

Kimberley Healthy Adults Project

Guides for Clinicians



2013

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How to Use These Guides

How to use

The guides were developed to complement each other but may be used as individual resources if desired.

Each guide provides background information and findings from the Kimberley Healthy Adults Project to assist clinicians in the screening and assessment process.

We have endeavoured to provide the most up-to date and context specific resources through obtaining advice from local health and community services; however the resource lists are not exhaustive.

The posters are intended to be displayed in HACC offices and relevant health clinics and distributed as appropriate.

Disclaimer

These guides have been developed as part of the Kimberley Healthy Adults Project and cover the five health domains explored within the study. The guides have been developed by the National Ageing Research Institute (NARI) in conjunction with advice sought from the project team and Kimberley Aged and Community Services.

These guides have been developed to assist clinicians working with older Aboriginal people living in the community. The guides are not intended to give information about how to diagnose or treat conditions, but rather as a guide to understand the predictors of these conditions and to identify interventions which could protect older people from experiencing them. Some flexibility may be required to adapt these guides to local settings and individual needs. Referral to a General Practitioner or specialist health care practitioner is recommended for circumstances requiring specific expertise or tailored interventions.

Overview of Project

Kimberley Healthy Adults Project

The Kimberley Healthy Adults Project (KHAP) focused on exploring the prevalence of chronic health conditions in the population of older Aboriginal people living in remote areas. The study aimed to determine the rates of memory and thinking problems, depression, risk of falls and injury, incontinence and chronic pain in order to understand the predictors of these conditions and to identify interventions which could protect older people from experiencing them.

The KHAP research study was funded by an Australian National Health and Medical Research Council (NHMRC) grant in 2010. The project team consisted of researchers from the West Australian Centre of Health and Ageing, Melbourne Health and the Kimberley Aboriginal Medical Services Council. The team worked closely with Kimberley Aged and Community Services: West Australian Country Health Services.

The project team has been involved in researching and responding to the medical conditions of the older population in the Kimberley for over ten years. The KHAP was an extension of earlier research that initially focused on exploring the prevalence of dementia in the region by developing and validating the now widely used culturally appropriate Kimberley Indigenous Cognitive Assessment (KICA) tool in 2003. The background to that project and the KICA tool can be found at <http://www.wacha.org.au/kica.html>.

Between 2010 and 2013, the project team assessed 289 people over the age of 45 years in the town of Derby and the remote communities of Ardyaloon, Mowanjam, Looma, Junjuwa, Wirramanu and Warmun. Participants were interviewed in their own homes. Wherever possible, carers and families were also surveyed, to explore the type of help they provide for their older family members and to ascertain what they consider the impact this role has on their lives. The survey used in the study was designed specifically for Aboriginal people living in rural and remote areas, and the project team will be analysing the results to determine if the

questionnaires could be used directly by health professionals and health workers to screen for the conditions studied.

As part of the project, the National Ageing Research Institute (NARI) has developed the following guides. They are intended to assist clinicians to identify factors contributing to increased independence and improved wellbeing for older people living in the region.

The research team would like to thank and acknowledge the invaluable contribution of all those working and living in Derby, Ardyaloon, Mowanjam, Looma, Junjuwa, Wirramanu and Warmun who assisted with this project.

Good Practice Principles

Good practice principles for working with Aboriginal people

There are various factors to consider when applying culturally sensitive principles to practice. These include good communication, use of interpreters and considering the family's role in providing care for the older person.

Using a person centred approach can enhance good practice. "Person centred care involves a 'collaborative and respectful partnership' where 'the service provider respects the contribution the service user can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs, and the service user respects the contribution the service provider can make, including their professional expertise and knowledge, information about the options available to the service user, and their values and experience'." [1]

Ways of communicating

It is important to be aware that Aboriginal people in remote communities may communicate in ways that are culturally specific and may be unfamiliar to others. Communication styles vary between places and it is important to be open to possible differences.

Some issues to be aware of are:

- In many places it is considered rude to make direct eye contact with the person you are speaking with
- Some Aboriginal people consider directly questioning someone as rude and may ask things indirectly or speak about other issues before getting to the point
- Communication is not always verbal and it is important to be aware of non-verbal cues provided by the other person
- People may pause for a long time before answering questions – this can be a sign of politeness and respect rather than a lack of understanding. Allow enough time for a thoughtful answer to be given

- Sometimes people will answer 'yes' to all questions regardless of the query. This can be because confrontation can be considered rude or because the questions are not understood and they do not want to seem impolite or foolish
- Often, when a person has died, their name and image is no longer used. Other people with the same name will change their name [2, 3]

A willingness to listen and be open to different communication styles and be responsive to others is the most important factor.

Interpreters

Many older Aboriginal people in remote areas do not speak English as their first language. For many it may even be a third or fourth language. In many areas the local language may be spoken as the primary language and Kriol may also be used in preference to English. Kriol can sound similar to English but the meaning can be very different and the English speaker should not assume they understand. It is a language in its own right and Kriol interpreters are available. It is important to assess whether an interpreter should be used during assessment or treatment.

Issues to consider when deciding if an interpreter is needed include:

- Whether English is the person's first language
- That an interpreter may still be needed even if the person can speak and understand basic English
- Relatives and children should not be used as formal interpreters
- The nature and objective of the conversation

The Kimberley Interpreting Service provides guidelines to determine if an interpreter is required and how to use them (see resources).

When using an interpreter, consider:

- Confidentiality issues
- Kinship relationships
- Gender issues

In small communities, confidentiality can be an issue when using an interpreter. If an interpreter is not a professional interpreter, and/or if they know the person or are related in some way this can create problems. In some cases it will also be appropriate to use an interpreter of the same gender as the client, as some issues can be considered inappropriate to be discussed between men and women, for example sexual health issues.

Providing as much information to the interpreter or interpreting service as is possible without breaking confidentiality prior to the interview can help make sure the interpreter is appropriate for the situation and translation is accurate and without bias. A professional trained interpreter should be used wherever possible.

Carers

A carer is anyone who provides unpaid support for another person to assist with any of the tasks of daily living that person is unable to perform. Carers can be of any age, as can the person being cared for. Older people may be carers or the recipients of care. They may also be carers but in need of care themselves, whether or not it is provided. Carers may also be caring for more than one person.

Aboriginal people may not define themselves as carers even when undertaking a caring role. The notion of a primary carer may also have less relevance as often the extended family will share the caring role and be responsible for different aspects of it. Undertaking a caring role and the nature of that role may also be influenced by cultural expectations and practices – for example kinship relationships may dictate who can care for or visit a person who is dying [4].

Most carers willingly take on the role; however it can put pressure on them. Carers may experience:

- Social isolation
- Financial hardship
- Stress and burnout
- Grief and loss
- Poor health themselves and neglect of their own health

Carers may need:

- To be informed about services and support available to them and encouraged and assisted

to access services (Carers payments or Carers Allowance, respite programs, home modification programs etc.)

- Encouragement to look after their own health and wellbeing and assistance to address any health problems they are experiencing
- Assistance with medication management for the person they are caring for
- Help with planning for the future
- Access to counselling or other support services for them

References

1. Dow B., B. Haralambous, F. Bremner and M. Fearn, *What is person-centred health care? A literature review*, 2006, Melbourne: Victorian Government Department of Human Services. Available from: <http://www.mednwh.unimelb.edu.au/pchc/index.htm>. Accessed 31 July, 2013.
2. Taylor, K. and P. Guerin, *Health Care and Indigenous Australians: Cultural Safety in Practice*, 2010, Melbourne: Palgrave Macmillan.
3. The Royal Australian College of General Practitioners. *An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives*. 2012 Available from: <http://www.racgp.org.au/download/Documents/AHU/2012culturalprotocols.pdf>. Accessed 31 July, 2013.
4. Taylor, J. *Practical ways to overcome isolation for Aboriginal and Torres Strait Islander carers: a literature review*. 2013; Available from: <http://www.carersaustralia.com.au/storage/CA%20Literature%20Review-Aboriginal%20and%20Torres%20Strait%20Islander%20carers.pdf>. Accessed 31 July, 2013.

Good practice principles—Resources for consideration

Resource Name	Resource Type	Organisation/Author	Weblink
Aboriginal and Torres Strait Islander Carers: Caring for our People	Booklet	Care Aware	http://careaware.com.au/wp-content/uploads/2013/06/6469-1004-Caring-for-Our-People-Book-Text-Print-LO.pdf
Talking in language: Indigenous language interpreters and government communication	Report	Commonwealth Ombudsman	http://www.ombudsman.gov.au/files/Talking in Language-Indigenous Interpreters REPORT-05-2011.pdf - not necessarily include – saved in resources
Guidelines to determine whether an Indigenous language interpreter is required	Guidelines	Kimberley Interpreting Service	http://www.kimberleyinterpreting.org.au/pdfs/Guidelines.pdf
Kimberley Interpreting Service	Service Provider	Kimberley Interpreting Service	http://www.kimberleyinterpreting.org.au/index.html
An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives	Guidelines	The Royal Australian College of General Practitioners	http://www.racgp.org.au/download/Documents/AHU/2012culturalprotocols.pdf
Person-Centred Practice Domain - Best care for older people everywhere: The Toolkit	Toolkit	Victorian Government Department of Health	http://www.health.vic.gov.au/older/toolkit/
Prepare to Care	Resource Kit	WA Carers	http://www.carerswa.asn.au/resources/PTC-RESOURCE-PACK-2012-WEB-FINAL.pdf

Falls Guide for Clinicians

Overview of falls and older people

A fall is an event which results in a person coming to rest unintentionally on the ground or other level. A fall also includes slips, trips and stumbles [1].

Falls are common among older people and are a major cause of injuries, ranging from abrasions and bruising to more serious consequences such as fractures and broken bones. A serious fall can result in hospitalisation, and can lead to death, serious complications, or other ongoing concerns such as:

- difficulty with walking
- difficulty with personal care activities such as dressing, showering and toileting
- a fear of falling again, which may lead to activity restriction and social isolation

Having a fall can also impact an older person's ability to manage activities such as shopping and cooking. This can lead to increased carer burden and may ultimately mean they cannot live independently in the community.

Every year, approximately 30% of Australians older than 65 years fall, with 10% of these falls leading to injury [2].

There are many risk factors for falls, and some can be avoided or easily changed.

Prevalence data

The Kimberley Healthy Adults Project found that 31.8% of those aged 45 and over fell at least once in the previous year, and that 45.9% were at risk of falling.

Risk factors

Health conditions:

- Chronic health conditions affecting balance and coordination including: diabetes, high blood pressure, kidney disease, diabetes, arthritis and stroke.
- Poor nutrition and inadequate hydration can lead to weakness, dizziness and poor bone and muscle health.
- Drinking alcohol can place someone at higher

risk of falling due to impaired judgement and balance.

- Poor eye health caused by cataracts or infections can increase falls risk. These can cause problems in judging distance and knowing how close or far away objects are.
- Walking can be made difficult by foot conditions such as ingrown nails, bunions and callouses.
- Reduced cognition can increase the number of risks due to impaired decision making.
- A history of falls is also an indication that a person may be at higher risk.

Medications:

- We know that many older people are prescribed multiple medications and that taking more than four different medications increases an older person's risk of falls.
- We know that some medications, such as sleeping tablets, have been linked to greater risk of falls.

Environmental factors:

- Wearing shoes such as thongs or slippers, or wearing only socks increase the risk of tripping or slipping. Loose or long clothing that hangs around the feet can be easily tripped over or caught on furniture.
- When outside, vision may be impaired by bright sunlight, dirt and flies. There may be hazards both inside and outside the house that may increase the risk of falling. Hazards inside the home might be inadequate lighting, frequently used items kept in hard to reach places, cluttered walkways or obstacles on the floor, and unstable or broken chairs or beds. Hazards outside the house may include uneven pathways, rubbish, cracked, bumpy or wet ground and dogs. Wet areas are also a big slip hazard [3].

Strategies

Screening for risk

An appropriate screening and assessment tool should be used to identify if the older person is at risk of falling. The Stay On Your Feet WA Falls Risk

Management Tool is recommended for use in Western Australia – see resources.

Comprehensive assessment

- Explore all factors that could be placing the older person at great risk of falls and explain your concerns with the older person and their family.
- Offer some initial information and discuss any referrals, for example, to the clinic or to a physiotherapist

Developing an Intervention plan

- Provide education to the older person and their family and gain consent to make referrals to occupational therapists, physiotherapists, geriatricians or eye specialists
- Regular clinic check-ups can identify health related risk factors and put appropriate interventions in place to reduce or remove falls risk. This may include treatment of any correctable health conditions such as vision impairments or low blood pressure, and regular review of medications.
- Where possible encourage the older person to remain physically active. This can be very important in maintaining balance, strength and endurance and helping the older person to stay as independent as possible.
- Regular exercise can improve strength and balance, and keep bones and muscles healthy. There are many simple balance exercises that can be done at home. A physiotherapist can give the older person some safe exercises to do.
- Consider a referral to a podiatrist to provide advice on specialist shoes and provide treatment for any foot conditions. It is important that shoes, if they are worn, are comfortable, flat and firm fitting.
- An occupational therapist can assess the older person's home and make suggestions to remove any risks. Walkways should be clear of anything that can be tripped over, such as mattresses and rubbish. Loose carpets, broken tiles or rugs should be stuck down, frequently used items in easy to reach places and lighting should be easy to turn on at night. A commode or urinal may be used at night to avoid walking in the dark.
- Consider whether the older person could benefit from using a walking aid such as a stick or frame. This may help the older person feel more safe and confident when walking and

moving around. A physiotherapist or occupational therapist can provide advice on what is most suitable for the person [4].

References

1. World Health Organisation. *Falls fact sheet*. 2013; Available from: <http://www.who.int/mediacentre/factsheets/fs344/en/>. Accessed 31 July, 2013.
2. Pointer S, Harrison J, and B. C. *National Injury Prevention Plan Priorities for 2004 and Beyond: Discussion Paper*. 2003; Available from: Cited at <http://www.aprs.com.au/australian-health-news/falls-prevention-in-australia>. Accessed 31 July, 2013.
3. National Ageing Research Institute. *Tips for healthy ageing*. 2012; Available from: http://www.mednwh.unimelb.edu.au/nari_tips_for_healthy_ageing/avoiding_falls.html. Accessed 31 July, 2013.
4. Victorian Government Department of Health, *Best care for older people everywhere - The toolkit*, 2012: Victoria, Australia.

Falls—Resources for consideration

Resource Name	Resource Type	Organisation/Authors	Weblink
Preventing Falls and Harm From Falls in Older People Best Practice Guidelines for Australian Hospitals (2009)	Booklet - Guidelines	Australian Commission for Safety and Quality in Health Care	http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf
Falls Are Not For Me (2005): A culturally appropriate falls prevention resource to use with Indigenous Elders in Residential Aged Care	Illustrated booklet	Australian Commission for Safety and Quality in Health Care	http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/fallprevindignsbk.pdf
Falls Prevention Model of Care for the Older Person in Western Australia (2008)	Booklet – Model of Care	Department of Health, Western Australia	http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Falls_Model_of_Care.pdf
Stay On Your Feet WA Falls Risk Management Tool	Screening and Assessment Tool	Department of Health, Western Australia	http://www.healthnetworks.health.wa.gov.au/projects/falls_risk.cfm
“Who Falls?”	DVD	Kimberley Aged and Community Services	
Falls can be a problem for healthy, active older people: A guide to potential risks and ways to avoid them.	Brochure	NARI	http://www.health.vic.gov.au/agedcare/maintaining/falls_dev/Section_a1c.htm
Falls Risk for Older People – Community setting (FROP-Com); & Falls Risk for Older People in the Community (FROP-Com) Screen.	Assessment Tool and Screening tool and Guidelines	NARI	http://www.health.vic.gov.au/agedcare/maintaining/falls_dev/Section_b1ba.htm
Tips on Health Ageing: Falls Prevention	Tip Sheet	NARI	http://www.mednwh.unimelb.edu.au/nari_tips_for_healthy_ageing/avoiding_falls.html
Falls prevention for Aboriginal people: a tool for Aboriginal health workers and Aboriginal communities (2010)	Booklet	Stay on your Feet WA	http://www.health.wa.gov.au/stayonyourfeet/docs/11827_SOYF.pdf
Mobility/Vigour/Self-care Domain - Best care for older people everywhere: The Toolkit	Toolkit	Victorian Government Department of Health	http://www.health.vic.gov.au/older/toolkit/
WACHS Falls Risk Management Tool	Assessment Tool	WA Country Health Service	
WACHS Falls memory screen (only for use with the Falls Risk Management Tool [FRMT])	Screening Tool	WA Country Health Service	

Pain Guide for Clinicians

Overview of pain and older people

“Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” [1]. It is always subjective and unpleasant.

People describe the experience of pain in many different ways and also describe different types of pain.

When people describe pain they might describe the:

- Physical sensation - for example words like aching, stabbing, burning. Can include how intense, where and for how long
- Emotional response - for example feeling scared, anxious, frustrated
- Impact on daily life - for example low mood, trouble with self-care, trouble walking

The experience of pain is subjective and is best described by the person experiencing it.

Pain is usually considered acute or chronic. Acute pain is caused by tissue damage (such as after trauma or surgery) and stops once the damage is healed or within three months.

Chronic pain is pain that is constant and lasts for more than three months. It continues after healing, or is caused by an illness that is not going to get better, or sometimes there is no cause that can be found. Chronic pain is considered an illness in its own right. It is estimated that around 23% of Australians aged 65 and over experience chronic pain [2].

Pain is more common in older people, but should not be seen as a normal part of ageing. Pain is both underreported and underdiagnosed. Not all pain can be eliminated, but almost all pain can be effectively managed.

Prevalence data

The Kimberley Healthy Adults Project found that 48.3% of respondents aged 45 years and over reported experiencing pain that was always present, for more than one week and was severe enough to interfere with activities.

Risk factors

Acute pain:

- Injury
- Surgery
- Medical conditions
- Infection

Chronic pain:

- Chronic illness e.g. arthritis
- Cancer and cancer treatment
- Previous injury or surgery, such as previous trauma from a motor vehicle accident, falls or bone fractures
- Peripheral neuropathy e.g. diabetes
- Back pain

Strategies

Screening for risk

Generally self-reporting is the best way to gauge a person's pain. However, older people do not always report pain, even if they are asked directly. Older Aboriginal people, especially men, may also be less likely to report pain. Clinicians should always be aware of other signs of pain or reasons why it is likely that the person would be in pain.

Observing the person's movements is also important as the pain may only be experienced while moving and may also be observable at this time.

The way a person perceives pain also changes with age. Older people experience:

- A high prevalence of pain
- Under reporting of pain
- Under recognition of pain
- Under treatment of pain
- More adverse treatment effects

Comprehensive assessment

It is important that a comprehensive assessment is completed and that this is regularly reviewed to gauge

the effectiveness of pain management strategies.

In order to most effectively treat a person's pain, it is important to ask the following questions and document the responses:

- When did the pain begin and how has it changed over time?
- How does it impact on function and mood?
- Where is the pain on the body?
- What type of pain is it?
 - Nociceptive pains are caused by damage to body tissue. They are often described as aching, cramping or stabbing and may be aggravated by movement
 - Neuropathic pains are caused by actual nerve damage. They are often burning, shooting or extremely sensitive to touch
- How severe is it?
- What things exacerbate or relieve it?
- Have you tried any medications and have they helped to date?
- When in the day does it occur?

A pain scale should be used to assess the level of a person's pain at that time. A pain scale can either be self-reported or observed. Self-reporting of pain is generally preferred as there is no objective way to measure a person's pain. For some people a visual scale rather than a numeric scale should be used for self-assessment of pain.

A person will not always volunteer that they are in pain or acknowledge their pain when asked. It may be important to look for other signs that the person is in pain. If a person cannot or will not provide information about their pain an observational pain assessment tool can be used, such as the Abbey Pain Scale. This is particularly useful in residential care settings, with people who have cognitive impairment.

It is also important to look for other signs of pain that are common in Aboriginal people e.g.:

- Pretending to be asleep
- Turning away and averting eyes
- Hiding under a blanket
- Lying very still [3]

Developing an intervention plan

Appropriate pain management will depend on the type of pain and the likelihood of recovery.

Acute pain management is focused on relieving pain and healing the cause of the pain, with an expectation that the pain will cease. Chronic pain management is focused on minimising or controlling the pain and maximising the person's functional abilities, rather than eliminating pain altogether.

Pain medications (analgesics) are generally used to manage pain. The medications used range from mild over-the-counter drugs such as paracetamol and ibuprofen to strong opioids such as morphine. It is important that clinical guidelines for the administration of pain relief are followed. Generally pain relief should be administered with a view to preventing pain occurring, rather than after pain has set in. It is also usually appropriate to utilise other strategies to minimise or manage pain. Non-drug pain management strategies can include:

- Physical exercise
- Self-management techniques, such as:
 - Relaxation and/or meditation
 - Pacing – being active at an even level that keeps movement occurring without causing pain flare-ups (see resources for more detailed information on pacing)
- Alternative therapies such as massage, acupuncture or applying heat rub cream. These must be used with caution in people with reduced sensation and/or cognition
- Use of heat packs on the site of the pain [4]

Chronic pain can cause depression or anxiety in some people. If this appears to be a factor, referral for assessment and treatment should be considered.

References

1. International Association for the Study of Pain. *Pain Definitions*. Available from: http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Defi...isplay.cfm&ContentID=1728. Accessed 31 July, 2013.
2. Access Economics, *The High Price of Pain: The Economic Impact of Persistent Pain in Australia*, 2007, Report for the MBF Foundation in collaboration with University of Sydney Pain Management Research Institute.
3. Fenwick, C., *Assessing pain across the cultural gap: Central Australian Indigenous peoples' pain assessment*. Contemp Nurse, 2006. 22(2): p. 218-27.
4. Australian Pain Management Association. *Self help*. 2013; Available from: <http://www.painmanagement.org.au/self-help>. Accessed 31 July, 2013.

Pain—Resources for consideration

Resource Name	Resource Type	Organisation/Author	Weblink
Acute Pain Management: Scientific Evidence	Clinical Practice Guidelines	<i>Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine</i>	http://www.anzca.edu.au/resources/college-publications/pdfs/Acute%20Pain%20Management/books-and-publications/acutepain.pdf
The Victorian Geriatric Medicine Training Program - Pain	Online training program	<i>Australian and New Zealand Society for Geriatric Medicine (Victorian Division)</i>	http://www.anzsgm.org/vgmp/Pain/index.html
Understanding Pain	Online Video	<i>Australian Pain Management Association</i>	http://www.painmanagement.org.au/content/understanding-pain
'I am absolutely shattered': The impact of chronic low back pain on Australian Aboriginal people	Journal article	<i>Authors: Lin, I.B. O'Sullivan, P. B., Coffin, J. A., Mak, D.B., Toussaint, S., & Straker, L. M.</i>	
Disabling chronic low back pain as an iatrogenic disorder: a qualitative study in Aboriginal Australians	Journal article	<i>Authors: Lin, I.B. O'Sullivan, P. B., Coffin, J. A., Mak, D.B., Toussaint, S., & Straker, L. M.</i>	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3641505/
Pain Management	Fact Sheet	<i>Better Health Channel</i>	http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Pain_management_adults
Abbey Pain Scale	Assessment Tool	<i>Department of Health and Ageing</i>	http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-abbey
Best Care for Older People Everywhere	Toolkit	<i>Department of Health Victoria</i>	http://docs.health.vic.gov.au/docs/doc/Best-care-for-older-people-everywhere-The-toolkit-2012
Pain Management Peer-Reviewed Fact Sheets	Fact Sheets (Clinical)	<i>Pain Australia</i>	http://www.painaustralia.org.au/healthcare-professionals/fact-sheets.html
Pain management	Website	<i>PainHEALTH</i>	http://painhealth.csse.uwa.edu.au/pain-management.html

Continence Support Guide for Clinicians

Overview of continence and older people

Incontinence refers to involuntary leakage from the bladder or bowel [1]. It is estimated that 33.5% of Australians over the age of 60 experience urinary incontinence. Women are nearly twice as likely as men to experience incontinence [2].

There are many different types of incontinence, each with different symptoms. Some of the most common types are:

- Stress incontinence - the leaking of small amounts of urine when coughing, sneezing, straining, lifting, playing sport or dancing
- Urge incontinence - the sudden need to urinate accompanied by bladder contractions and involuntary leakage
- Overflow incontinence - where the bladder does not empty properly and urine may leak out
- Nocturia – needing to get up more than two times at night to urinate [3]

Continence problems can have a significant impact upon a person's self-esteem and emotional wellbeing. It is commonly and incorrectly thought of as a normal part of ageing. It can affect people of all ages and can be successfully treated and managed, and in some cases even cured.

Prevalence data

The Kimberley Healthy Adults Project found that 23.9% of people over 45 reported urinary incontinence. Of these people, 20.0% reported that their incontinence stopped them doing things they wanted to do sometimes or all the time.

Risk factors

Health conditions –Continence problems indicate some sort of dysfunction with the bladder or bowel, which can be a symptom of many different health conditions or illnesses. These may include urinary tract infections, diabetes, and neurological disorders such as stroke and Parkinson's disease which can affect nerve control of

the bladder. Constipation, being overweight, smoking, and some medications can also affect continence.

Women: Specific risk factors for women include being pregnant and giving birth (particularly if a large baby or prolonged pushing during birth) as this can lead to weak pelvic floor muscles.

Men: Specific risk factors for men can include an enlarged prostate; the prostate usually grows bigger as a man gets older. A large prostate can cause a blockage, making it hard to urinate.

Issues for Aboriginal people: Problems with the bladder or bowel are not commonly or openly discussed among Aboriginal people, and in particular not with people of a different gender. Body functions are a private topic, and many people may feel too fearful, embarrassed or shamed to admit to experiencing continence problems. People may worry that family will laugh at them if they have to use a commode or products. Elderly Aboriginal people may be scared they will be moved to a nursing home if they have a continence problem [4].

Other factors: Reduced mobility conditions can prevent a person from getting to the toilet in time, and reduced dexterity can make managing clothing difficult. Drinking alcohol, diet drinks and caffeinated beverages can irritate the bladder and make a person need to go to the toilet more often.

Strategies

Screening for risk

A screening tool, such as the Revised Urinary Incontinence Scale (RUIS), can be used to identify current continence problems or incontinence risk (see resources).

Comprehensive assessment

Incontinence can be a very sensitive issue for people to discuss. In Aboriginal communities males may prefer to speak with a male health worker and likewise a female may prefer to speak to a female health worker. It is important that the client has some input into what would be the best treatment for them.

Depending on the type of incontinence the person is

experiencing and their symptoms, they may need referral to the clinic or a specialist, or referrals for continence aids, while some people may only need written / pictorial materials or guidance on how to manage their incontinence.

Developing an intervention plan

The most appropriate intervention plan will depend on the person's individual symptoms.

Treatment

Pelvic floor exercises can be helpful for good bladder and bowel control by making the muscles stronger. If the pelvic floor muscles are not strong, then leakage from the bladder or bowel can occur. These exercises can be helpful for both men and women.

A continence nurse can help the older person with bladder calming techniques or a bladder training program. These are helpful for people with urgency and frequency problems. They aim to calm the bladder and reduce discomfort, and to teach the bladder to hold on. There are many different continence products that are available to help a person to stay dry, comfortable, and not embarrassed if accidents occur when they are with other people. Options include both disposable and washable pads and pants, mattress and chair protectors, urinals and commodes, and catheters and drainage bags.

Prevention

Help the person to practice good toilet habits to prevent bladder and bowel control problems. A person should avoid going to the toilet 'just in case', only going when the bladder is full. Learning calming techniques can reduce discomfort while the bladder is filling up. The bladder should be completely emptied when going to the toilet, and people should not rush going to the toilet. A person should also try to keep their bowel movements regular by not delaying going to the toilet when there is the urge to go.

Encourage the person to avoid straining when going to the toilet as this can weaken the pelvic floor muscles.

Provide advice on healthy food and drink. A diet high in fibre can help to keep bowel movement regular and bladder irritating drinks such as coffee, cola, diet drinks and alcohol should be avoided. Water intake should be about 6-8 glasses per day [5].

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1. Continence Foundation of Australia. *What is incontinence?* 2012; Available from: <http://www.continence.org.au/pages/what-is-incontinence.html>. Accessed 31 July 2013.
2. Hawthorn, G., *Measuring Incontinence in Australia*, 2006, National Continence Management Initiative.
3. State Government of Victoria. *Better Health Channel: Incontinence and continence problems*. 2013; Available from: http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Incontinence_management. Accessed 31 July 2013.
4. Sutherland, A. and J. Billimoria. *Aboriginal and Torres Strait Islander Continence Training in Rural and Remote Australia*.
5. St John, W., et al., ... *What now? Helping clients live positively with urinary incontinence*, 2007, Australian Government, Department of Health and Ageing: Griffith University Research Centre for Clinical & Community Practice Innovation.

Continence—Resources for consideration

Resource Name	Resource Type	Organisation/Author	Weblink
<i>Let's Yarn About It</i> Resources: - Diabetes and pee or poo problems - Grog and pee or poo problems - Hard poo (constipation) - Leaking pee - let's yarn about women's business - Leaking pee after having a baby - Men and strong pelvic floor muscles - Pads, clothes and bedding to help if you are wet - Pelvic floor muscle exercises for women - The prostate and pee problems - Training the bladder (pee bag) "The Continence Gang"	Brochures	Continence Foundation of Australia & Australian Government	http://www.continence.org.au/resources
	DVD	Kimberley Aged and Community Services	
First steps in the Management of Urinary Incontinence in Community-Dwelling Older People: A clinical practice guideline for primary clinicians (registered nurses and allied health professionals) 3 rd Ed 2010	Clinical Practice Guidelines	Queensland Government	http://www.health.qld.gov.au/mass/resourcescont.asp
Second Steps in the Management of Urinary Incontinence in Community-Dwelling Older People: A clinical practice guideline for clinicians with a special interest in incontinence 2 nd Ed 2008	Clinical Practice Guidelines	Queensland Government	http://www.health.qld.gov.au/mass/resourcescont.asp
... What now? Helping clients live positively with urinary incontinence	Booklet	Research Centre for Clinical & Community Practice Innovation, Griffith University/ Australian Government Department of Health and Ageing	http://www.bladderbowel.gov.au/assets/doc/helpingclients.pdf
Revised Urinary Incontinence Scale (RUIS) (2010)	Screening Tool	University of Wollongong's Centre for Health Services Development	http://ahsri.uow.edu.au/chsd/projects/coms/index.html (project information) http://www.bladderbowel.gov.au/assets/doc/ncms/Phase3InformationAndEvidence/
Continence Domain - Best care for older people everywhere: The Toolkit	Toolkit	Victorian Government Department of Health	http://www.health.vic.gov.au/older/toolkit/

Depression Guide for Clinicians

Overview of depression and older people

Depression is not just feeling sad or down - it is an illness that affects a person's ability to function in their day to day life. It can have severe consequences for the person's physical and mental wellbeing.

Approximately 8.2% of older Australians living in the community experience depression, and 34.7% of those living in residential aged care [1].

Depression is not a normal part of getting older - it can be experienced by people of all ages. Depression can be treated [2].

Prevalence data

The Kimberley Healthy Adults Project found that 16.0% of those aged over 45 showed some symptoms of depression on a screening test, and 5.4% - 6.1% were later diagnosed with depression by specialist assessment.

Risk factors

Physical health

- Being in poor health with chronic illness, such as diabetes or heart disease can increase a person's risk of developing depression.
- Being in constant pain
- Side effects of some medications
- Having had depression or other mental illness in the past, or having a family history of depression
- Stopping treatment for depression
- Substance misuse

Social health

- Grief and loss – experienced by an individual or an entire community e.g. loss of land
- Being admitted to hospital or going into an aged care facility
- Trauma or stress – recent or historic e.g. the impact of the Stolen Generation
- Social isolation

Aboriginal issues

- People with depression may not recognise it in themselves and may not seek help
- Partners/family of people with depression may not recognise it and may think the person is being lazy
- Separation from culture or country – this can often happen if older people need treatment or care away from home [3]

Many older Aboriginal people experience more risk factors for depression than the community as a whole.

Strategies

Screening for risk

An older person may be depressed if for more than two weeks they have been:

- Feeling sad, down or miserable most of the time OR
- Lost interest or pleasure in most of their usual activities

AND experienced several of these symptoms:

- Being constantly tired and having no energy, or staying in bed more
- Feeling worthless or guilty about things that are not their fault
- Thinking a lot about dying
- Wanting to be alone more than usual and avoiding social situations
- Finding it hard to cope with day-to-day tasks
- Finding concentrating or making decisions difficult
- Being moody and irritable, or even aggressive
- Finding it hard to sleep or sleeping a lot more than usual
- Not wanting to eat or eating a lot more than usual, resulting in changes in weight
- Feeling sad all the time or crying more readily
- No longer enjoy doing things that they used to
- Lacking confidence and motivation

If depression is suspected a comprehensive assessment should be completed.

Comprehensive assessment

There are a number of tools suited to Aboriginal people that can be used to help assess whether a person has depression – these are listed in the resources section. All assessment tools are based on the person's self-reported feelings, and require a level of trust in the assessor in order to gain an accurate picture of the situation. Building trust is important as depression and negative feelings can be thought of as a shameful thing by some people – it is important to reassure the person that what they say is confidential and is not shameful.

Some of the symptoms of depression are the same as for dementia, so it is important to rule this out, especially in older people.

It is also important to be aware that some people's behaviours can be misinterpreted as depression because they may be culturally different to those of the assessor. For example, in some cultures it is considered rude to make eye contact but this can be seen by other cultures as a sign of being down or lacking confidence.

Assessment should also take into account whether there are other physical or mental health problems the person might have and whether these need to be looked into further.

Developing an intervention plan

If assessment has shown that a person is depressed, a care plan should be developed with that person. A number of people should be involved in caring for the depressed person and be included in the care plan:

- If possible, the person should be referred to the local mental health authority, a GP, a psychiatrist or psychogeriatrician (a psychiatrist specialising in treating older people) to develop a treatment plan. If antidepressant medication is needed it can be prescribed and other treatment options can be explored. Possible underlying medical causes of depression need to be investigated and treated. The Australian and New Zealand Clinical Practice Guidelines for Depression should be followed along with culturally relevant protocols (see resources).
- Referral to a counsellor or psychologist if a 'talking therapy' is part of treatment

- If appropriate, involvement of family with the person's permission
- Treatment by a traditional healer
- Work on reducing the person's risk factors and increasing protective factors where possible. Protective factors include:
 - Sense of belonging and being connected to others
 - Connection to land and culture
 - Feeling in control and valued
 - Being active [4]

If you think the person may be at risk of committing suicide, seek urgent help. A hospital emergency department or mental health assessment team are the best options for urgent care. If you can't access these services, call Lifeline on 13 11 14. Please note that there may be additional options or services specific to your community.

References

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2. beyondblue. *Depression.* 2013; Available from: <http://www.beyondblue.org.au/the-facts/depression>. Accessed 31 July, 2013.
3. Government of Western Australia Mental Health Commission. *Aboriginal mental health.* 2010; Available from: http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_aboriginal.aspx. Accessed 31 July, 2013.
4. Mental Health First Aid Australia, *Depression: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*, 2008, Mental Health First Aid Australia and beyond blue: the national depression initiative 2008: Melbourne.

Depression—Resources for consideration

Resource Name	Resource Type	Organisation/Author	Weblink
Depression	Poster	AIMhi	http://menzies.edu.au/sites/default/files/images/file/AIMHI/DEPRESSION_OCT08.pdf
Brief wellbeing screener	Assessment tool	AIMhi	http://menzies.edu.au/sites/menzies.edu.au/files/file/aimhi/Brief%20Wellbeing%20Screener.pdf
Mental health	Booklet	AIMhi	http://menzies.edu.au/sites/menzies.edu.au/files/images/file/AIMHI/MAKE+CHANGE+GROW+STRONG+3.pdf
Mental health	Assessment tools and Care Plans	AIMhi	http://menzies.edu.au/menziesresources/aimhi-mental-health-care-plans
Yarning about mental health: an easy guide to mental health assessment	Flipchart	AIMhi	http://menzies.edu.au/sites/menzies.edu.au/files/images/file/AIMHI/YAMH%20Flip%20Chart-14%20final%20%28CRAH%29%20October%202009.pdf
Yarning about sadness	Brochure	Australian Integrated Mental Health Initiative (AIMhi), Menzies School of Health Research	http://menzies.edu.au/sites/menzies.edu.au/files/file/aimhi/6084-Yarning%20About%20Sadness%20Brochure-5.pdf
Keeping Strong	Flyer	Beyond Blue	https://www.bspg.com.au/dam/bspg/product?client=BEYONDBLUE&prodid=BL/0821&type=file
Information for Aboriginal and Torres Strait Islander People	Website and online videos (Stories for Keeping Strong)	Beyond Blue	http://www.beyondblue.org.au/resources/for-me/aboriginal-and-torres-strait-islander-people
Information for older people	Website	Beyond Blue	http://www.beyondblue.org.au/resources/for-me/older-people
Depression in Older People	Fact Sheet	Black Dog Institute	http://www.blackdoginstitute.org.au/docs/DepressioninOlderPeople.pdf
Guidelines for Depression in ATSI people	Guidelines	Mental Health First Aid	https://www.mhfa.com.au/cms/mental-health-first-aid-guidelines-project/
Australian Indigenous Mental health site	Website	Royal Australian and New Zealand College of Psychiatrists	http://indigenous.ranzcp.org
Australian and New Zealand Clinical Practice Guidelines for Depression	Clinical Practice Guidelines	Royal Australian and New Zealand College of Psychiatrists	http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Depression-pdf.aspx (full guidelines)
			http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Publications/CPG/Clinician/APY530-pdf.aspx (summary guidelines)

Dementia Guide for Clinicians

Overview of dementia and older people

“Dementia is a general term used to describe a physical condition or illness that results in significant loss of abilities such as memory, problem solving, planning and thinking, that is severe enough to interfere with what a person is able to do and how they live their everyday life” [1]. A person’s decline in ability is usually noticeable to those who know them well.

Dementia is more common in older people and the likelihood of developing dementia increases with age. In 2011, 2.4% of Australians aged 45 and over had dementia. For those aged 65 and over, the rate was 9% and for those aged 85 and over the rate was 30% [2].

There are many different types of dementia. Some of the most common are:

- Alzheimer’s disease – brain cells lose their connections to each other and die
- Vascular dementia – blood vessels in the brain become damaged. This leads to a stroke or a series of mini strokes (infarctions)
- Frontotemporal dementia - caused by a number of degenerative diseases which mainly affect the front part of the brain
- Dementia with Lewy bodies - a condition related to Parkinson's disease
- Acquired brain injury - Dementia associated with excessive consumption of alcohol or head injuries [3]

People with dementia:

- Have trouble remembering things that happened recently
- Have trouble knowing what day or time it is or where they are
- May no longer be able to do things they used to do easily – like cooking or driving
- Have trouble speaking and understanding people
- Show mood or personality changes

A person may have Mild Cognitive Impairment (MCI) rather than dementia. This is where memory is affected

but the other symptoms of dementia are not present. MCI is diagnosed in the same way as dementia and is a significant risk factor for developing dementia.

Other conditions can also mimic the symptoms of dementia, and may co-exist with it. These include depression, delirium and side effects from the use of multiple medications (particularly some sedatives and bronchial medications).

Most types of dementia are degenerative – they continue to get worse over time. Eventually the person with dementia dies as their brain can no longer perform even basic functions, or because they experience complications from the disease. People with dementia often demonstrate behaviours that can include depression, anxiety, delusions and hallucinations. They can also include things like wandering, shouting and disturbed sleep [4].

Prevalence data

The Kimberley Healthy Adults Project found that prevalence of dementia in Aboriginal people aged 45 and over in the Kimberley is 12.4% and the prevalence of cognitive impairment not dementia was 8% [5]. Of those aged 60 and over, the prevalence of dementia was 23.8% and the prevalence of cognitive impairment not dementia was 13.7% [5]. The recent KHAP survey revealed similar rates of dementia of between 10.5% and 11.2% of those over the age of 45 years. These rates are significantly higher than non-Indigenous Australians.

Risk factors for dementia

The causes of dementia are not known, however there are a number of risk factors associated with developing dementia. An absence of risk factors does not guarantee that a person will not develop dementia. However, evidence shows that reducing risk factors can lower the chance of developing dementia or delay its onset.

In remote populations of older Aboriginal people, risk factors associated with developing dementia include:

- Current smoking
- Previous stroke
- Epilepsy
- Previous head injury
- Poor mobility
- Incontinence
- Falls
- Lack of formal education
- Being male [6]

Other risk factors identified in the general population include Type 2 diabetes, untreated high blood pressure or high blood cholesterol, poor diet, lack of exercise, lack of social or mental stimulation, being obese or underweight, and a family history of dementia.

Excessive consumption of alcohol is also a risk factor for developing dementia, especially alcohol-related dementia [7].

Strategies

Screening for risk

A person should be screened for cognitive decline if:

- They are showing some of the symptoms of dementia. This can present in ways such as seeming forgetful during a general health assessment, forgetting to take their medications, or becoming withdrawn

OR

- There is concern about their behaviour from anyone who knows them well, such as a family member or close friend

If initial screening shows potential cognitive decline a comprehensive assessment should be undertaken.

Although dementia is more common with age, it is not inevitable, and symptoms should not be dismissed as normal signs of ageing.

Comprehensive Assessment

In order to diagnose dementia a thorough evaluation is needed.

Diagnosing dementia involves ruling out other possible reasons a person may be confused or acting differently, such as depression and delirium.

A thorough conversation needs to be had with the person, using interpreters if necessary, in order to

diagnose dementia. People close to the person should also have the opportunity to discuss the changes in their behaviour.

The Kimberley Indigenous Cognitive Assessment - the KICA - should be used if you think a person may be showing signs of dementia. The KICA is a validated tool made up of a number of tests and questionnaires that was developed to assess if a person has dementia. It was developed especially for Aboriginal people living in remote communities. An interpreter may be needed when administering the KICA.

If the KICA indicates that there is cognitive impairment a full clinical assessment should be undertaken. This should include:

- Current risk factors and strategies for minimising them
- Use of medications and possible contribution to symptoms
- Brain imaging and blood tests
- Neurological changes
- The onset and progression of the disease
- Existence of depression and behavioural and psychological symptoms

Developing an intervention plan

There is no cure for dementia, but there are some adjustments that the individual and their family can make to ease the burden and distress associated with the person's decline.

These include:

- Education and counselling for the individuals and their families
- Initiating community support e.g. HACC services, home care packages or carer respite
- Attending to other medical problems e.g. medications, safety issues, driving etc.
- Personal planning e.g. advance care directives, and sometimes exploring the need to appoint an administrator/guardian is necessary as a last resort
- Treating with appropriate medications early
- Minimising risk factors

The earlier in the progression of the disease that diagnosis occurs, the easier it is to begin these adjustments and the more input the person with

dementia is able to have in making decisions for their future.

There is evidence to suggest that certain medications have been successful in slowing the disease progression in some people. There are also some medications that have been helpful in controlling symptoms such as depression or agitated behaviour.

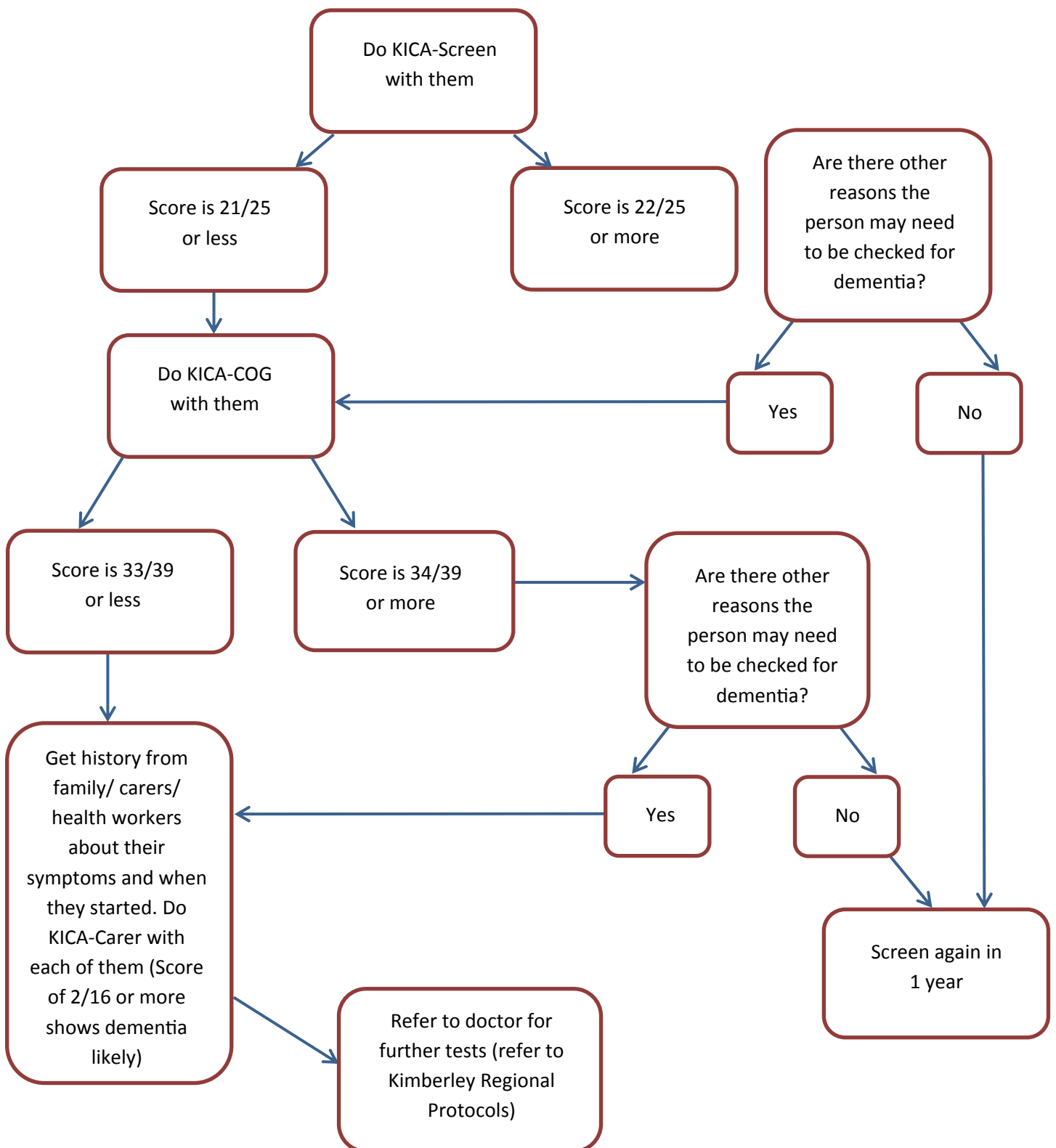
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2. Australian Institute of Health and Welfare, *Dementia in Australia*, 2012, Australian Institute of Health and Welfare: Canberra.
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5. K. Smith, et al., *High prevalence of dementia and cognitive impairment in Indigenous Australians*. *Neurology*, 2008(71): p. 1470-1473.
6. Fitzsimons, E. *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*. 2013; Available from: <http://www.racgp.org.au/your-practice/guidelines/national-guide/preventive-health-for-the-elderly/dementia/>. Accessed 31 July, 2013.
7. Farrow, M. and E. O'Connor, *Targeting brain, body and heart for cognitive health and dementia prevention*. *Alzheimer's Australia Paper 29*, 2013, Alzheimer's Australia: Canberra.

Dementia—Resources for consideration

Resource Name	Resource Type	Organisation/Author	Weblink
Dementia resources for Aboriginal and Torres Strait Islanders	Website, Fact Sheets	<i>Alzheimer's Australia</i>	http://www.fightdementia.org.au/content/aboriginal-and-torres-strait-islander-resources-and-publications
Looking Out for Dementia	DVD	<i>Alzheimer's Australia NT</i>	Information and available to order from http://www.fightdementia.org.au/content/looking-out-dementia
Dementia Learning Resource for Aboriginal and Torres Strait Islander Communities	Kit	<i>Department of Health and Ageing/ Alzheimer's Australia</i>	http://www.fightdementia.org.au/understanding-dementia/dementia-learning-resource-for-aboriginal-and-torres-strait-islander-communities
National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people	Clinical Guideline	<i>Royal Australian College of General Practitioners</i>	http://www.racgp.org.au/your-practice/guidelines/national-guide/preventive-health-for-the-elderly/dementia
Person-Centred Practice Domain - Best care for older people everywhere: The Toolkit	Toolkit	<i>Victorian Government Department of Health</i>	http://www.health.vic.gov.au/older/toolkit/
Chronic Disease Protocol – Dementia	Kimberley Regional Protocols	<i>WA Country Health Service/ Kimberley Aboriginal Medical Service Council</i>	http://resources.kamsc.org.au/downloads/cd_dem.pdf
Dementia poster for Aboriginal Communities	Poster	<i>Western Australia Centre for Health and Ageing</i>	http://www.wacha.org.au/docs/misc/Indigenous-Dementia-Poster.pdf
Kimberley Indigenous Cognitive Assessment	Assessment Tool	<i>Western Australia Centre for Health and Ageing</i>	http://www.wacha.org.au/kica.html

When you suspect someone is displaying symptoms or signs of dementia or memory loss



Falls

Falling over can be very bad for older people



What can happen if I fall?

If older people fall they can:

- Bruise or cut themselves
- Break bones
- No longer be able to look after themselves
- Even have to move to an old people's home

Older people might fall because they:

- Have diabetes, high blood pressure or other health problems
- Are dizzy because they are not drinking enough water or eating properly, or because of their medicines
- Are confused or have dementia
- Have bad eyesight
- Have feet problems or the wrong type of shoes
- Drink too much grog



What can I do so I don't fall?

Things that can help:

- Seeing a doctor or health worker to check health and medicines
- Simple exercises—speak to a physiotherapist
- Eating properly and drinking enough water
- A podiatrist can help with foot problems and getting the right shoes
- An occupational therapist can help to make sure their house is safe—like that there aren't things to trip over and the light is bright enough
- A physiotherapist can help decide if a walking stick or walking frame is needed



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Pain

Older people shouldn't put up with pain



I'm paining

Older people may be paining because of:

- Injury
- Surgery
- Chronic illnesses like arthritis
- Cancer or cancer treatment
- Nerve damage - often from diabetes

The best way to find out if someone is paining is to ask them. They will not always tell you if they are paining. You may need to look for other signs.

If you know someone is paining try to find out more about:

- How long they have been paining
- Where the pain is
- What it feels like
- How bad it is
- Things that make it better or worse
- How it affects their mood
- Are they able to do everyday tasks

The more you know the more you can understand what helps their pain and if it gets better or worse over time.



What can be done about my pain?

Things that can help:

- Medicines—see a doctor, nurse or health worker
- Exercise—speak to a physiotherapist
- Meditating and relaxing
- Massage
- Heatpacks

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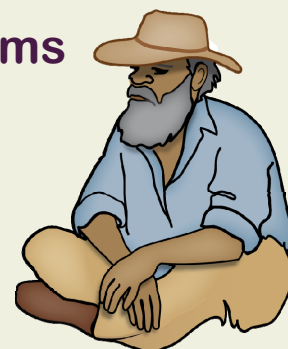


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Continence

Help for older people with toilet problems



Toilet problems can make people feel shame
and stop them doing things they enjoy

Things that can cause toilet problems:

- Diabetes
- Being overweight
- Some medicines
- Smoking
- Too much grog
- Constipation
- Childbirth (women)
- Enlarged prostate (men)

Things that can help stop leaking:

- Talking to health worker or specialist
- Pelvic floor exercises—making the muscles strong can stop leaking problems
- Drinking enough water
- Eating lots of fruits and vegetables
- Practising waiting to go to the toilet—training the bladder
- Sometimes medicine or an operation can help

How do I
stop
leaking?



What can
help if I still
leak?



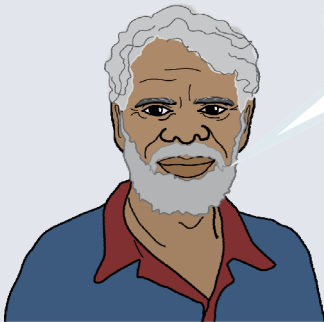
Things that can help when a person leaks:

- Pads and pants—these can be disposable or washable
- Mattress and chair protectors
- Urinals and commodes (chair toilets)
- Bedpans
- Drainage bags

More information is available in the *Let's Yarn About This* booklet series produced by the Continence Foundation of Australia.
www.continence.org.au 1800 33 00 66

Depression

Depression is not a normal part of getting older

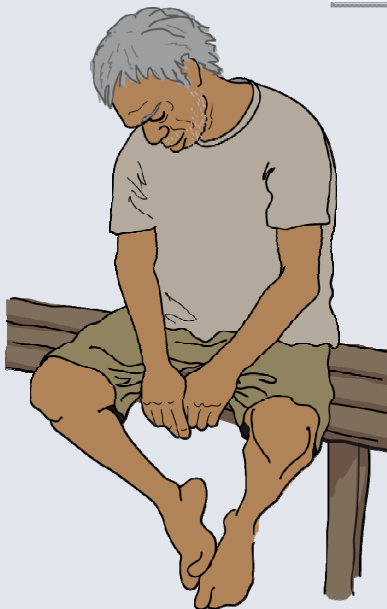


What is depression?

People who are depressed are people who are feeling very sad inside —making them feel no good most of the time

They might:

- Think of dying
- Be tired all the time
- Feel guilty
- Cry for no reason
- Not look after themselves
- Sit down alone



These things can cause depression:

- Illness and pain
- Grief and loss
- Too much grog
- Family history
- Side effects of medicines
- Going to hospital
- Moving to an old people's home

What might help:

- Clinic nurse or clinic doctor
- Seeing a counsellor or psychologist for talking therapy
- Antidepressant medicine
- Talking to family or a friend who understands
- Traditional healer
- Going back to country
- Stopping grog

What can help?



Developed in collaboration with the Menzies Aboriginal and Islander Mental health initiative (AIMhi) info@menzies.edu.au



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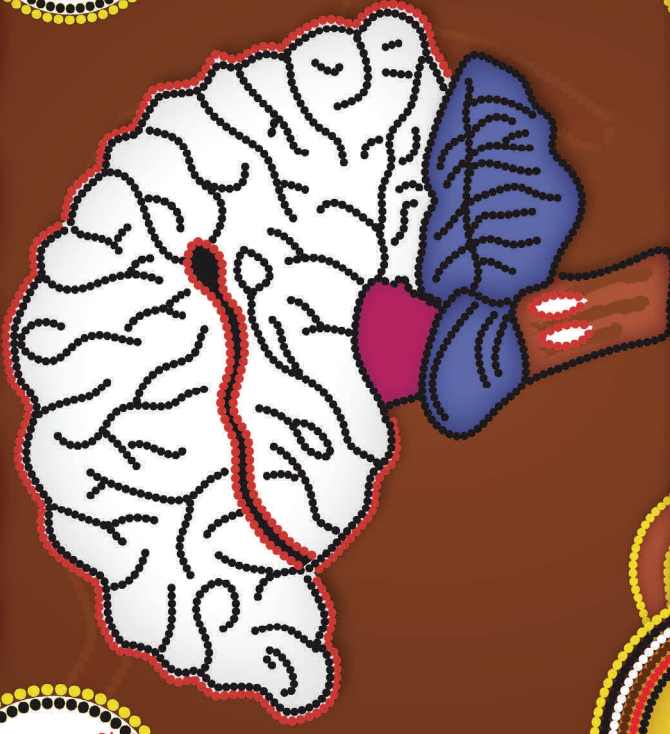


Illustrations by



Memory Problems (Dementia)

ARE CAUSED BY DAMAGE TO THE BRAIN



Forget
Payday or
Where
Things Are

Walking Away
& Getting Lost,
Saying The Names
Of People Who
Have Died

Trouble
Cooking,
Repeating
Themselves
Over & Over

Growing
More

Signs Of
Dementia
Things To
Look For

NEED TO LOOK AFTER BLOOD PRESSURE,
DIABETES, EXERCISE AND EAT HEALTHY
& NOT DRINK TOO MUCH GROC

What
Causes
Dementia

Smoking

Epilepsy
Fits

Head
Injury
Fighting,
Car/Horse
Accident

Stroke
Weak On
One Side

- ★ Loss Of Memory
- ★ Acting Differently
- ★ Trouble Looking After Themselves

If You Are Worried For Someone Or Yourself,

Ask At Your Clinic.....

Or Call Carelink 1800 052 222

Indigenous Dementia Services Study

www.wacha.org.au

- ★ Men Are More At Risk
- ★ People Show Signs Of Dementia As They get Older



