

Wheatbelt Aboriginal Aged Care Framework Document Review

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Executive Summary

Healthy ageing is important to ensure the vitality and continued contribution of Indigenous elders to their families and communities. However, Aboriginal and Torres Strait Islander people in the older age groups are less likely to report good or excellent health than non-Indigenous Australians of the same age with higher proportions of Aboriginal and Torres Strait Islander people having disabilities and needing help with daily living.

Social, political, historical and economic factors have contributed to multi generational disadvantage in the Aboriginal and Torres Strait Islander community which has impacted on health, ageing well and life expectancy. In 2011 there were less than 4% of Aboriginal and Torres Strait Islander people aged over 65,¹ however, there is a growing number of the community who are living to over 75 who require health and community care services to support them in older age.

An important factor for positive health and wellbeing within Aboriginal communities is the vast knowledge, guidance and vision from elders. Increasingly elders are unable to participate fully in cultural practices due in part to large numbers of the population suffering from chronic illness requiring regular treatment away from home and the lack of appropriate care services within or close to communities. Many Indigenous groups have a deep connection with the land and the community and staying close to family to participate in essential business limits access to much needed medical and support services.

Purpose of the Background Paper

A key finding in the development of the Wheatbelt Integrated Aged Care Plan is older Aboriginals in the region are not receiving the care they require.

In response to this finding research into best practice and culturally appropriate care for older Aboriginal people and the social, cultural and health issues which impact on access to appropriate services has been conducted and summarised in this background paper.

Best practice, flexible models of care for the older Aboriginal communities in the Wheatbelt region of Western Australia should be informed by the findings of the background paper.

Demographics describing the older Aboriginal population of the Wheatbelt region will be presented in a later element of this project and will be used in conjunction with key findings from this paper to create a holistic model of aged care for the Indigenous population of the Wheatbelt Region.

Traditional Land Owners of the Wheatbelt Region

The main Aboriginal group of the Wheatbelt region of Western Australia is the Noongar. Their country extends from Esperance located on the southern coast through to the Wheatbelt region. Archeological evidence from Perth and Albany suggests the Noongar people have lived in the area for at least 45,000 years. The Gubrun people who are from a separate language group also have traditional ownership of areas of the Wheatbelt region.

The Wheatbelt region is home to 4 Aboriginal Clans:

- Njaki-Njaki Noongar People

¹ ABS, 2011

- Yued Noongar People
- Gubrun People
- Ballardong Noongar People

Impact of Illness

In Aboriginal culture diseases associated with ageing including dementia and chronic illnesses not only affect the person but the entire community due to the role of older Aboriginal people being the custodians of traditional stories, dance and music. Support for healthy and interdependent relationships between families, communities, land and culture is vitally important for Aboriginal and Torres Strait Islander peoples. Ill health is considered to result from an imbalance in these factors.

This view of health is vastly different to the western concept which focuses on treating the illness. Services for older Aboriginal people will need to consider this worldview.

Care options for older Aboriginal people living in rural and remote areas are limited and require development. Access to mainstream and Aboriginal and Torres Strait Islanders services can be achieved through joint planning and building partnerships between government, non government and community organisations and should include full participation of Aboriginal people and their communities in the decision making process and determination of priorities. Positive impact can be achieved with the involvement and ownership by Aboriginal communities in the uptake of new and continuing services.

Health Issues and Life Expectancy of Older Aboriginal People Key Findings

- The need for aged care and community services for Aboriginal people often occurs at a younger age than in the general population, due in part to poorer health status and socioeconomic disadvantage.
- There are many challenges around engaging older aboriginals in aged care including providing culturally appropriate care which may include language, care workers and access to services and transport.
- Like older Australians as a whole, Aboriginal Australians like to be cared for in their communities, close to family and their land.
- The prevalence of dementia in Aboriginal people is almost five times the general Australian population due to high risk factors including chronic disease.
- A lack of understanding about dementia and a fear of the medical system can preclude many older Aboriginals from accessing early intervention services.

Social and Cultural Issues Key Findings

- There are a multitude of interconnected social, political, and economic factors which have had an influence on the ageing experience of Aboriginal people which contribute to poorer health outcomes and life expectancy.
- Very few Aboriginal people access government support programs, particularly those in remote communities.
- The provision of culturally appropriate care for older Aboriginal people by Aboriginal people is seen as a way of addressing issues of inequity in aged care and health care for Aboriginal people.

- Financial, physical and emotional abuse as well as neglect of older people has been raised as an issue in some Aboriginal communities.

Models of Aboriginal Aged Care key Findings

- Developing best practice Models of Aboriginal Aged Care should involve research into localised information about communities and social histories as well as considering the social determinants of health and cultural perspectives and approaches to wellness, ageing and care giving in different Aboriginal cultures.
- A partnership approach with community health services, families and communities may enable this care to take place.
- Building a responsive and flexible Aboriginal workforce is a key driver in the ability to provide appropriate care.
- Many Aboriginal people express a desire to die in their own communities.
- Flexible models of palliative care are needed to support these wishes.

Approaches addressing the social, historical, biophysical and cultural determinants of health and ageing and the Aboriginal world view should be considered in the development of the Wheatbelt Aboriginal Aged Care Framework. Building partnerships with Aboriginal communities and service providers will enable increased participation both in the provision of and access to essential services for the older Aboriginal population.

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1 The Wheatbelt Aboriginal Aged Care Framework

1.1 Introduction

Older Aboriginal Australians are vital in the continuation of Aboriginal history, culture and values. They are viewed as knowledge keepers and facilitate the continuation of culture and history through storytelling, dance and other cultural practices. They pass on lessons in traditional law, land and language. Diseases of age particularly dementia and chronic disease can impact not only on the sufferer but the entire extended community.² The need for aged care and community services for Aboriginal people often occurs at a younger age than in the general population, due in part to poorer health status and socioeconomic disadvantage.³ There are many challenges around engaging older aboriginals in aged care including providing culturally appropriate care which may include language, care workers and access to health and community care services and transport. Like older Australians as a whole, Aboriginal Australians like to be cared for in their communities, close to family and their land.

Scope

In an examination of the aged care needs of the Wheatbelt region it was found there were populations of older Aboriginals whose care needs are not being met. These people tend to live in the more remote areas of the Wheatbelt. This paper has undertaken a targeted review of Commonwealth and Western Australian policy and issues facing Aboriginal communities including:

- Aboriginal Perspectives of Health, wellbeing and ageing;
- Health issues and life expectancy of older Aboriginals;
- Social and cultural issues;
- Models of Aboriginal aged care.

Wheatbelt Aboriginal Aged Care Framework

The development of the Wheatbelt Aboriginal Aged Care Framework will take a holistic outlook to the care of older Aboriginal people in the region.

Within the document review consideration has been given to:

- Chronic disease education and management including renal dialysis strategies and approaches
- Culturally informed palliative care practices with attention to the role of the family and cultural response to death and dying
- Insights that support best practice principles that can guide local planning for aged care services to meet the needs of the Aboriginal populations of the Wheatbelt.
- A number of commonwealth and state health, aged care and disability policy and programs in order to gain a global view of the most effective ways of engaging

² Australian Institute of Health and Welfare 2011. Older Aboriginal and Torres Strait Islander people.

³ Australian Institute of Health and Welfare 2011. Older Aboriginal and Torres Strait Islander people.

Aboriginal populations in services and to confirm unmet needs and issues which may face the older Aboriginal population in order to create effective, comprehensive and culturally appropriate services

The Wheatbelt Integrated Aged Support and Care Solution

More than 150 community members have participated in the first round of community forums as part of the Wheatbelt Integrated Aged Support and Care Solution/s (WIASCS) project.

The project is a partnership between 27 Wheatbelt Local Government Authorities (LGAs), the Wheatbelt Development Commission (WDC), the WA Country Health Service's Royalties for Regions-funded Southern Inland Health Initiative (SIHI) and Regional Development Australia Wheatbelt (RDAW) aimed at developing and assisting in the implementation of a series of integrated solutions to deal with aged care within the region.

The 27 Local Governments involved include the Shires of Beverley, Brookton, Corrigin, Chittering, Cunderdin, Dandaragan, Dalwallinu, Dowerin, Goomalling, Gingin, Kondinin, Kulin, Moora, Narembeen, Narrogin, Northam, Pingelly, Quairading, Tammin, Toodyay, Victoria Plains, Wagin, Wandering, Wickepin, Wongan Hills-Ballidu, York and Town of Narrogin.

The WIASCS project is an extension of planning in the Central Eastern Wheatbelt, which involved 11 LGAs, the WDC, RDAW, South West Medicare Local, WA Country Health Service (WACHS) and WACHS' SIHI. The WIASCS will follow the Central East Aged Care planning model by engaging a range of key stakeholders, including community members and service providers.

Traditional Land Owners of the Wheatbelt Region

The main Aboriginal group of the Wheatbelt region of Western Australia is the Noongar. Their country extends from Esperance located on the southern coast through to the Wheatbelt region. Archeological evidence from Perth and Albany suggests the Noongar people have lived in the area for at least 45,000 years. The Gubrun people who are from a separate language group also have traditional ownership of areas of the Wheatbelt region.

The Wheatbelt region is home to 4 Aboriginal Clans:

Njaki-Njaki Noongar People

The Njaki-Njaki people land covers 31,200sqkm. Their country covers the Wheatbelt towns of Nungarin, Trayning, Kununoppin, Doodlakine, Hines Hill, Kellerberrin, Merredin, Westonia, Carrabin, Bruce Rock, Corrigin, Hyden, Karlgarin, Kondinin, Kulin, Muntadgin, Shackleton and Narembeen.

Yued Noongar People

The Yued people land covers 16,900sqkm. Their country covers the Wheatbelt towns of Dalwallinu and Wubin.

Gubrun People

The Gubrun people land covers 88,000sqkm. Their country covers the Wheatbelt towns of Beacon, Bencubbin, Koorda, Mukinbudin, Bodallin, Carrabin, Westonia, Moorine Rock and Southern Cross.

Ballardong Noongar People

The Ballardong people land covers 27,300sqkm. Their country covers the Wheatbelt towns of Tammin, Wongan Hills, Dowerin, Wyalkatchem, Cunderdin, Meckering and Quairading.

The social structure of these groups is based on family clans which occupy distinct areas of Noongar and Gubrun country and is based on shared culture, language and connection to country.

1.2 National Policy Context

A number of Commonwealth and State policies have been developed with a focus on providing better health and community care services to meet the unique needs of Aboriginal people. These policies also address issues of equity of access to appropriate services and engaging the Aboriginal community in the workforce. Attention to these policies in the development of an Aboriginal Age Care Framework for the Wheatbelt Region will assist in creating a robust, person centred framework.

The National Aboriginal and Torres Strait Islander Flexible Care Program

The National Aboriginal and Torres Strait Islander Flexible Care Program was developed through a series of consultations with Aboriginal communities and organisations and aims to meet the care needs of older Aboriginal people with a focus on equity of access to services. The National Flexible Aboriginal and Torres Strait Islander Aged Care Program provides funding to organisations to provide flexible, culturally appropriate care in both residential or community settings based on the changing needs of the community.⁴ Many services in the program have been established in rural and remote areas close to Aboriginal communities where little or no services were available.

National Partnerships Agreement on Closing the Gap

A number of Indigenous-specific National Partnership Agreements have been agreed through COAG. They commit governments to a common framework of outcomes, progress measures and policy directions to guide Indigenous reform. The agreements build on current initiatives, address shortfalls and in many cases provide significant additional funds.⁵ These include:

- National Partnership on Closing the Gap in Indigenous Health Outcomes
- National Partnership on Remote Indigenous Housing
- Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development
- National Partnership on Indigenous Economic Participation
- National Partnership Agreement on Remote Service Delivery
- Closing the Gap: National Partnership Agreement on Remote Indigenous Public Internet Access
- Closing the Gap in the Northern Territory National Partnership Agreement

⁴ Australian Government, Department of Health and Ageing. Aged care for older people from Aboriginal and Torres Strait Islander communities. March 2013

⁵ <http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/closing-the-gap/closing-the-gap-national-partnership-agreements>

National Partnership on Closing the Gap in Indigenous Health Outcomes

Signed in December 2008, the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes commits \$1.57 billion over four years from 1 July 2009 to tackle the burden of chronic disease in the Indigenous community. It is targeting risk factors, improving chronic disease management and follow-up, and expanding the capacity of the Indigenous health workforce

National Partnership on Indigenous Economic Participation

Agreed in December 2008, the National Partnership Agreement on Indigenous Economic Participation provides \$228.8 million over five years to help create sustainable Indigenous employment opportunities.

The agreement covers:

- The conversion of positions in Community Development Employment Projects (CDEP) to paid work in government service delivery
- Public-sector recruitment
- Public-sector procurement policies
- The development of Indigenous workforce strategies across other COAG reform areas.

National Partnership Agreement on Remote Service Delivery

Agreed in December 2008, the National Partnership Agreement on Remote Service Delivery is providing \$291.2 million over six years from 1 July 2009 to improve the delivery of services in 29 priority locations across the Northern Territory, Western Australia, Queensland, New South Wales and South Australia.

The strategy will progressively deliver to these communities the facilities and services enjoyed in other Australian towns of comparable size, location and need.

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013 was based on a commitment to nine principles including:⁶

- Cultural respect
- A holistic approach to health
- Health sector responsibility
- Community control of primary health care services
- Working together
- Localised decision making
- Promoting good health
- Building the capacity of health services and communities
- Accountability

It aimed to set the agenda for Aboriginal and Torres Strait Islander health and to address approaches to primary health and population health to ensure optimal health outcomes. It was intended for the use of health services and providers and to guide planners and policy makers.

⁶ National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, NATSIHC, Canberra

Development of a National Aboriginal and Torres Strait Islander Health Plan

The development of a National Aboriginal and Torres Strait Islander Health Plan is currently underway. A discussion paper released in 2012⁷ highlights the historical, cultural and social determinants of health and plans to address such issues to improve the health outcomes and longevity of the Aboriginal community. The plan will take a collaborative approach between Aboriginal controlled services, public and private sector organisations by promoting a shared responsibility to achieving health gains.⁸ The new plan seeks to promote and target Aboriginal Health programs which are consistent with the holistic concept of health and wellbeing in Aboriginal communities. The plan will build on links with other major health and broader Government reforms and programs currently operating.

Living Longer Living Better Age Care Reforms

“The Government currently funds more than 58,000 Home Care packages. Demand for these packages far outstrips supply, leaving many people forced to wait a long time for care. The Government will more than double the number of Home Care packages available across Australia over the next 10 years - more than 80,000 new packages by 2021-22. The Government is committing \$880.1 million over the next five years to expand care in the home, reducing the emphasis on residential care.”⁹

“These reforms will enable older Australians to get the help they both need and deserve so they can remain living in their own homes for as long as possible.”¹⁰

Programs and Services

The current processes in place for supported access to aged care, the types/names of services available and even the provision of support for people with dementia will all change during the implementation of the aged care reforms.

Firstly, there is the amalgamation of CACP, EACH and EACHD into **Home Care Packages**. These packages will be provided along a Level A, Level B, Level C and Level D continuum (with Level D being EACH and Level B being CACPs). The expansion of Home Care packages will include two new types of packages (Level A and Level C), one for people with intermediate care needs and one for people with basic care needs. New fee arrangements will be implemented including a cap on costs so that full pensioners will pay no more than the basic fee. Costs for the packages are yet to be determined. There will be a dementia supplement applicable to these care levels to enable the provision of support for people with dementia whatever their care needs.

Further support will be provided to **people with dementia** by:

- Expanding the scope of Dementia Behaviour Management Advisory Services (DBMAS) to include support for people with dementia in primary care and hospitals, so that health professionals will be better able to support people with dementia presenting with behavioural and psychological symptoms; and
- Supporting GPs to make a more timely diagnosis of dementia allowing opportunities for earlier medical and social interventions, reduced risk of premature admission to aged care services and reduced hospital admissions.¹¹

“Around 4,900 new Home Care packages will be offered through the 2012-13 Aged Care Approvals Round (ACAR), which will be advertised later this calendar year. These new Home Care Packages will be available to older people from 1 July 2013,

⁷ Australian Government. Department of Health and Ageing. Development of a National Aboriginal and Torres Strait Islander Health Plan, Discussion Paper. 2012

⁸ Australian Government. Department of Health and Ageing. Development of a National Aboriginal and Torres Strait Islander Health Plan, Discussion Paper. 2012

⁹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-7.htm>

¹⁰ Media Release, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb032.htm>

¹¹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 65

and will be offered as **Consumer Directed Care** packages, building on the success of the recent trial.”¹² Current consumer directed care packages will be ‘mainstreamed’ into the aged care system. Packages will “support greater choice and control for aged care recipients, by embedding consumer directed care into mainstream aged care program delivery ... All new Home Care packages allocated after 1 July 2013 will be required to be offered on a consumer directed care basis.”¹³

Supporting these Home Care Packages is the **Home Support Program** which as of 1st July 2015 will encompass HACC, NRCP, Day Therapy Centres and the Assistance with Care and Housing for the Aged Program. The Home Support Program will have a focus on prevention and reablement as the first level of care in an end-to-end aged care system. The Government will grow this program to meet increasing demand for support at home.

Further to these reforms, **support for carers** will be increased through an:

- Expansion of both emergency and planned respite care currently funded under the National Respite for Carers Program;
- Increase in carer counselling; and
- Establishment of a network of Carer Support Centres around Australia.¹⁴

A new gateway to Aged Care and the My Aged Care Website

Arising from consumer consultations and conversations on ageing held across Australia, the need for additional research was highlighted. “Provider organisations and researchers also raised the need for better access to information and data to support research across the life course. The need for consumers to be more informed and involved in their care was also raised, including the need for advocacy and support.”¹⁵

“Information about aged care services is not readily available or reliable, and assessment processes are often repetitive and inconsistent. The Government is providing \$198.2 million over five years to progressively establish a gateway to aged care services to address these problems. The first steps will be establishing a new **My Aged Care website and national call centre** to be the main entry point for the aged care system. This will be followed by reforms to assessment arrangements and establishing a new linking service to help the most vulnerable older people to access services.”¹⁶

The provision of quality services will ensure through the “development of quality indicators for residential care and home care services, which will be published on the My Aged Care website and which will be used to provide a basis for establishing a star rating system for aged care services...”¹⁷

“To help consumers, their families and carers to make informed decisions about the type of aged care services they receive and who they receive them from, new quality indicators and a rating system will be developed. The results will be published on the My Aged Care website [similar to the My Schools website]. The My Aged Care website and a national call centre will be launched in 2013 to make it easier for consumers, their families and carers to obtain information and make informed decisions about aged care services. A streamlined system for assessing the needs of consumers and a new linking service will be introduced from 2014.”¹⁸

¹² <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-7.htm>

¹³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 42

¹⁴ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-9.htm>

¹⁵ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-2.htm>

¹⁶ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-6.htm>

¹⁷ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 83

¹⁸ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-6.htm>

Ratings for Home Care Packages will be published from 1 July 2016 following the establishment of the Australian Aged Care Quality Agency from 1 July 2014 (see below).

Workforce improvements

“The Government is developing and implementing an Aged Care Workforce productivity strategy in collaboration with the sector to ensure a skilled workforce is attracted and retained to meet growing demand. A new Workforce Compact, between government, unions and aged care providers, will improve the capacity of the aged care sector to attract and retain staff through:

- Higher wages;
- Improved career structures;
- Enhanced training and education opportunities;
- Improved career development and workforce planning; and
- Better work practices.

Additional funding will be provided to aged care providers who sign up to the Compact. The Compact will be developed by an independently chaired Workforce Advisory Group to ensure that workforce reforms lead to improvements in services for older people and benefits for the workforce. The Compact will ensure a strong focus on addressing workforce pressures in regional, rural and remote areas, including action to improve the recruitment and retention and overall geographical distribution of aged care workers.”¹⁹

The Australian Aged Care Quality Agency

In order to enhance the consistency of aged care regulation across residential and community/home care services, from 1 July 2014 there will be a single agency, the Australian Aged Care Quality Agency which will accredit and monitor service providers. “This will be the sole agency that providers will deal with in relation to the quality assurance of the aged care services that they deliver. It will replace the Aged Care Standards and Accreditation Agency thus emphasising the focus on monitoring quality.”²⁰

Aged Care Funding Instrument

Following the ACFI Review in May 2011, a key measure within the reforms is improving the ACFI. “Work will also be undertaken to adapt the ACFI to enable it, in the future, to be more easily applied by independent assessors, who do not have a financial stake in the funding outcome. In addition, further work will be done to revise the ACFI so that it can be used outside residential settings, to determine funding for both residential and community aged care.”

“Introducing independent assessors and broadening the ACFI’s scope to include community care is fundamental to giving consumers greater flexibility and choice in how to spend their subsidy, and will be a key building block for the development of an aged care entry point in future. This is in line with the Productivity Commission’s recommendation that entitlements be attached to care recipients instead of providers.”²¹

¹⁹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-11.htm>

²⁰ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 86

²¹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 89

New Special Needs Group

“The Productivity Commission’s report *Caring for Older Australians* noted that many older Australians from the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community have experienced considerable discrimination over the course of their lives and this may continue in aged care where their sexuality or gender identity may not be recognised or supported. Both during the inquiry and in community consultations following the release of Commission’s final report, groups representing the LGBTI community have strongly advocated for the need to improve the provision of aged care services for older LGBTI people, including by ensuring aged care workers receive sensitivity training.”²²

“Older people in the LGBTI community will be included as a special needs group under the Aged Care Act 1997, which will help ensure that members of the LGBTI community can access appropriate care suitable to their needs.

This measure aligns with the Government’s social inclusion agenda and is consistent with Australia’s human rights obligations. Supporting activities that ensure recognition, awareness and respect for older Australians from the LGBTI community will have a significant benefit on their wellbeing and facilitate social inclusion.”²³

Aboriginals and Torres Strait Islanders

Under the Living Longer Living Better aged care reforms 200 additional aged care places will be made available for Aboriginal communities.²⁴

1.3 Western Australian Policy Context

Model of Care for the Older Person in Western Australia

The Model of Care for the Older Person in Western Australia promotes the wellbeing and quality of life for older people and focuses on keeping people out of hospital through prevention, health promotion and self management approaches to health conditions.²⁵ This document aims to give guidance to providers across the care spectrum from primary care through to acute and aged care services and to those entering older age to becoming frail aged. The overarching objectives are to:²⁶

- Extend the period in which people are well aged;
- Promote services that keep people out of hospital;
- Increase care in the community;
- Deliver services across the care continuum and promote smooth transitions to different care settings as needs escalate.

WA Health Aboriginal Leadership Strategy 2013 -2016

The purpose of this strategy is to build leadership opportunities within WA Health for Aboriginal people in order develop the health system to effectively respond to the needs and to improve the health of the Aboriginal community.

This strategy acknowledges the need to embed Aboriginal leadership within the organisation to encourage the growth in the Aboriginal workforce and to be guided by

²² <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 80

²³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm> page 81

²⁴ Australian Government, Department of Health and Ageing. Aged care for older people from Aboriginal and Torres Strait Islander communities. March 2013

²⁵ Aged Care Network Western Australia. Model of Care for the older person in Western Australia

²⁶ Aged Care Network Western Australia. Model of Care for the older person in Western Australia

Aboriginal people to do things differently to develop better and more appropriate services for Aboriginal people.²⁷

WA Health Aboriginal Cultural Learning Framework

This document sets the agenda for creating equitable health services for everybody in Western Australia. The document acknowledges the differing health perspectives that Aboriginals have and aims to close the gap in health outcomes through designing a cultural framework and building a health workforce which is responsive to the needs of Aboriginal people and will encourage participation by them. This document also contains an implementation plan which can be followed by the different health services to achieve better practice and outcomes for Aboriginal people.

²⁷ Government of Western Australia, Department of Health, Aboriginal Health. WA Health Aboriginal Leadership Strategy 2013-2016.

2 Aboriginal Perspectives of Health, Wellbeing and Ageing

There are a multitude of interconnected social, political, and economic factors which have had an influence on the ageing experience of Aboriginal people which contribute to poorer health outcomes and life expectancy.²⁸ A reluctance to trust western institutions and services has grown out of racist policies of past governments including the removal of children from their families and forced relocation of people from their lands. This has often lead to barriers in education and training opportunities which in turn increase the levels of poverty and disadvantage across generations, this impacts on an increased risk of disability, chronic disease and early death. Such perspectives need to be taken into consideration when developing an Aboriginal Framework for Aged Care.

2.1 Concepts of Health and Wellbeing

The Aboriginal concept of health and wellbeing takes in to consideration not only the physical health of the person but having a balance between physical, emotional, cultural and spiritual health.²⁹ Some health issues such as dementia are described as having a “sick spirit” due to the loss of connection with their land and traditional relationships rather than being viewed as a medical condition. Similarly the western concept of disability has not translated into Aboriginal parlance; rather Aboriginal people with a disability are seen as having an impairment or sickness that may prevent them from carrying out certain tasks within the clan, yet they were still involved in the kinship system with roles and responsibilities.³⁰

2.2 Social Determinants of Health

Aboriginal people are some of the most disadvantaged people in Australia. They have poorer life expectancy, literacy rates and health outcomes than non Indigenous people. The Commonwealth has adopted a social model of health³¹ to address the inequities faced by the Aboriginal population particularly in closing the gap in life expectancy and acting on the social determinants of health through health promotion and community development to empower individuals and communities to improve health outcomes and longevity.

There are five key determinants of health including:³²

- Income and social status;
- Education and literacy;
- Early childhood development;
- Social inclusion;
- Gender.

²⁸ The Benevolent Society. Working with older Aboriginal and Torres Strait Islander people. 2013

²⁹ The Benevolent Society. Working with older Aboriginal and Torres Strait Islander people. 2013

³⁰ Stopher, Kerry and D'Antoine, Heather. Aboriginal people with Disability: Unique Approaches to Unique Issues.

³¹ Helen Keleher and MacDougall, Colin. Understanding Health, A determinants Approach. Oxford University Press 2009.

³² Helen Keleher and MacDougall, Colin. Understanding Health, A determinants Approach. Oxford University Press 2009.

Addressing these issues and the inequity faced by Aboriginal communities will enable an improvement in health, wellbeing and longevity. Whilst campaigns to address these issues are in place and improvements in these areas are slowly emerging, there is still work to be done to bring Aboriginal Australians on par with non Indigenous Australians.

There is a dire need to address the significant difference in health outcomes between the Aboriginal and non-Aboriginal communities. Models of care should be designed taking into account cultural sensitivities, historical background and social issues, which have contributed to the level of chronic disease and the effective management of it. The Commonwealth has proposed service delivery principles for Indigenous Australians within the Council of Australian Governments (COAG) National Indigenous Reform Agreement.³³ This agreement outlines the following approach:

- Priority - Programs and services should contribute to targets endorsed by COAG while being appropriate to local community needs.
- Indigenous engagement - Involvement of Indigenous men, women and children and communities should be central to the design and delivery of programs and services.
- Sustainability - Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.
- Access - Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.
- Integration - There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services.
- Accountability - Programs and services should have regular and transparent performance monitoring, review and evaluations.

One of the key action areas identified was to increase Aboriginal and Torres Strait Islander participation³⁴ in order to develop and implement culturally appropriate services through increased community engagement, improved health education and encouragement of patient independence in care.

³³ National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan

³⁴ Department of Health and Community Services, Northern Territory Government, Renal Services Strategy, 2005. Pp 38

3 Health Issues and Life Expectancy of Older Aboriginals

3.1 Life Expectancy

Indigenous Australians currently experience more illness, disability and injury than other Australians. They also die at younger ages compared with non-Indigenous Australians. The graph below shows estimates of life expectancy for Indigenous and non-Indigenous Australians. Indigenous females born between 2005 and 2007 may be expected to live around 9.7 years less than non-Indigenous females born during the same time period. For males this gap is even greater at around 11.5 years.

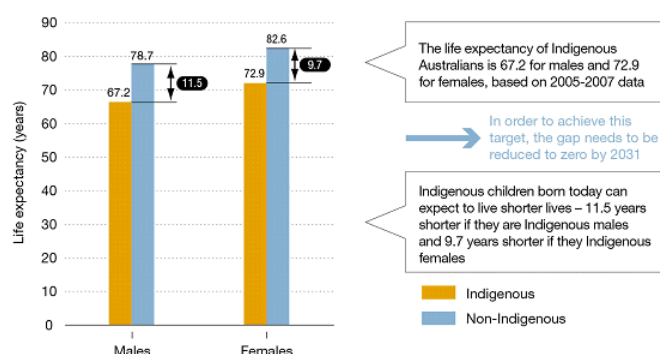


Figure 1: Life expectancy estimates for Indigenous and non-Indigenous Australians³⁵

The graph below shows the leading causes of death for Aboriginal and Torres Strait Islander people during the period 2006 to 2010. Around two-thirds of the gap in health outcomes between Aboriginal and Torres Strait Islander Australians and other Australians is due to long-term health problems, such as heart attack, stroke, cancer, diabetes, respiratory disease and kidney disease. Suicide and transport accidents and other injuries are also leading causes of death.

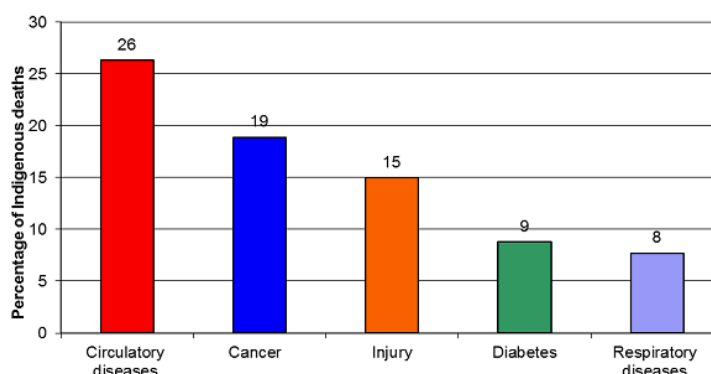


Figure 2: Leading causes of death for Aboriginal and Torres Strait Islander peoples 2006-2010³⁶

³⁵ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-discussion-paper-natsihp-discussion-paper-5>

³⁶ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-discussion-paper-natsihp-discussion-paper-5>

3.2 Dementia

Research into the prevalence of dementia in Aboriginal and Torres Strait Islander people has focused on rural and remote communities with much of the research being conducted in the Kimberley region of Western Australia.³⁷ More recent studies have been conducted in NSW across urban and regional Indigenous communities and confirm the result of the earlier Kimberley studies.³⁸ The Koori Growing Old Well Study conducted between 2009 and 2012 found demographic evidence of a change in the ageing profile of the Aboriginal and Torres Strait Islander population with an increase in the number of older Aboriginals. The life expectancy of Aboriginal people still falls well below the rest of the Australian population. Much of the effects of ageing such as dementia have an earlier onset in Aboriginal people with Indigenous Australians in the 45-64 age group having much greater proportions of people with dementia than the general Australian population.³⁹ The prevalence of dementia in Aboriginal people is almost five times the general Australian population due to high risk factors including chronic disease. However, very few people access government support programs, particularly those in remote communities.⁴⁰ Issues with receiving culturally appropriate services in both remote and urban settings also impacts on the uptake of dementia support services. In living areas of rural and remote Western Australia there are a reported 12.4% of Indigenous people affected by dementia compared to 2.6% of the general population.⁴¹

Risk factors to poor health through out the life of Aboriginal people impacts on ageing well. Poor maternal health and increased risk factors including poor living conditions, high levels of poverty and poor access to health care greatly increase the risk of disability and early death from chronic disease.⁴²

Aboriginal Cultural Understanding of Dementia

Dementia is often described and experience by older Aboriginal people as a “sick spirit” or being “out of balance”.⁴³ A lack of understanding about dementia and a fear of the medical system can preclude many older Aboriginals from accessing early intervention services. When cultural taboos and norms are broken by a person with dementia, this is when communities tend to seek help.⁴⁴

Key Findings

- Dementia services need to consider the Aboriginal concept of health and well being
- Early Intervention and outreach services are needed
- Development and distribution of community information and education about dementia is needed

³⁷ Alzheimer’s Australia. Dementia: A major health problem for Indigenous people. August 2007

³⁸ Neuroscience Research Australia Media Release. Dementia in Aboriginal Australians three times as likely. 14 May 2013

³⁹ Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkey S and Broe GA. Ageing, Cognition and Dementia in Australian Aboriginals and Torres Strait Islander Peoples: Neuroscience Research Australia and Muru Marri Indigenous Health Unit, University of NSW. June 2010

⁴⁰ Australian Institute of Health and Welfare 2011. Older Aboriginal and Torres Strait Islander people.

⁴¹ Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkey S and Broe GA. Ageing, Cognition and Dementia in Australian Aboriginals and Torres Strait Islander Peoples: Neuroscience Research Australia and Muru Marri Indigenous Health Unit, University of NSW. June 2010

⁴² Benevolent Society. Research to Practice Briefing 8. *Working with older Aboriginal and Torres Strait Islander people*. May 2013

⁴³ Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkey S and Broe GA. Ageing, Cognition and Dementia in Australian Aboriginals and Torres Strait Islander Peoples: Neuroscience Research Australia and Muru Marri Indigenous Health Unit, University of NSW. June 2010

⁴⁴ Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkey S and Broe GA. Ageing, Cognition and Dementia in Australian Aboriginals and Torres Strait Islander Peoples: Neuroscience Research Australia and Muru Marri Indigenous Health Unit, University of NSW. June 2010

3.3 Chronic Disease

Chronic disease is a major issue in the Aboriginal population. The majority of deaths in Western Australia between 2006 and 2010 were due to chronic disease.⁴⁵ Most notably Aboriginal people died at 9 times the rate of non Aboriginal people from diabetes with a reported 43% of Aboriginal people aged 55 and over living with diabetes. The rate of those being treated for end stage kidney disease (often a co morbidity of diabetes) was almost 12 times the rate for non Aboriginal people with the rate increasing to 21.2 times the rate for non Aboriginal people in the 45-54 age group.⁴⁶ Hypertension or high blood pressure is also a major health issue facing Aboriginal people with higher rates being reported in remote Aboriginal communities of Western Australia.⁴⁷

Key Findings

- Aged Care and community services may need to integrate chronic disease management and treatment into care plans and arrangements for Aboriginal clients.
- Wound care, assistance with dialysing at home or in community centres, medication management and dietary control.
- Organisation of safe and reliable transport to allow for attendance at essential medical appointments for treatments not available in communities.
- Partnering with Aboriginal Controlled Health Services and mainstream health services to meet the care needs of the older Aboriginal populations.

⁴⁵ Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework Western Australia. 2012

⁴⁶ Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework Western Australia. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework Western Australia. 2012

4 Social and Cultural Issues

4.1 Culturally Appropriate Care

The provision of culturally appropriate care for older Aboriginal people by Aboriginal people is seen as a way of addressing issues of inequity in health and aged care for Aboriginal people. However, such care is not readily available and many Aboriginal people feel uncomfortable about having non Aboriginal people in their homes and are fearful of judgment by service providers about their living conditions often impeding the person and the family seeking assistance from mainstream providers.⁴⁸

There are number of Aboriginal people who caring for elderly members of their community, children and grandchildren and are often doing so on scare resources and limited budgets with health issues of their own. Culturally appropriate respite care and support is needed by many, yet not sought out. Many are unaware of support that is available particularly respite care. However, services that are available are often not culturally appropriate. An initiative between the Aboriginal Corporation and Silver Chain, a not for profit community, clinical and health care provider suggested a number of services which were needed for Aboriginal people across Western Australia including:

- Provision of community housing for older clients with family visitation
- Provision of respite services in local communities so older people do not have to be removed from traditional life
- Provision of activities and opportunities to interact with other people from the community in a secure environment

Cultural Competency and Cultural Safety

Aboriginal people are not from one homogenous cultural group but are made up of a broad range of groups with distinct cultural practices, laws and traditions. Aboriginal people from rural, regional and urban backgrounds may also have a range of traditional and mainstream needs.⁴⁹ Cultural sensitivity is required when planning and delivering services to older Aboriginal people and when interacting with their families.

There is much research and policy about providing culturally appropriate care for older people from diverse backgrounds particularly those of a non English speaking or Aboriginal background. Care provided by community members and those of the same kinship background is optimal, however, the workforce does not always reflect such diversity. The current practice of teaching cultural competence to care providers focuses on culture in terms of ethnicity and health professionals becoming competent in responding to various cultural needs of their clients. This may be difficult due to the large array of differing cultural groups within the Aboriginal population.

Another valuable way to provide appropriate and sensitive care is by utilising the idea of cultural safety. Cultural safety takes a broader view of culture and avoids fixing culture in terms of discrete knowledge that one can become competent in using to provide care. Instead it is a reflective process for the providers to examine their response to clients who differ from themselves in relation not only to ethnicity, but

⁴⁸ Office of the Public Advocate. Mistreatment of Older People in Aboriginal Communities Project. An Investigation into elder abuse in Aboriginal Communities. 2005

⁴⁹ The National Palliative Care Program. Providing culturally appropriate palliative care to Aboriginal and Torres Strait people.

socio-economic status, politics, religion, gender or sexual orientation. Health Care providers do not need to research or understand the person who they are caring for's culture, rather they acknowledge their culture is different and do not impose their beliefs on those they serve.⁵⁰ Whichever framework is adopted, the need for training in cultural safety, cultural competence, and especially cross-cultural communication exists at every level of the health and aged care services.

4.2 Culturally Sensitive Palliative Care

Palliative care is a treatment approach which aims to improve the quality of life of patients and their families facing life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.⁵¹

The importance of offering a palliative care model in health services and aged care is receiving greater attention. Advance Care Planning or End-of-Life planning can be confronting for the patient, family and carers, however, these plans are helpful in being able to support the patient to die in the way they want. The National Palliative Care Program has produced a set of practice principles for providing culturally appropriate palliative care to Aboriginal and Torres Strait Islanders. The principles include three implementation strategies which are:⁵²

- Involving Aboriginal and Torres Strait Islander people and organisations in the planning, provision and monitoring of palliative care to ensure culturally relevant requirements are addressed and preferences of the patient and or their family are considered
- Communicate with the patient and their family and community in a sensitive way that values cultural difference
- Provide training to all personnel to enable the provision of culturally appropriate palliative care to Aboriginal and Torres Strait Islander people

Many Aboriginal people express a desire to die in their own communities. Flexible models of palliative care are needed to support these wishes. Working in partnerships with community health services, families and communities may enable this care to take place.⁵³

Visiting the sick and dying is very important to Aboriginal people and often large numbers of people convene in the rooms of the patient. Relatives often travel long distances and have made great sacrifices to be present. Attention to other cultural practices including 'sorry time' and cleansing ceremonies may also be needed.

Working with Aboriginal Liaison Officers can help a smooth facilitation of planning for death and ceremonies and traditions when death is immanent.

Palliative care for some older Aboriginals may also require input from specialists in chronic disease. Due to the high rates of diabetes, chronic kidney disease and hyper tension within the community, symptom control within a palliative care model will also be needed.

In July 2012, the Western Australian Department of Health released the Pathway for Renal Palliative Care Services in Western Australia. This report provides a comprehensive overview of conservative management of chronic kidney disease and the need to integrate conservative treatment with renal palliative services.⁵⁴ It

⁵⁰ Austin Health. Respecting Patient Choices. Advance Care Planning with Aboriginals and Torres Strait Islanders. 2006

⁵¹ Palliative Care - WHO definition (2002)

⁵² The National Palliative Care Program. Providing appropriate care to Aboriginal and Torres Strait Islanders. Practice Principles.

⁵³ The National Palliative Care Program. Providing appropriate care to Aboriginal and Torres Strait Islanders. Practice Principles.

⁵⁴ Department of Health Western Australia, Pathway for Renal Palliative Care Services in Western Australia. July 2012

includes a systematic and formalised palliative care pathway for patients suffering chronic kidney disease. The pathway described suggests a number of care and assessment approaches and tools including:

- Advance Life Planning - Palliative Care Australia defines Advance Care Planning as provides a mechanism to improve the quality of end of life care for people. It enables the coordination of their desired access to resources and services, to match their anticipated care needs;
- Gold Standard Framework for supporting the patient's end of life preferences;
- Patient Centred Care- involves placing the patient at the centre of decision making about the care they are to receive. This is achieved through education and allowing the patient and their families and carers to make informed choices.
- Quality of Life Assessment tool- usually a survey with a number of questions where the patient ranks from zero to ten how they feel emotionally, spiritually and socially.
- Symptom Assessment Scale- survey completed by patients to assess psychological and physical symptoms;
- Liverpool Pathway for Terminal Care- The pathway was developed to aid members of a multi-disciplinary team in matters relating to continuing medical treatment, discontinuation of treatment and comfort measures during the last days and hours of a patient's life. The Liverpool Care Pathway is organised into sections ensuring that evaluation and care is continuous and consistent.

These tools may be useful in developing a model of palliative care or Advance Care planning for Aboriginal people in Western Australia and could be used by community and residential aged care providers.

4.3 Elder Abuse

Financial, physical and emotional abuse as well as neglect of older people has been raised as an issue in some Aboriginal communities. These issues often intersect and can be perpetuated by kinship obligations and responsibilities and complexities between western and aboriginal understandings or definitions of abuse.

Elder abuse refers to “any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.” (Australian Network for the Prevention of Elder Abuse, 1999) Abuse can be financial, physical, sexual, social, psychological, spiritual or can involve neglect. A 2005 report by the Western Australian Office of the Public Advocate into elder abuse in Aboriginal communities found through consultation with Aboriginal service providers, found that abuse of older people in the communities was occurring and took on many different forms.⁵⁵ There was a reported feeling among the consultees that ‘abuse’ of older people is normalised within Aboriginal communities with the most common form being financial abuse. It was reported by a prominent Aboriginal man that the Aboriginal cultural obligation to share was often taken advantage of by younger members of the community. Some organisations and communities have developed strategies to deal with financial abuse including:⁵⁶

- Key cards being held by the local bank and only certain family members being able to withdraw money from bank accounts

⁵⁵ Office of the Public Advocate. Mistreatment of Older People in Aboriginal Communities Project. An Investigation into elder abuse in Aboriginal Communities. 2005

⁵⁶ Office of the Public Advocate. Mistreatment of Older People in Aboriginal Communities Project. An Investigation into elder abuse in Aboriginal Communities. 2005

- Creating alcohol free drop in centres for older Aboriginal people to create a sheltered meeting place and reduce the vulnerability during pension day.
- Reports of physical abuse were often linked with financial abuse. This report found that in almost all the cases where abuse was reported of an older Aboriginal person, kinship was a factor in the relationship and the perpetrator had used this relationship to abuse the older person.⁵⁷

Strategies for intervention to protect older people from abuse contained in the report include:

- Partnerships between community workers, police, welfare and health workers to respond to and identify abuse
- Developing support mechanisms for carers and older people
- Developing education programs for children about respect for older people
- Raising community awareness of elder abuse
- Providing training opportunities for Aboriginal people in the provision of appropriate care for their old people

4.4 Housing for Older Aboriginal People

Poor housing and living conditions remain a chronic issue in Aboriginal communities and urban centres. Poor living conditions have contributed to on going disadvantage and health issues within the Aboriginal community. Those affected most by poor living conditions are the elderly and the very young. The Housing for Health program aims to address these issues and create safer, healthier homes for Aboriginal people which will contribute to ageing well.

The Housing for Health program fixes and maintains non working health hardware⁵⁸ or fixtures within the home which contribute to healthy living, including showers, toilets and electricity. The Housing for Health program has been integrated into the National Housing for Indigenous Guide and should be considered when designing residential care for Aboriginal people or improving living conditions of those remaining in their homes.

At the heart of the Housing for Health method are the Healthy Living Practices (HLPs).

These link the safety and health of people to the functions of key parts of the house and surrounding living environment. The HLPs are prioritised to maximise the health benefit for any resources used for improvement.

Healthy Living Practice 1 - Washing People

Being able to use functioning washing facilities reduces the spread of diseases, including diarrhoeal disease, respiratory disease, hepatitis and infections. The rates of these diseases in some Australian Indigenous communities are as high as in many developing countries and are many times higher than for non-Indigenous children. Diarrhoeal and respiratory diseases, in particular, are the major causes of illness amongst Indigenous children and also play a major role in the malnutrition experienced in the first three years of life.

⁵⁷ Office of the Public Advocate. Mistreatment of Older People in Aboriginal Communities Project. An Investigation into elder abuse in Aboriginal Communities. 2005

⁵⁸

Healthy Living Practice 2 - Washing clothes and bedding

Being able to regularly wash clothes and bedding can help reduce the incidence of infectious diseases, such as diarrhoeal disease, respiratory infections, scabies and other skin infections.

Healthy Living Practice 3 - Removing waste water safely

Waste water leaks and overflows around the living environment can make people sick. Disease-causing bacteria can be transmitted if people or animals come into direct contact with waste water or if the drinking water supply is contaminated with waste water. So removing waste water safely from living areas, and managing it safely around the community, is critical to keeping people healthy.

Healthy Living Practice 4 - Improving nutrition, the ability to store prepare and cook food

Poor nutrition is one factor contributing to Indigenous people having high rates of obesity, diabetes, cardiovascular disease and renal disease. Poor nutrition is also a major cause of infectious diseases in children. In remote communities, choosing a healthy diet is complicated by factors such as low incomes, the cost of food, local store management practices and the ability to store, prepare and cook food at home.

Healthy Living Practice 5 - Reducing the negative impacts of over-crowding

Crowded living conditions increase the risk of the spread of infectious diseases, such as meningococcal disease, rheumatic fever, tuberculosis and respiratory infections. In a crowded house it can also be more difficult to access health hardware, such as a working shower, toilet, hot water and washing machines. Increasing house size does not guarantee reduced crowding. Increasing house function does.

Healthy Living Practice 6 - Reducing the negative effects of animals, insects and vermin

People's health is badly affected by contact with animals, vermin and insects in the living environment.

Healthy Living Practice 7- Reducing the health impacts of dust

Many small communities, particularly in rural and remote areas, experience problems with dust, caused by either unsealed roads or vacant land in the community or from dust that is blown into the community from surrounding arid, rural or drought affected lands.

Dust causes direct health problems through the irritation of mucosal surfaces and the skin, which contributes to eye diseases, such as trachoma, respiratory disease and skin infections.

Healthy Living Practice 8 - Controlling the temperature of the living environment

Living in houses that are too cold or too hot can contribute to a range of physical illnesses, as well as emotional distress. The young and elderly are most at risk from temperature extremes. Dehydration is a major risk factor for young children.

Healthy Living Practice 9 - Reducing hazards that cause trauma

If houses are poorly designed and constructed, or not well maintained, there is an increased risk that residents may be injured. Elderly people, people with disabilities and young children are particularly at risk. Injuries may require medical treatment or hospitalisation and could result in infections or even disability.

Key Findings

- Integrating Housing for Health program with community services to ensure safety and optimal health outcomes of occupants

4.5 Workforce

Building a responsive and flexible workforce is a key driver in the ability to provide appropriate care. A number of workforce strategies have been developed to encourage the participation of Aboriginal workers in the Health and Aged Care workforce. The reviewed literature suggests utilising community members to provide services and care to the older members of their community. This enables buy in and ultimately the success of the programs. Building partnerships with Aboriginal controlled health services and training and education providers can enhance the workforce and lead to successful service provision in a culturally appropriate manner.

5 Models of Aboriginal Aged Care

What is a Model of Care?

A model of care defines and describes the way in which health and community care and services are to be delivered. It can provide a practical framework for health and community workers to engage with people and services. It can also recommend how care is delivered to provide optimal outcomes for the recipients.

Developing Aboriginal Models of Care

Evidence shows that to engage with health and community services Aboriginal people need a holistic model of care which encompasses health, wellbeing, spirituality and family. There are few current models of care for older Aboriginal people. However, drawing on the determinants of health and engaging with the healthcare system can provide valuable insight into the development of an Aboriginal and Torres Strait Islander Framework for aged care in the Wheatbelt.

Models of care need to address issues associated with Aboriginal health including chronic disease management and providing care in both community and residential settings. Due to historical distrust of institutions, gaining trust is as integral as providing the care.

Developing best practice models of Aboriginal aged care will need to involve research into localised information about communities and social histories as well as considering the social determinants of health and cultural perspectives and approaches to wellness, ageing and care giving in different Aboriginal cultures.⁵⁹

Building partnerships with community members to provide training and to provide input into the perceived needs of the community enables buy in by the locals and a sense of community control.

In a 2010 a mapping and gap analysis of services for Indigenous people of the Wheatbelt Region of Western Australia it was suggested that a facilitating approach should be taken in the development of services for Aboriginal people.⁶⁰ This partnership approach has been recognised by the commonwealth and state governments and Indigenous people as the most effective way of developing and implementing services for Aboriginal people. Research conducted through the Wheatbelt Indigenous Services Assessment found Indigenous people within the community wanted to take responsibility for the delivery of services but need experienced people to work beside them until they were able to effectively deliver high quality services themselves.⁶¹

5.1 Conceptual Models of Care

The Wheatbelt Indigenous Services Assessment conducted in July 2010 found a number of services within the community where being delivered in a “fractured” way. Rather than increasing wellbeing and community participation, the delivery of these services where having little impact on closing the gap between Indigenous and non Indigenous people.⁶² Aboriginal people in the Wheatbelt region expressed the need for holistic models of care delivered through partnership arrangements between

⁵⁹ Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkey S and Broe GA. Ageing, Cognition and Dementia in Australian Aboriginals and Torres Strait Islander Peoples: Neuroscience Research Australia and Muru Marri Indigenous Health Unit, University of NSW. June 2010

⁶⁰ Ellis-Smith, Graham. Wheatbelt Indigenous Services Agreement. July 2010. Pg 153

⁶¹ Ellis-Smith, Graham. Wheatbelt Indigenous Services Agreement. July 2010. Pg 153

⁶² Ellis-Smith, Graham. Wheatbelt Indigenous Services Agreement. July 2010. Pg 153

a number of services providers as the most effective option. This approach is operational in a number of health care programs, whereby the person is treated rather than just the illness. A number of models of care have been described below which may be suitable to be used in the development of the Aboriginal Aged Care Framework. It is worth noting, different communities may require different models of care depending on cultural proclivities.

NSW Aboriginal Chronic Disease Management Plan Model of Care

The Aboriginal Chronic Disease Management Plan provides a culturally sensitive model of chronic care for Aboriginal people. The need to consider an alternate approach to the prevention and treatment of chronic disease in the Aboriginal community is recognised by addressing a number of factors which contribute to chronic health conditions in Aboriginal communities including historical, biomedical, psychosocial /cultural, risk behaviours, environmental, the health care system, economic and non modifiable risk factors this model of chronic care may be able to increase optimal health outcomes for Aboriginal people and reduce the burden of disease on the hospital system. This model of care focuses on treating the people who have a disease and not just the disease itself.

Eight essential elements were identified for inclusion in this model of care.

They are:

- Identification
- Trust
- Screening and assessment
- Clinical indicators
- Treatment
- Education
- Referral
- Follow up



Figure 1: Aboriginal Chronic Disease Model of Care⁶³

⁶³ Source: http://www0.health.nsw.gov.au/initiatives/chronic_care/aboriginal/

This model of care aims to tackle the issue of chronic disease, however, the eight elements which constitute this model are relevant to all health and community services with a continued focus for improved outcomes related to health promotion, prevention, detection, management, self management, rehabilitation and end of life care.⁶⁴ This model requires workers to develop a relationship of trust between the Aboriginal person and the community or health care provider. Developing the trust of the community and the Aboriginal person requires taking the time to listen and be respectful and meeting on the Aboriginal people's terms.⁶⁵

The Orchid Model⁶⁶

The Orchid model was designed in consultation and collaboration with Wheatbelt Indigenous people in 2006. It was designed primarily as a tool to help engage the Indigenous community in their own economic development. However, it has been suggested the aspects described in this model are relevant to improve and assess community well being. The model has five significant aspects which make up community and individual wellbeing. These include:

- Cultural and environmental factors
- Social and emotional factors
- Vocational factors
- Male ways
- Female ways

Each of the five factors, expressed as petals need to be in balance and considered when designing and delivering services for the Indigenous community.

5.2 Community Based Aboriginal Aged Care Models

Below are selected examples of service models for community and health services for older Aboriginal people which has grown out of community consultation and been built on collaboration and partnership with mainstream and Aboriginal controlled and operated services.

Sydney Indigenous Aged Care Scoping Study

The Sydney Indigenous Aged Care Scoping Study was commissioned in response to concerns from Sydney's Aboriginal community about lack of access to appropriate and affordable aged care for their community. Evidence of best practice and consultation with service providers, Aboriginal consumers of aged care and their families enabled the study leadership to make recommendations on what a best practice Aboriginal model of aged care should entail.⁶⁷ Recommendations included:

- A local management framework governed by the structures and norms of community tradition;
- Development of culturally relevant models of care based upon local cultural protocols within this framework;
- Culture as central, rather than incidental to the provision of services;
- Adaption of mainstream services to a cultural worldview;

⁶⁴ National Health Priority Action Council (NHPAC) (2006), *National Chronic Disease Strategy*, Australian Government Department of Health and Ageing, Canberra.pp8

⁶⁵ NSW Health. Clinical Services Redesign Program. Chronic Care for Aboriginal People. 2011

⁶⁶ Ellis-Smith, Graham. Wheatbelt Indigenous Services Agreement. July 2010. Pg 144

⁶⁷ Burns Aldis. Sydney Indigenous Aged Care Scoping Study Final Report. 2012

- Care delivered by Indigenous workers within a relationship of trust;
- Continuity in the relationships between individual workers and their clients;
- Emphasis on quality of life as understood from an Indigenous perspective;
- Service provision which honors clients right to make decisions about their own care;
- Appreciation of the importance of end-of-life ceremonial practices and a commitment to supporting the cultural aspects of mourning;

Some of the models of care which were most attractive to those consulted involved care provided by Aboriginal care workers in Aboriginal community controlled and Aboriginal identified residential services. Small aboriginal group homes were considered to be attractive as was being accommodated in a mainstream facility living in Aboriginal clusters with care provided by Aboriginal workers.

The Lungurra Ngoora Service Model

The Lungurra Ngoora service model is a project based in the remote Western Australia community of Looma. It was developed by The Kimberley Cognitive Assessment Research Group in partnership with the local community. Based on extensive community consultation with older people, families, carers, community members and stakeholders, a model of care was developed to address unmet needs for the target population and their carers in the remote community of Looma, Kimberley. The model was implemented and evaluated over 12 months. The main outcome measures included the number of services (including home services, meals, transport, respite, personal care and advocacy) provided. Outcomes of community participation, capacity building, resources, partnerships, workforce, service delivery and cultural protection were assessed qualitatively by an external evaluation.⁶⁸

This service model coordinated resources between programs running within the community and formed partnerships for collaboration with service providers and the community. Services, activities and respite were culturally appropriate and provided flexibly. A major success factor in this project was employing staff who were from the community and accepted by the community with on going mentorship, training and development of staff and the community.⁶⁹

The results of this pilot project saw a marked increase in community care services including home, personal care and respite services which enabled many clients to return to participating in community activities. There was also a significant increase in community employment, ensuring culturally appropriate practices and education and training for those entering the workforce.⁷⁰

However, ongoing funding is needed to ensure the services remain viable.

La Perouse Aboriginal Community Health Centre⁷¹

After extensive consultation with the local Aboriginal community into areas of need and the development of a local Aboriginal committee, The La Perouse Aboriginal health centre was created. The centre acts as a health hub providing community and health services across the life span from mothers and infants to aged care services. Consultations with the community were conducted over ten years and the centre reused an old site in La Perouse where Aboriginal health services had been delivered previously. The former site was unsafe and a new modern centre was built. Funding

⁶⁸ <http://www.alzheimersanddementia.com/article/S1552-5260%2812%2901193-4/fulltext#article-outline>

⁶⁹ Aboriginal Ageing, Growing Old in Aboriginal Communities Linking Services and Research. August 2010

⁷⁰ LoGiudice DC, Smith K, Shadforth G, Lindeman M, Carroll E, Atkinson D, Schaper F, Lautenschlager N, Murphy R, Flicker L. Lungurra Ngoora - a pilot model of care for aged and disabled in a remote Aboriginal community - Can it Work? Rural and Remote Health 12: 2078 2012

⁷¹ <http://www.seslhd.health.nsw.gov.au/POWH/documents/arc/AboriginalHealthandAgeingALifecycleApproach0711.pdf>

for on going chronic disease care and aged care was sought as well as funding for research into ageing well.

Extensive research conducted by this group found that to improve adult health, the social determinants of child health had to be addresses alongside providing chronic disease, dementia and aged care services. In 2006 a new Aboriginal Community Health Centre was opened which is now providing a multi-disciplinary, multi modal service which is driven by Paediatrics and Geriatrics.

The Aboriginal Community Health Centre now runs 40 clinics and services each month:

- GP Clinics daily
- Community Health; Home visits; Audiology; Speech Therapy
- Health Promotion, Health Education; Vascular Health
- Child, Adolescent & Adult Mental Health;
- Mothers & Babies; Child Health; Immunisation; Paediatrics;
- Cardiology; Diabetes; Men's Health; Chronic Disease Management
- Complex Care; Geriatrics; Home Visiting, Home Care

5.3 Residential Based Aboriginal Aged Care Models

There are a number of varying housing models for older Aboriginal people operating through out Western Australia and the Northern Territory delivering flexible care, respite care and using community members to build and work in the new facilities. Below are selected examples of successful residential and respite care models operating in Aboriginal communities.

Nganampa Health Council Aged Care Program⁷²

The aim of the Nganampa Health Council Aged Care Program is to enable aged, frail Anangu to remain on their land for as long as possible rather than being hospitalised or seeking residential placement in a large and distant regional centre. Such a move results in a loss for the older person of family, friends, country and their essential role in the cultural and spiritual life of the community. In addition, the community loses the traditional role and knowledge that is the responsibility of that senior person.

The aged care facility Tjilpiku Pampaku Ngura provides residential and respite care to older Anangu people. There are 13 places, 10 of which are currently occupied by permanent residents. A number of clients have regular respite, enabling them to remain in their communities and providing their usual family carers with a break from the responsibilities of daily care.

An important focus of the care provided at Tjilpiku Pampaku Ngura is to ensure residents retain their significant links with family and country and that they are able to continue their creative interests and cultural practices. Regular outings and bush trips are arranged to facilitate this.

A Home and Community Care service is provided as well to the local Pukatja community. This involves provision of meals and personal care services for eligible clients.

⁷² <http://www.nganampahealth.com.au/programs/aged-care.html>

A significant proportion of the staff are Anangu, many of whom have completed, or are completing, formal qualifications in aged and disability care. TAFE South Australia provides on site training.

Residents have access to high quality clinical care, through an Aged Care Program registered nurse. This includes access to 24-hour emergency clinical services provided by nursing staff at the Pukatja clinic. In addition, there is always a Nganampa Health Council Medical Officer available for consultation and support in emergency situations. Residents have access to a range of visiting health services, including podiatry, physiotherapy and oral health.

East Arnhem Carer Respite Centre

The East Arnhem Carer Respite Centre provides a flexible and innovative respite service that responds to the individual needs of Carers in the whole of East Arnhem, including Groote Eylandt. The Centre aims to support and maintain the quality of life of carers and those for whom they care for.

- Target group: Carers of aged/frail people and Carers of children and adults with a Disability (including Mental Illness).
- Residential Respite is provided in the Respite room at the Gove Hospital, in Aged Care facilities in Darwin, at Aboriginal Hostels or by using the Anglicare Respite flat in Nhulunbuy.
- Community Respite is provided by direct support from support workers (as in the town of Nhulunbuy and the close-by communities of Yirrkala and Ski Beach),
- A Mobile Outreach Service provides community based respite to remote communities in East Arnhem during the Dry Season.
- The Centre can provide other forms of respite depending on the needs of the individual carers. E.g. the Centre can assist a family member with transport and food to be able to support a carer in the community.

Models of Care Key Findings:

- A coordinated care approach provided by integrated care teams has been successful in service provision in Aboriginal communities.
- Partnerships between service providers and Aboriginal community controlled health and community services have facilitated increased community participation in service provision and service use.
- Retention of links with family, country and cultural practices need to be ensured when designing models of care.
- Development of culturally relevant models of care based upon local cultural protocols are needed;
- Care delivered by Indigenous workers within a relationship of trust is optimal with employment of staff who are from the community and accepted by the community;
- On going mentorship, training and development of staff and the community within the health and community services provided.⁷³

⁷³ Aboriginal Ageing, Growing Old in Aboriginal Communities Linking Services and Research. August 2010

6 Register of Reviewed Documents

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