmann, 2009).

Conclusion

The literature demonstrates that providing access to services including aged care, health and housing for older homeless people with multiple complex problems including mental illness who are hard to reach and do not seek services, is challenging. Therefore a combination of outreach using multidisciplinary teams to initially build trust with older homeless people, make assessments and evaluate the type of care needed, as well as an effective pathway through the aged care system to permanent housing either in the community or in residential aged care, is recommended. [O'Connell, 2004; Yang et al 2006; Crane et al, 2008; Rogoz et al, 2008) Ultimately, the best model for care of older homeless people is a one stop service that provides prevention, outreach, assessment and evaluation, all types of housing including crisis, transitional, community and residential, supportive services such as mental health, addiction etc; assistance with all aspects of daily living and continuity of care (Green 2005)

Fortunately with the recognition of homelessness as a special needs group since 2009, the situation for older homeless people in terms of housing and care in Australia has greatly improved. Instead of the merry-go-round of crisis intervention and back onto the streets, homeless people can now expect early intervention leading to continuity of care. The original ACHA packages were the only government funded housing assistance and support that older homeless people had prior to the

changes in the ACA, albeit too few of them, these packages continue to be offered through a large number of government, not-for-profit and private aged care services. As previously described there are two packages specifically targeted to people formerly homeless or at risk of being homeless. The evidence shows that the ACHA service has been very effective in helping older homeless people secure housing and co-ordinate services through which other support and care can be provided. (Morris et al, 2008) As well as ACHA there are the HACC funded outreach services that have enabled harder to reach older homeless populations receive support, although as stated by Dalton et al, (2008) collaboration and service flexibility remain a challenge.

Much of the literature indicated the importance of health professionals being able to locate, engage, screen and assess older homeless people with cognitive impairment. Staff also needed to be skilled in liaising with and co-ordinating services, sharing of information, program delivery and program management. (Green 2005; Dalton et al, 2008; Rogoz et al, 2008; Siegmann, 2009) The findings from the literature review made clear that specialist knowledge and skills are not only required to provide the best care but also in order to manage some of the risks to staff and their clients associated with dealing with the myriad of acute and chronic illnesses that older homeless people are at risk of, or live with. However, there was a distinct lack of information in relation to cognitive impairment and the needs of the staff working with homeless persons with dementia. Further research in this area is warranted. The evidence also showed that it is critical to an effective outcome for older homeless people to have seamless service delivery enabled through effective co-ordination between aged care, health and housing.

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