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Corresponding Author Mail id : **Dina.Logiudice@mh.org.au**

The Health of Older Aboriginal and Torres Strait Islander peoples

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Abstract

The health of Aboriginal Australians is poorer than that of all other Indigenous cultures in developed nations, and recent studies suggest high rates of dementia and other conditions that are common in old age. This has implications for health promotion, provision of services and planning for older age in these communities. This article provides an overview on the health of Older Aboriginal Australians.

Key words:

Aboriginal and Torres Strait Islander peoples

Ageing

Dementia

Frailty of care

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Introduction

The Aboriginal and Torres Strait Islander culture is considered to be one of the oldest and most diverse cultures in the world, with over 250 languages spoken and a multitude of cultural traditions in use (1), (2). Aboriginal and Torres Strait Islander (ATSI) peoples, respectfully hereafter referred to as Aboriginal people are a minority group in Australia, comprising 3.0 % of the total population, with 25% living in remote areas. Despite the Aboriginal population having a younger age structure than the wider Australian community, the young old (45-64 years) group (3) are rapidly growing (2). The number of Aboriginal people is projected to treble in those aged 65 years and over from 22,700 to 61,900 by 2026. Discrepancy in poor health status and rates of chronic diseases continues and life expectancy remains 10 years less than the rest of the Australian population (1). There are approximately 400 million Indigenous people world-wide, who experience similar disparities in health and ageing demographic changes (4, 5), including our Maori neighbours.

Aboriginal older people play a key role in the health of their communities, including holding cultural rights and responsibilities for the maintenance of connections to country, caring for extended family members including grandchildren, and providing leadership and support within communities (6, 7). The important role that older Indigenous people play in their community is illustrated by this quote from a study of carers living in the Kimberley *“even for the little kids they learn a lot off her as well...She teaches in languages. Words right and wrong, how to respect others, she does a lot of things..”*(7). Yet there remains a lack of awareness of what it means to “age well” within an Aboriginal context. The World Health Organisation definition of ageing well includes "optimising opportunities for good health, so that older people can take

an active part in society and enjoy an independent and high quality of life" (5), yet the many bio-psychosocial factors that might contribute to this are likely to be substantially different for Aboriginal older people living in their communities. In addition, there is a lack of knowledge among health service providers and planners as to how to meet the unique needs of this group.

Australia and New Zealand have undertaken significant landmark studies that have demonstrated alarmingly high prevalence and incidence rates of dementia of up to 3-4 times that of the wider community of Australians, occurring at a younger age (typically 10-15 years earlier) in both urban and rural regions (8-11). In addition frailty and falls appears common (unpublished data). Despite these emerging data, there are many examples of Aboriginal Australians living healthy lives well into their 80s (2), yet the factors that contribute to these differences are unknown. In line with increasing awareness of the complex needs of this group, the the National Aboriginal and Torres Strait Islander Health Plan of 2013-23 (NATSIHP), which among other key priorities states that older Indigenous Australians "should be able to live out their lives as active, healthy, culturally secure and as comfortable as possible".

Geriatric syndromes in older Aboriginal Australians

Aboriginal people are exposed to multiple environmental and endogenous insults throughout their life that may increase the risk of geriatric syndromes at an earlier stage of life. Whereas previously it was thought that Aboriginal people did not live long enough to acquire diseases commonly seen in older people, recent evidence demonstrates that this does not appear to be true. The life cycle approach described by Professor Broe and his team in NSW, gives insights into the high levels of dementia, frailty and disability seen in those over 50 years. Factors that contribute to the health disparity of Aboriginal

Australians are many and include low employment and education, poor health linkages and financial barriers, associated with substandard housing and sanitation on a background of years of social and political changes including separation from families and lack of trust with governmental bodies (2, 12). To understand syndromes such as dementia and frailty in the context of Aboriginal communities the multiple and unique socio-political contributors must be considered, in the setting of exceedingly high rates of chronic conditions such as hypertension, diabetes and renal failure that are known contributors to the development of syndromes of the aged.

Dementia

The cultural understanding of dementia may vary within societies and communities, and impact on the presentation and experience of dementia for the person, their carers, families and communities. For health professionals this cultural context of understanding dementia is essential for appropriate assessment, provision of care and education.

In Aboriginal communities, dementia has been described in many ways, including *“Dementia is a sick spirit, a lost spirit looking for help ... It may not need to get fixed as long as the individual is safe and the family and the community is safe ... Other causes of a sick spirit ... is the past history of the stolen generation, dispossession, physical, social and emotional trauma, child abuse, drug and alcohol abuse, poor diet, a lack of traditional healers and herbal medicine being understood and used ...”*(2). A recent qualitative survey explored community members and workers’ knowledge of dementia, giving examples such as head injury, lack of family visits and ageing as reasons for developing dementia. *“Ah talk like um silly and ...yeah walk around*

everywhere sometimes he used to get lost” (7). Other issues such as a high tolerance of behavioural issues within the community setting, poor health literacy, and fear of being admitted to care facilities away from their country may impact on seeking assessment and assistance (13, 14) (see Figure 1).

Our knowledge on the burden of dementia in Aboriginal populations has been improved by development of culturally appropriate cognitive screening tools such as the Kimberley Indigenous Cognitive Assessment tool (KICA Cog) for remote and rural Aboriginal Australians (15). The KICA cog was assessed and validated in three different populations (and there appears to be no education bias found), and is most reliable at a cut-off point of 33/39 and is freely available on www.wacha.org.au. A shorter version, the KICA-Screen was adapted and validated in Northern Queensland, including with Torres Strait Islander people with a cut off point of 21/25(16) and a modified KICA has been successfully tested in an urban sample of La Perouse NSW, as part of the Koori Growing Well Older Study comprising 336 participants over 60 years, although in the latter study, standard screening tests were also utilised (17). The KICA is recommended by aged care assessment teams as most suitable for cognitive screening of older Aboriginal peoples, and other tools have been described for younger people (18). The KICA has been translated and validated in Persian, and is currently being adapted for use in First Nation peoples in Canada, and Indigenous Brazilians.

Utilising the KICA, supplemented by clinical assessment, the prevalence of dementia in remote Aboriginal communities, was estimated as 12.4% in those over 45 years, approximately five times greater than reported for the corresponding age group in the wider Australian population (2.4%), and 26.8% of participants aged over 65 years (19). These figures are amongst the highest

reported worldwide (20). Alzheimer's disease accounted for 24% on clinical assessment, Vascular dementia 13% and dementia related to alcohol abuse was only 4%. Similar rates were found in a study in urban Sydney (9). Follow up study of the Kimberley survey at 5 years, demonstrated that of the original cohort, almost 1/3 had died, and the incidence dementia was 21.0 (10.5, 42.1) per 1,000 person-years (380.3 person-years total) over the age 60 years, comparably high to other populations. Longitudinal risk factors associated with decline from normal cognition to impairment were age and head injury. Other associations with cognitive decline were stroke, non-aspirin analgesics, lower BMI and higher systolic BP (8). This is in stark contrast with recent studies describing a decreasing incidence of dementia as a result of improved lifestyle in Western countries. Recent studies highlight lower socioeconomic status and living in rural areas as factors that may contribute to differences in rates of dementia in diverse ethnic groups (21). Culturally sensitive preventive strategies to diminish head injury and other trauma, and highlighting cardiovascular protection, could potentially lead to a reduction in the burden of dementia and cognitive impairment in remote and rural Indigenous populations, and the importance of prevention from birth is currently being explored (2).

Other syndromes.

Dementia has been the syndrome most researched in this population but evidence is emerging that other syndromes of the aged may be high, again occurring at younger age. For example, utilising data from the Kimberley cohort, a frailty index was utilised comprising 20 health related items, and demonstrated that over half the population could be considered frail, including at a younger age, and was associated with mortality (unpublished data). In addition, utilising adapted screening tools for falls and mobility, pain and continence in representative sample of 184 adults over 45 years 33% had fallen in the last year, 56% described

poor mobility, 17% were in constant pain, 40% were incontinent of urine, 43% had poor vision and 20% poor hearing and one third described sustaining a head injury at some time of their life (8, 10). Further analysis of this data is underway, however highlights the potential significance of these conditions. Understanding how frailty and other conditions might be prevented or ameliorated is therefore important, given its contribution to disability, mortality, and burden on health systems

Approach to care

The importance of the older person remaining in their community close to family and country is well documented, *'it is still important for them to feel connected to their country and taking them away like I am sure that they want to die and pass in their country. You know that's their spirituality that's their connection'*(2, 22). Residential facilities are often seen as a place where people are sent to die, and this perception is compounded by the fact that the facility may be a long distance from their country. The need to investigate effective approaches to ageing well in Aboriginal communities (both urban and rural) have largely been ignored, although with improvement in chronic health outcomes, an emerging understanding of the complexities of ageing and service provision for this population is increasing. There are a number of Government funded programs that assist with provision of care to Aboriginal older people, including National ATSI Flexible Aged Care program (23), and quality standards and indicators are under current review and development to support community care services. Yet despite many programs available, the contributing issues of social and economic disadvantage, geographic challenges and cultural differences, may impede the adequate provision of care at all stages of ageing (including preventative management to end of life care). It is documented that Aboriginal people have less access and use of specialist care after an event requiring hospitalisation and residential care (3, 23), although high relative use

of home care assistance. Adherence to medical advice may be compromised by different belief systems and barriers in communication barriers (24) and less understanding of the broader health care system. In turn, service providers often do not fully understand either the needs of the older person or the needs of Indigenous people who experience cultural and service barriers in accessing services (25).

Best principles for provision of culturally responsive care are documented, and include adequate funding, genuine consultation, participation, leadership and quality assurance, with the aim to enhance cultural resiliency, empowerment and assistance with education and advocacy. In addition encouraging the importance of local workforce engagement supported by appropriate education and training (26). The few examples of successful service development include these principles (22, 27), but in each instance were not replicated in other settings to test for reproducibility, assessed for cost effectiveness, or for outcomes including quality of life.

Conclusion

The conditions of dementia, chronic pain, falls, incontinence and others are common in older Aboriginal Australians. Cultural, social, and environmental factors play a role in the prevalence, assessment and management of these conditions, and need to be acknowledged if we are to improve the quality of life of older Aboriginal Australians already greatly affected by many disabling and costly conditions.

Prevention or delay of onset of many of these common conditions of the aged require increasing engagement and education by local health service providers, where traditionally the primary focus has been on children and chronic diseases. There is a shortage of Aboriginal people employed in health and aged care at all levels, including aged care policy development and decision making. Aboriginal

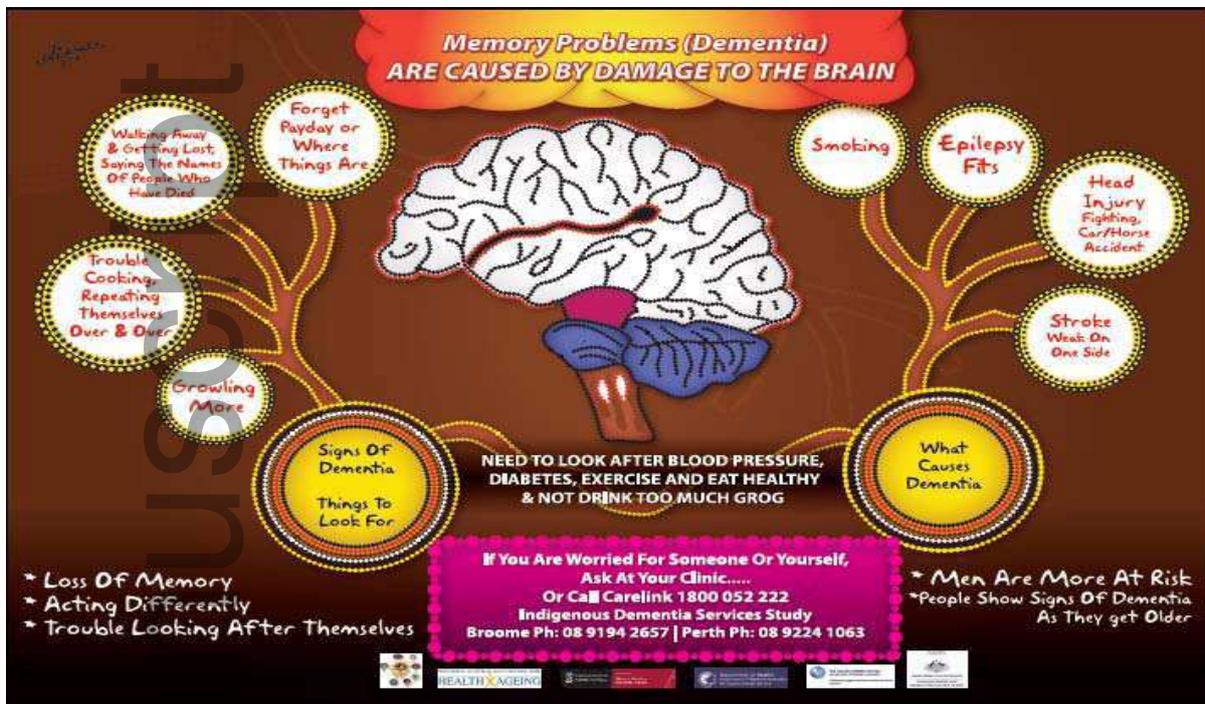
specific aged care training and best practice guidelines are required for all health professionals that work with this population. Discussions about advance care planning and end of life care needs to begin within the primary care setting. Ongoing research into the prevention and management of conditions such as falls, cognitive impairment and chronic pain is required. In addition, appropriately delivered and sustainable models of care for Aboriginal communities are essential. Although there is a long way to go, there are many examples of Aboriginal people ageing well, who are leaders, artists and advocates in their communities, who can provide knowledge to improve the outcomes for older Aboriginal Australians.

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This painting is aimed at an Aboriginal audience and depicts the brain and “the snake eating away the life of your memory” to represent dementia.





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Author/s:

LoGiudice, D

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