RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part B. Older Aboriginal and Torres Strait Islander people

General principles

- Major barriers exist for Aboriginal and Torres Strait Islander peoples to access both residential aged care facilities (RACFs) and community aged care.
- Aboriginal and Torres Strait Islander people are more likely to experience dementia, falls, pain and urinary incontinence at younger ages compared to their non-Indigenous counterparts.
- The provision of services for Aboriginal and Torres Strait Islander peoples in rural and remote locations is particularly problematic.
- Cultural safety training for all staff is crucial to increase access to mainstream services for Aboriginal and Torres Strait Islander peoples.
- The importance of family and relationships, connection to place and country, respect for Elders and their roles in the community need to be considered in provision of culturally safe care.
- The use of culturally appropriate assessment tools assists in the provision of valid assessments.

Introduction

There are major barriers for Aboriginal and Torres Strait Islander peoples when trying to access aged care.[1] For both residential aged care facility (RACF) and community aged care, Aboriginal and Torres Strait Islander peoples find it difficult to navigate what has become a complex and convoluted system. Low health literacy and poor access to information technology can affect timely access to services and care that this population group requires.[2]

Aboriginal and Torres Strait Islander peoples are more likely to live in areas that do not have an RACF in close proximity. Importantly, there are concerns regarding cultural safety.[3] Most RACF staff have not had the appropriate

cultural training, which reflects the challenges of workforce shortages and financial models for operating services in regional, rural and remote settings. Many RACF staff do not understand the need for culturally safe practices for Aboriginal and Torres Strait Islander peoples (eg care to be provided by a specific gender).[4] Lack of understanding of the need for trauma-informed care, distrust of services and racism are barriers to receiving adequate care.[5]

For these and other reasons, despite Aboriginal and Torres Strait Islander peoples accounting for approximately 3% of the overall Australian population, only 1% of residential care beds are occupied by Aboriginal and Torres Strait Islander people.[1]

For community care, other barriers exist, but the main barrier is navigating the increasingly difficult models of care associated with consumer-directed care.

The costs of medications for older people with multiple medical problems can be daunting. Eligible Aboriginal and Torres Strait Islander people living with, or at risk of, chronic disease have access to the Pharmaceutical Benefits Scheme (PBS) Closing the Gap Co-Payment Measure that can markedly reduce the costs of co-payments.

Geriatric syndromes in younger age groups

Many of the health conditions that are common in older non-Indigenous Australians are experienced at younger ages in Aboriginal and Torres Strait Islander peoples. These health conditions include dementia, which is found at five times the prevalence of non-Indigenous Australians;[6] the most common diagnosis is Alzheimer's disease (refer to Part A. Dementia). Other conditions such as falls (refer to Part A. Falls), pain (refer to Part A. Pain), urinary incontinence (refer to Part A. Urinary incontinence)[7] and frailty[8] (refer to Part A. Frailty) are found in greater prevalence in younger age groups.

In addition, Aboriginal and Torres Strait Islander people are much more likely to develop type 2 diabetes mellitus[9] and renal failure.[10] These premature health conditions result in disability many years earlier than in the general, non-Indigenous population.

The presence of these geriatric syndromes at younger ages means that Aboriginal and Torres Strait Islander peoples probably require the same amount of aged care services as their proportion of the total Australian population despite their decreased longevity (refer to Part B. Geriatric syndromes).

The fact that Aboriginal and Torres Strait Islander people are much younger when they enter RACFs often increases the discomfort of residents, staff and families.

Rural and remote populations

Aboriginal and Torres Strait Islander peoples are more likely to live in rural and remote locations than non-Indigenous Australians, although the majority live in urban areas (refer to Part B. Older people in rural and remote communities).[1]

The provision of care services to older people in rural and remote locations is subsidised by the federal government; however, these services are provided by non-governmental organisations (NGOs).[11] NGOs have difficulties with economies of scale, and find the provision of services to small communities in remote regions to be non-viable. This often means that many remote regions are not serviced by NGOs, resulting in limited choice of services or complete lack of home care services. The lack of personal and home care may mean that older Aboriginal and Torres Strait Islander people with a disability live in poor environments and circumstances, further discouraging social contact and support (refer to Part B. Disability in aged care).

Residential care services also require a reasonable number of people within a catchment area to service (ie for financial operability). Many small rural or remote communities are unable to support standalone RACFs. Multipurpose services help fill some of these gaps, but the quality of these services is highly variable, depending on the training and interests of the staff. Attending to the special cultural needs of Aboriginal and Torres Strait Islander peoples and employing suitably qualified staff may present major challenges.

The remaining option for most Aboriginal and Torres Strait Islander people is to move to an RACF located long distances from their family, Country and communities, often further potentiating a sense of dispossession. This is especially important as most older people want to return to their Country at the end of their life.

The use of telemedicine can be helpful in rural and remote situations, particularly in the provision of specialist services. However, it is important that these services are adequately supported by staff at the distal site. These staff

should have been trained in cultural safety as well as be able to facilitate assessments and interventions. If appropriately trained staff are not available at the distal site, adequate assessments cannot be performed and any recommended interventions will not be completed satisfactorily.

Cultural safety

One of the major issues in providing high-quality community and RACF care for older Aboriginal and Torres Strait Islander people is the availability of staff who have undergone cultural safety training.[4] Many aged care and healthcare workers lack this specific training.

The use of inappropriate language and practices with vulnerable older people discourage Aboriginal and Torres Strait Islander people from using the available services. The financial resources of many Aboriginal and Torres Strait Islander people are very limited, and this hinders the purchase of additional or alternative services.[12] Trained healthcare and RACF staff who have successfully completed cultural safety training may be nonexistent or based long distances from the client. The lack of choice in choosing staff members may further discourage seeking appropriate care.

All healthcare and residential care staff who see substantial numbers of Aboriginal and Torres Strait Islander people should complete cultural safety training. Cultural safety training should be made compulsory throughout all residential aged care, and should include an understanding of context and a tailoring of practice with face-to-face training, and regular follow-up and refreshment of training.

The understanding of context includes awareness and respect of the history, background and culture of Aboriginal and Torres Strait Islander peoples. The recent history is one of trauma and dispossession.[13] An attachment to land for Aboriginal and Torres Strait Islander peoples is one of the important understandings. The local community of Aboriginal and Torres Strait Islander people is extremely important, and community consultation is often a necessary first step for provision of any service.

Individual communities can differ significantly; not all Aboriginal and Torres Strait Islander peoples have the same culture, language or lore, and each individual is different. This variation in needs has to be accommodated. Tailoring of practice to local community needs and responsibilities can be manifested in many ways; however, an important proactive practical step is to facilitate the employment of trained Aboriginal and Torres Strait Islander healthcare and care workers within RACFs and general practices, as far as possible.

Cultural safety must underpin the provision of all aged care services to Aboriginal and Torres Strait Islander peoples. There needs to be the creation of genuine multidisciplinary partnerships between general practitioners (GPs), Aboriginal and Torres Strait Islander communities, RACF and general practice staff, other specialist medical practitioners and allied health professionals that are based on community consultation (refer to Part B. Collaboration and multidisciplinary team-based care).

There are major consequences of not providing culturally safe care to Aboriginal and Torres Strait Islander peoples. Firstly, patients with high needs will simply not use services perceived as being culturally inappropriate, which may result in further and worsening morbidity, avoidable hospital admissions and early mortality.

Secondly, Aboriginal and Torres Strait Islander people who use services that are not culturally safe will be unhappy and distrustful, which may manifest in several ways (eg behaviours of concern in the patient, angry family members who may not feel safe to visit unless in large groups). This in turn causes further breakdowns in the relationship between the patient, family and care staff.

Healthcare and care workers may be required to augment traditional roles or allow clients to accept ‘risks’ in order to adequately tailor services. For example, these risks may include participation in important cultural practices while the patient is unwell, and allowing suboptimal personal care by untrained family members. These risks should be taken after appropriate consultation with community and family members and the wider multidisciplinary healthcare team.

When care for an older person can no longer be provided by family and community services, the decision for residential care is significant, particularly if the older person needs to move away from their Country or place. For older Aboriginal and Torres Strait Islander people, a feeling of wellbeing encompasses family, culture, community and Country. Factors such as respect, sense of Eldership, spirituality and feeling safe and secure are integral in facilitating wellbeing at the end of life, and can be particularly challenging to meet in residential care. In addition, many older Aboriginal and Torres Strait Islander people are from the Stolen Generation, and may hold particular memories regarding previous institutional care, and a trauma-informed approach to care is essential.

Talking about death and dying requires knowledge around local customs and traditions that will vary across diverse cultural and language groups. There are varying customs and traditions attached to death and dying that need to be taken into consideration by communities and professional carers. There are useful culturally appropriate guides to assist with discussions of advance care planning that should be considered by healthcare professionals, carers and communities (eg Palliative Care Australia). For those who work in residential care, cross-cultural training and liaison with family and cultural advisors about the older person's needs are essential.

Culturally appropriate assessment tools

As with all patients in RACFs, unrecognised geriatric syndromes are commonplace and must be carefully assessed. Unrecognised pain is also common, along with the geriatric syndromes of cognitive impairment, falls, immobility and incontinence.

Culturally appropriate assessment tools have been developed and may be useful in the assessment of older Aboriginal and Torres Strait Islander people. The Kimberley Indigenous Cognitive Assessment (KICA) tool was developed after considerable consultation in response to the need for a cognitive screening tool for older Aboriginal and Torres Strait Islander people.[14]

An important property of the KICA is it can be translated into local Aboriginal languages and not lose its effectiveness. The KICA has been validated in multiple regions of Australia, including urban, regional and remote, and is used extensively.

Other important assessment tools include the KICA-Dep, which can be used to screen for depression.[15]

The Stolen Generation

The Stolen Generation refers to Aboriginal and Torres Strait Islander people who, under acts of parliaments, were forcibly removed from their families as children by federal, state and territory government agencies and church missions.

The practice occurred commonly between 1910 and 1970. There is evidence that members of the Stolen Generation, and their descendants, have, on average, higher levels of risk factors and poorer health status than the general Aboriginal and Torres Strait Islander population.[16]

The Stolen Generation may number approximately one in seven Aboriginal and Torres Strait Islander people aged ≥50 years, and many of these individuals are now entering community and RACF care. They have specific needs relative to the general Aboriginal and Torres Strait Islander population.

Evidence is currently limited; however, these people appear to be understandably anxious regarding re-institutionalisation, abandonment and separation from family, community and land.[16] In the presence of cognitive impairment, traumatic past experiences are frequently relived.

These individuals will often require additional assessment, and support and engagement with the local Aboriginal and Torres Strait Islander communities. At the time of writing, there is hope that co-designed funded programs will soon be available for this vulnerable group of older people.

There are large variations in the needs of this population group, with some preferring specific Aboriginal and Torres Strait Islander peoples' services, whereas others prefer to use the local, mainstream service to minimise further family fragmentation. Thus, all such mainstream services must be capable of providing culturally safe care.

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