

Aged Care, Homelessness and Brain Injury

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Abstract

Service providers have been frustrated with the lack in availability of specialised long-term supported accommodation for older people, particularly older homeless people, living with an acquired brain injury (ABI) and significant behaviours of unmet need. Although the incidence of ABI (particularly alcohol-related brain injury) is far wider than being confined to the homeless population, it is frequently misdiagnosed and very often misunderstood. Wintringham is an independent welfare company which provides secure, affordable, long-term accommodation and high quality services to older homeless people living in Australia. Over an eight-year period and two phases of a research project (Wicking I and Wicking II Projects), Wintringham has been at the forefront of developing an appropriate model of care to support these individuals. The Projects have investigated, designed, trialled and evaluated a purpose-designed 'Specialised Model of Residential Care' specifically aimed at providing long-term care and support to older homeless people who are also trying to manage the symptoms of an acquired brain injury.

Keywords: Ageing; Homelessness; Alcohol; Alcohol related brain injury

Introduction

For over 25 years Wintringham aged care services in Melbourne, Australia have been supporting people who have experienced or are at a high risk of experiencing homelessness [1]. Older men and women from homeless and low socio-economic backgrounds often face disadvantage with respect to equity of access to quality health and aged care. Coupled with other significant social, health and psychosocial challenges, these individuals are placed at greater risk of a rapid decline in health and wellbeing with subsequent premature ageing and mortality. As a consequence many are in need of aged care at younger ages than the general population. For this reason, Australia as with many other nations, has deemed that people aged 50 years and older who are experiencing homelessness are eligible to receive the support of government funded aged care services. This in itself has created obstacles to the access and delivery of appropriate care to people who have aged physically but not psychologically and therefore do not easily assimilate with mainstream aged care populations.

Another, more compounding impediment to the delivery of appropriate aged care to this population is the high prevalence of behaviours manifesting from unmet need exhibited by its constituents. Although the group of people living with an acquired brain injury (ABI) constitute only a small proportion of the total number of aged care residents living with some form of cognitive impairment, they present severe and ongoing challenges to support services. Most problematic is the frequency with which significant problems with impulse control, social skills and self-awareness accompany the diagnosis of an ABI. Brain dysfunction due to trauma from multiple sources, leads many service users to display preservative, high risk behaviours which are often aggressive in nature.

Research evidence has shown that the presence of a brain injury is highly prevalent within the older homeless population. People

experiencing homelessness report an exceptionally high rate of trauma exposure [2]. Approximately fifty percent of homeless service users (58% of homeless men and 42% of homeless women) have a history of traumatic brain injury [3]. The most common of which are acquired brain injuries (ABI) arising from long-term exposure to the harmful levels of alcohol intoxication and/or head trauma [4]. People living with multiple diagnoses including mental illness, substance abuse and ABI often find it difficult to access appropriate services. These individuals can be slow to respond to questions and perform tasks, due to slower thought processing speeds and may have trouble negotiating complex systems due to cognitive or behavioural problems. Commonly accompanying these injuries is an overlay of complex behaviour that may further alienate the individual from social inclusion and accessing mainstream aged care support.

This is particularly evident when an individual is affected by the influence of alcohol or other drugs. Of Wintringham's 1,500 service users, approximately 20-30% of its residential and community aged care recipients have experienced or are continuing to experience an addiction to alcohol. It is estimated that within this group, over 50% (300 people) are affected by an alcohol related brain injury (ARBI) and very frequently this is accompanied by a traumatic brain injury. People living with an ARBI receive less empathy and often attract more judgemental attitudes in the public view than people living with age-related dementias. People living with an ARBI and ongoing addiction are often preoccupied with activities directed toward the procurement of alcohol. In the absence of adequate funds, they often resort to whatever means possible in order to access alcohol including criminal activity, aggressive stand-over tactics, begging or selling-on possessions of any significant value. Vulnerable co-residents can easily fall prey to such behaviours as can personnel who may not have the required skills to manage them.

The behaviour characteristics commonly associated with ARBI have been shown to differ from that of age-related dementias particularly with regard to social skills and social interactions resulting in a completely different set of complex care needs [5,6]. People living with

an ARBI may present with behavioural disturbances which are predominantly attributed to an impairment of the frontal lobes of their brain. The diversity of symptoms can include impediments in executive functioning, ability to learn (learning difficulty), thought processing and emotional regulation [7].

Alcohol related brain injury is caused by a combination of Thiamine (vitamin B1) deficiency, general cerebral shrinkage (secondary to alcohol consumption), and a range of other insults to the brain including repeated head injury or assault [7]. There is a growing body of research examining the effects of aging in association with long-term alcohol abuse; however the increased complexity of these two factors in the homeless population has received little attention [8,9]. The relationship of alcohol and drug use to homelessness is interactive and iterative in that it can be both a cause and an effect of homelessness [10]. In a study in Melbourne, 43% of an elderly homeless population reported having issues with alcohol [11]. Problems were more commonly reported by men (48%) than women (28%) with nearly half the men admitting to heavy drinking or alcohol dependence.

The Wicking Projects I and II (2007-2015) were undertaken under the auspices of Wintringham. They were designed to develop and deliver dignified residential aged care to older people experiencing homelessness while living with an alcohol related brain injury [12]. The Wicking Projects delivered a specialised model of residential aged care which reframed challenging behaviour among its participants to be interpreted as self-protective/defensive or responsive behaviour that occurs as a result of unmet needs. Primarily the philosophy of managing behaviour of unmet need was underpinned by the acknowledgement of the presence of an acquired brain injury. The focus of the project was to ensure that these individuals received the care and support to which they were entitled and was appropriate to their needs.

In the field of research into the delivery of aged care to a population of people experiencing brain injury, in particular alcohol addiction, it becomes apparent that there are numerous areas in which the gold standard research design, the randomized controlled trial (RCT), can be extremely difficult to achieve and in some instances impossible [13]. This is due to the high prevalence of varied and multiple pathologies, both physical and psychological among its members, their frequently chaotic and disenfranchised lifestyles including homelessness, the high attrition rates, small sample sizes, and limited survival times. Furthermore, a number of important issues need to be considered including disparities in access to and length of engagement within social welfare and health care services, frequent stigmatization of individuals, their behaviour or lifestyles, and the presence of significant barriers to establishing rapport and trusting relationships.

The Wicking Projects were therefore evaluated using action research methodologies which were exploratory in nature with a mixed methods design incorporating both qualitative and quantitative data. The outcomes of the Projects have elicited essential components of a care model designed to provide aged care to people living with an ARBI. These include: the delivery of a harm minimisation program involving a controlled drinking and smoking programs for those who were actively drinking; centring the individual in the delivery of a psychosocial model of care; working together with neuropsychologists in the application of behaviour management strategies based functional behaviour assessments and the development of behaviour support plans; developing and delivering individualised structured

activity programs and; delivering care in a purpose-built environment by a team of highly trained and skilled personnel.

Essentially the successful outcomes achieved for the participants in The Wicking Projects have led to a greater understanding of what is achievable through a highly supportive model of residential care. It has also led to a shift in emphasis and direction from traditional models of residential care where the expectation is that residents adapt and assimilate to the aged care environment to a more specialised model that truly focuses on individualised care.

With a high percentage of people presenting with long and established histories of drinking, smoking, gambling, crime and acquired brain injuries, not many aged care services are willing, or have sufficient expertise, to allow clients their preferred lifestyle choice. Often service providers are challenged to support the diversity of need exhibited within a single service setting because of the scarcity of trained staff and available resources. Consequently, in order for support services to deliver care that is appropriate and effective, they must possess knowledge of the underlying, and often multifactorial cause of the behaviour, and be skilled in the delivery of effective responses taking into consideration the limited cognitive capacity of individuals living its effects.

References

1. <http://www.wintringham.org.au/>
2. O'Donnell M, Varker T, Cash R, Armstrong R, Di Censo L, et al. (2014) The Trauma and Homelessness Initiative. Report prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria, Australia.
3. Hwang SW, Colantonio A, Chiu S, Tolomiczenko G, Kiss A, et al. (2008) The effect of traumatic brain injury on the health of homeless people. *CMAJ* 179: 779-784.
4. Sabaz M, Simpson GK, Walker AJ, Rogers JM, Gillis I, et al. (2014) Prevalence, comorbidities, and correlates of challenging behavior among community-dwelling adults with severe traumatic brain injury: a multicenter study. *J Head Trauma Rehabil* 29: E19-30.
5. Oscar-Berman M, Shagrin B, Evert DL, Epstein C (1997) Impairments of brain and behavior: the neurological effects of alcohol. *Alcohol Health Res World* 21: 65-75.
6. Higgins ST (1997) Applying learning and conditioning theory to the treatment of alcohol and cocaine abuse. Lippincott-Raven, Philadelphia, USA, pp. 367-385.
7. Cox S, Anderson I, McCabe L (2003) Report of the Expert Group on Alcohol Related Brain Damage June 2003. Dementia Services Development Centre. University of Stirling, Stirling, Scotland.
8. Hawkins JD, Graham JW, Maguin E, Abbott R, Hill KG, et al. (1997) Exploring the effects of age of alcohol use initiation and psychosocial risk factors on subsequent alcohol misuse. *J Stud Alcohol* 58: 280-290.
9. Antai D, Lopez GB, Antai J, Anthony DS (2014) Alcohol drinking patterns and differences in alcohol-related harm: a population-based study of the United States. *Biomed Res Int* 2014: 853410.
10. Johnson AK, Cnaan RA (1995) Social work practice with homeless persons: state of the art. *Research in Social Work Practice* 5: 340-382.
11. Rota-Bartelink A, Lipmann B (2007) Causes of homelessness among older people in Melbourne, Australia. *Aust N Z J Public Health* 31: 252-258.
12. Aarons GA, Hurlburt M, Horwitz SM (2011) Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Adm Policy Ment Health* 38: 4-23.
13. Li L, Ma Y, Hu X (2001) [A research of infant refraction in Kunming Municipality]. *Zhonghua Yan Ke Za Zhi* 37: 24-27.