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Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over

2019

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Please note that there is the potential for minor revisions of data in this report.

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Contents

Summary

This report presents new data on vulnerability experienced by older Aboriginal and Torres Strait Islander Australians. It brings together data from more than 20 sources and shows that many Indigenous people have complex and varied needs. It presents information on potential risk factors, including functional dependency, disability, poor physical health, mental illness, substance use, traumatic events, economic hardship and safety.

Selected data for Indigenous Australians aged 50 and over

	Representation of Indigenous Australians		
Measure	%	no.	Reference period
Population size	***1.5% of total population aged ≥50 were Indigenous***	***124,012***	***30 June 2016***
Accessing aged care services			
Aged Care Assessments	1.4% of all Aged Care Assessment Program clients aged ≥50 were Indigenous	2,309	2015–16
Commonwealth Home Support Programme	3.1% of all Commonwealth Home Support Programme clients aged ≥50 were Indigenous	20,102	2016–17
Home Care Packages Program	3.9% of all Home Care Packages Program clients aged ≥50 were Indigenous	2,196	30 June 2017
Residential aged care	0.9% of all aged care residents aged ≥50 were Indigenous	1,679	30 June 2017
Overall hospital service use			
Admitted patient care	3.4% of all hospitalisations for the total Australian population aged ≥50 were for Indigenous Australians	434,598	2014–16
Admitted patient care (excluding dialysis)	1.4% of all hospitalisations (excluding dialysis) for the total Australian population aged ≥50 were for Indigenous Australians	143,963	2014–16
Emergency department presentations	3.1% of all presentations for the total Australian population aged ≥50 were for Indigenous Australians	164,065	2015–17
Mental health service use			
Mental health related admitted hospital care	1.9% of all mental health related hospitalisations among those aged ≥50 were for Indigenous Australians	6,137	2014–16
Mental health related emergency department presentations	6.3% of all emergency department presentations for mental and behavioural disorders among those aged ≥50 were for Indigenous Australians	8,359	2015–17
Community mental health services	3.6% of all community mental health service patients aged ≥50 were Indigenous Australians	3,457	2015–16

continued

Selected data for Indigenous Australians aged 50 and over (continued)

Measure	Representation of Indigenous Australians		Reference period
	%	no.	
Housing assistance			
Public housing	5.0% of all public housing tenants aged ≥50 were Indigenous Australians	9,126	30 June 2016
State owned or managed Indigenous housing	85% of all state owned or managed Indigenous housing tenants aged ≥50 were Indigenous Australians	4,326	30 June 2016
Income support	1.8% of all Australians aged ≥50 receiving income support were Indigenous Australians	59,489	30 June 2016
Alcohol and drug service use			
Emergency department presentations for alcohol/drug abuse and induced mental disorders	18% of all emergency department presentations for alcohol/drug abuse or induced mental disorders among those aged ≥50 were for Indigenous Australians	5,367	2015–17
Hospital admissions —alcohol related	5.3% of hospitalisations related to alcohol use among those aged ≥50 were for Indigenous Australians	2,888	2014–16
Hospital admissions —drug use related	3.7% of hospitalisations related to drug use among those aged ≥50 were for Indigenous Australians	757	2014–16
Specialised drug/alcohol treatment for own use	8.5% of clients aged ≥50 receiving assistance for their own drug use were Indigenous Australians	1,210	2016–17
Safety			
Hospital admissions due to non-fatal assault	17% of hospitalisations due to non-fatal assault among those aged ≥50 were for Indigenous Australians	1,025	2014–16
Police recorded—victims of assault	7.2% of all victims of assault aged ≥50 were Indigenous Australians	868	2016
Police recorded victims of family and domestic violence assault	11% of all family and domestic violence assault victims aged ≥50 were Indigenous Australians	563	2016
Homicide victims	5.1% of all homicide victims aged ≥50 were Indigenous Australians	83	1989–90 to 2013–14

Notes:

1. This table presents a summary of information presented across the report. For source information and notes around these data refer to the relevant chapters.
2. Data for police recorded victims of assault are not national and are presented for NSW, SA and NT combined.
3. Proportions among Indigenous population aged 50 and over are calculated excluding not stated Indigenous status.

1

Introduction

In 2017, the Australian Law Reform Commission completed the report *Elder abuse—a national legal response*. It had 43 recommendations, including the development of a national plan to combat elder abuse (recommendations 3.1-3.4) and conducting a national study into the prevalence of elder abuse (recommendation 3.5) (ALRC 2017).

The Commission called for governments to consider the different experiences and needs of older people, including those of Aboriginal and Torres Strait Islander people. There is limited research available in relation to the abuse of older Indigenous people. The Commission identified the importance of undertaking research on risk factors, protective factors and needs of particular groups, including older Indigenous people.

The Attorney-General's Department has commissioned research to improve understanding of the dynamics and drivers of elder abuse, focused on estimating the prevalence of elder abuse in Australia.

This report adopts a holistic, multi-level approach to understanding elder abuse, reflecting a complex interaction of individual, interpersonal, community and societal level risk factors. Drawing on available literature and a range of administrative and survey data on Indigenous people aged 50 and over, it describes their characteristics and experiences of adversity and identifies where they engage with services.

In the first instance, the Attorney-General's Department asked the Australian Institute of Health and Welfare (AIHW) to review data already routinely collected to identify potential measures of factors that may be associated with vulnerability to abuse. This is consistent with international approaches—for example, the United States National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect considered that data on vulnerability should be routinely collected and analysed, since diminished capacity for selfcare or self-protection is a key feature of elder abuse (Bonnie & Wallace 2003).

Other related research activities include the design of a National Elder Abuse Prevalence Study, and insights into abuse of older people based on analysis of the Australian Bureau of Statistics (ABS) data sets (Katz & Hill 2019).

1.1 Defining elder abuse

There is no one definition of elder abuse, and definitions of abuse, violence and neglect of older people continue to evolve. A widely cited definition of elder abuse, developed by the World Health Organization, decribes it as a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

Commonly recognised categories of elder abuse include physical, psychological, financial and sexual abuse, as well as neglect (ALRC 2017). Older people can experience one specific type of abuse, but can also experience multiple forms concurrently.

1.2 An applied ecological approach

The 2017 National Ageing Research Institute framework theorises that factors associated with abuse can be understood through an applied ecological framework that comprises:

- individual level factors—relate to the circumstances of the 'older' person or the 'person of trust', including demographics, living situation, health and wellbeing, risk taking behaviours, as well as personal relationships
- community level factors—relate to broader level factors; for example, those associated with living in aged care and service availability
- society level factors—encompass beliefs and cultural norms at a society level around, discrimination, ageism and family violence (Joosten et al. 2017).

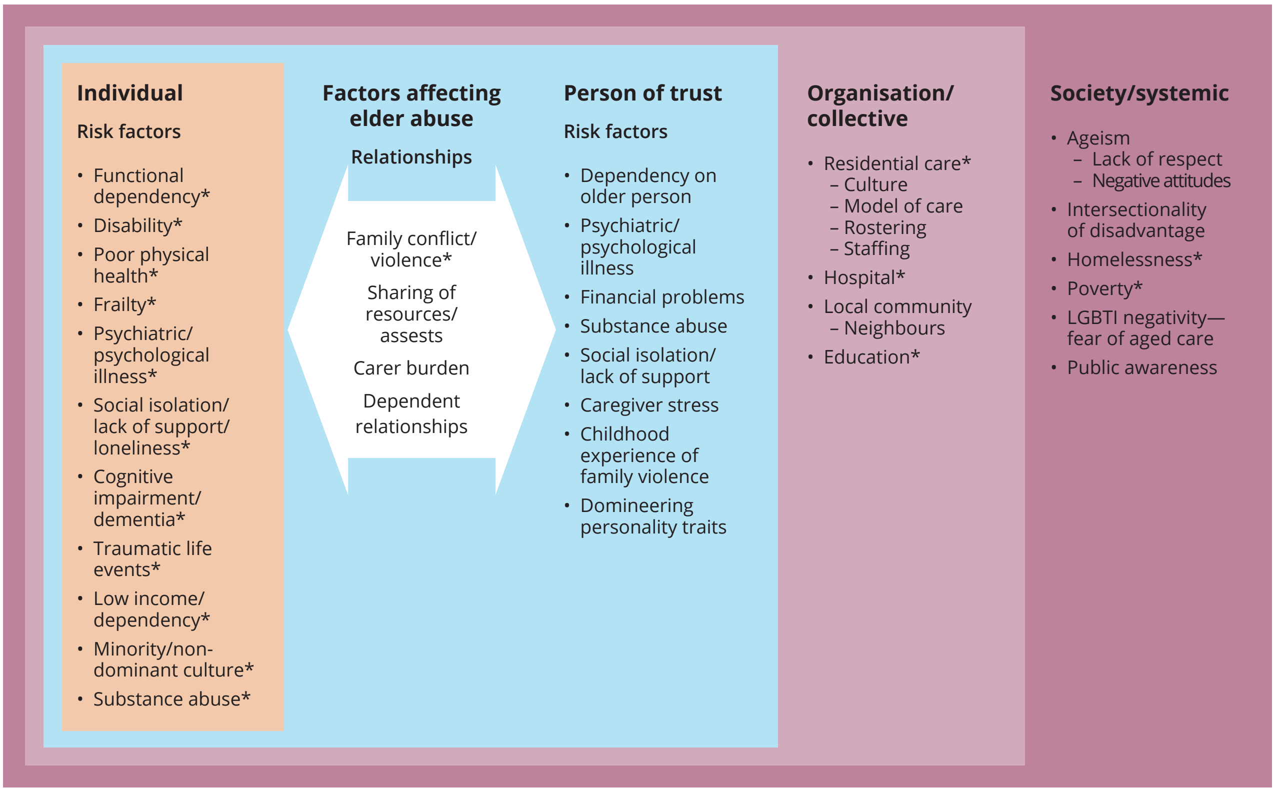
This framework allows vulnerabilities among Indigenous Australians aged 50 and over to be better understood, recognising that outcomes arise from a complex interaction of risk factors and protective factors. These factors, which Day and others (Day et al. 2016) found may arise at each of the three levels in the framework, and can allow or inhibit the abuse of older people.

Society-wide factors such as ageism and discrimination affect both Indigenous and non-Indigenous Australians; however, the experiences of older Indigenous people reflect a unique cultural and historical context. Aboriginal and Torres Strait Islander people represent the oldest living continuous culture. The health and wellbeing of their communities continue to be affected by the legacy of colonisation and intergenerational trauma.

Much is yet to be understood on how individual, relational, community and societal factors may protect against abuse, or contribute to the risk of abuse. This applies to both Indigenous and non-Indigenous Australians. Potential risks or protective factors need to be considered with this in mind (Kaspiew et al. 2016).

This report presents data mapped to a number of factors identified in the applied ecological framework presented in Figure 1.1. The focus is on descriptive information on Indigenous Australians aged 50 and over covering demographics, health and functioning, social and emotional wellbeing, socioeconomic determinants and safety.

Figure 1.1: Applied ecological approach to elder abuse at the population level



* Indicates factors that are reported on for Aboriginal and Torres Strait Islander Australians aged 50 and over.

Source: Amended with permission from Joosten et al. 2017.

1.3 Data sources used in this report

This report brings together national data on Aboriginal and Torres Strait Islander people aged 50 and over. The main data sources are a mix of Census, surveys and administrative collection. Selected data are published alongside this report in a set of supplementary tables, which will be referred to throughout this report, as for example Table S2.1 (available at www.aihw.gov.au).

As this report looks at Indigenous Australians aged 50 and over, unless stated otherwise, references to rates 'per 1,000 population' reflect the rate 'per 1,000 Indigenous Australians aged 50 and over'.

While the AIHW has tried to use the latest possible data, the collections reflect a range of time periods available at the time of drafting. These data sources also vary in their use of definitions, data items collected and reporting mechanisms, so they cannot be easily compared. The availability of information on Indigenous status varies across data sources used in this report, but throughout the report rates are calculated excluding these not stated records (see supplementary Table S1.1 for more information).

Further detail on each data source is also available in Appendix A.

2

Indigenous Australians aged 50 and over

In 2016, there were around 124,000 Aboriginal and Torres Strait Islander people aged 50 and over, representing 16% of the total Indigenous Australian population (see Box 2.1 for information on the population data used in this report).

Box 2.1: Population data used in the report

Estimated resident population (ERP) data are the official measure of the Australian population. These estimates are counts from the ABS Census of Population and Housing, with various adjustments—for example, taking into account people missed and those whose Indigenous status was not recorded.

In this chapter, 2016 Census-based ERP data for 30 June 2016 are used to describe the age, sex and remoteness distribution of the Indigenous population. Unadjusted 2016 Census counts have also been used to describe other selected characteristics of the Indigenous population.

Across the report (as 2016 Census-based ERP were not yet available over time), rate calculations on administrative data (for example, hospitals data) use 2011 Census-based projection estimates to ensure consistency of denominators.

2.1 Population

Population estimates (ERP based on the 2016 Census) show that, as at 30 June 2016, Indigenous Australians aged 50 and over, comprised 1.5% of the total Australian population aged 50 and over. In comparison, among Australians of all ages, 3.3% identified as being Indigenous (Figure 2.1). There is a higher proportion of Indigenous women than men in the older age groups—with women representing 66.3% of those aged 85 and over.

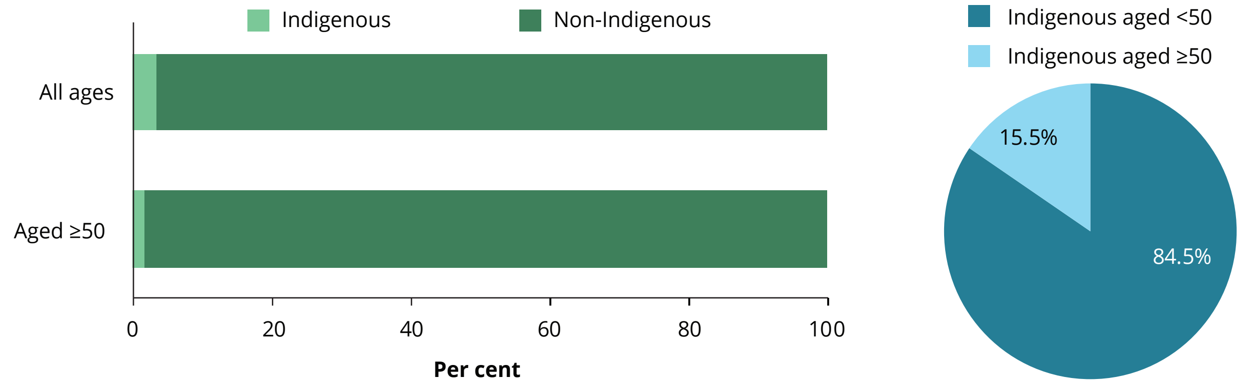
In 2016, among those aged 50 and over who identified as Indigenous:

- 91.3% (113,251) identified as being of Aboriginal origin only
- 5.7% (7,117) identified as being of Torres Strait Islander origin
- 2.9% (3,644) identified as being of both Aboriginal and Torres Strait Islander origin (ABS 2018a).

Population estimates (ERP data) based on the 2016 Census show that, as at 30 June 2016:

- there were 90,000 Indigenous Australians aged 50–64 (11.3% of the Indigenous population), and a further 34,012 aged 65 and over (4.3% of the Indigenous population)
- nearly 1,900 Indigenous Australians were aged 85 and over (0.2% of the Indigenous population)
- Indigenous women outnumbered Indigenous men in the older age groups, with women comprising 53% of Indigenous Australians aged 50–64, 54% of those aged 65–84, and 66% of those aged 85 and over (see Table 2.1).

Figure 2.1: Australian population as at 30 June 2016



Note: Data for this figure and notes about the analysis are shown in Table 2.1 and S1.1.

Source: AIHW analysis of ABS Estimates of Aboriginal and Torres Strait Islander Australians, June 2016 (using TableBuilder) (ABS 2018a).

Table 2.1: Indigenous Australian population by sex and age group, 30 June 2016[(a)]

	Number			% of Indigenous population			% of total Australian population
Age group	Males	Females	People	Males	Females	People	
Population aged under 50							
<50	340,346	334,007	674,353	42.6	41.8	84.5	4.2
Population aged 50 and over							
50–54	17,666	19,549	37,215	2.2	2.4	4.7	2.4
55–59	14,433	15,928	30,361	1.8	2.0	3.8	2.1
60–64	10,649	11,775	22,424	1.3	1.5	2.8	1.7
65–69	7,335	8,081	15,416	0.9	1.0	1.9	1.3
70–74	4,071	4,806	8,877	0.5	0.6	1.1	1.0
75–79	2,164	2,859	5,023	0.3	0.4	0.6	0.8
80–84	1,119	1,706	2,825	0.1	0.2	0.4	0.6
85+	630	1,241	1,871	0.1	0.2	0.2	0.4
Total 50+	*58,067*	*65,945*	*124,012*	*7.3*	*8.3*	*15.5*	*1.5*
Total population							
All ages	**398,413**	**399,952**	**798,365**	**49.9**	**50.1**	**100.0**	**3.3**

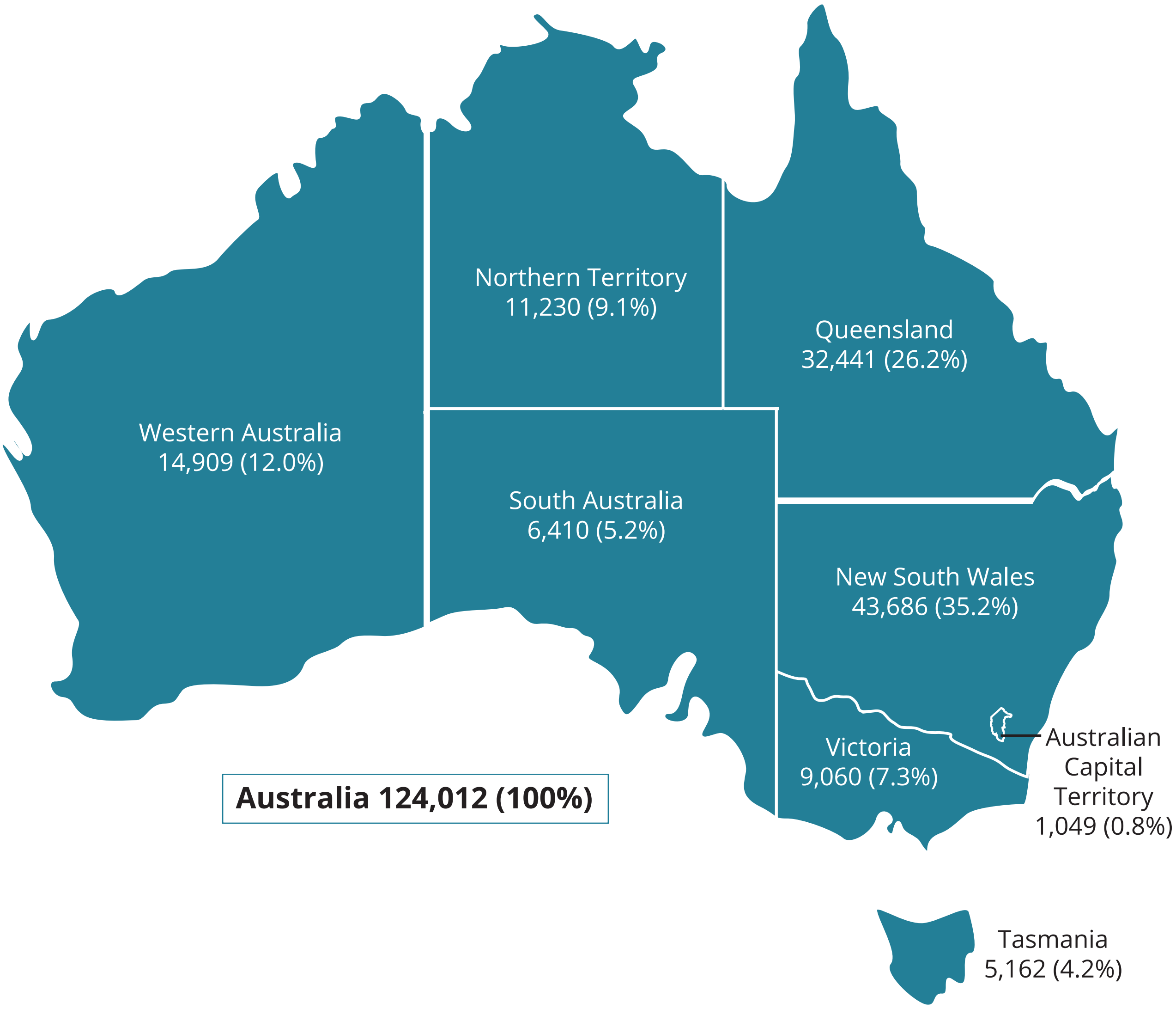
(a) ERP data based on the 2016 Census (see also Box 2.1).

Source: AIHW analysis of ABS 2018a.

2.2 Geographic distribution

On 30 June 2016, New South Wales had the largest population of Indigenous Australians aged 50 and over, with nearly 35% (43,700) of the total Indigenous Australians aged 50 and over. Queensland had the second largest—26% (32,400) of the older Indigenous population. The smallest population of Indigenous Australians aged 50 and over was in the Australian Capital Territory (0.8% or about 1,000 people) (Figure 2.2).

Figure 2.2: Indigenous population aged 50 and over, by state and territory, 30 June 2016[(a)]



(a) ERP data based on the 2016 Census (see also Box 2.1).

Source: AIHW analysis of ABS 2018a.

2.2.1 Remoteness

As observed with the overall Indigenous population, Indigenous Australians aged 50 and over are more likely to live in urban and regional areas than in remote areas. Using 2016 Census-based estimates, at 30 June 2016:

- about 4 in 5 (81%) Indigenous Australians aged 50 and over lived in either *Major cities* (35%) or *Inner regional* and *Outer regional* areas (46%).
- about 1 in 5 (20%) Indigenous Australians aged 50 and over lived in *Remote* and *Very remote* areas combined.
- the proportion of the total population aged 50 and over who were Indigenous Australians was higher in more remote areas. The proportion of the population who were Indigenous was 0.8% in *Major cities*, compared with 2.3% in *Inner regional* and *Outer regional* areas, and 16.8% in *Remote* and *Very remote* areas (Table 2.2).

Table 2.2: Indigenous Australian population aged 50 and over by remoteness area, 30 June 2016[(a)]

Remoteness area	Number	%	% who were Indigenous
Major cities	43,062	34.7	0.8
Inner regional	29,477	23.8	1.7
Outer regional	27,336	22.0	3.5
Remote	9,770	7.9	10.4
Very remote	14,367	11.6	28.5
Total	**124,012**	**100.0**	**1.5**

(a) ERP data based on the 2016 Census (see also Box 2.1).

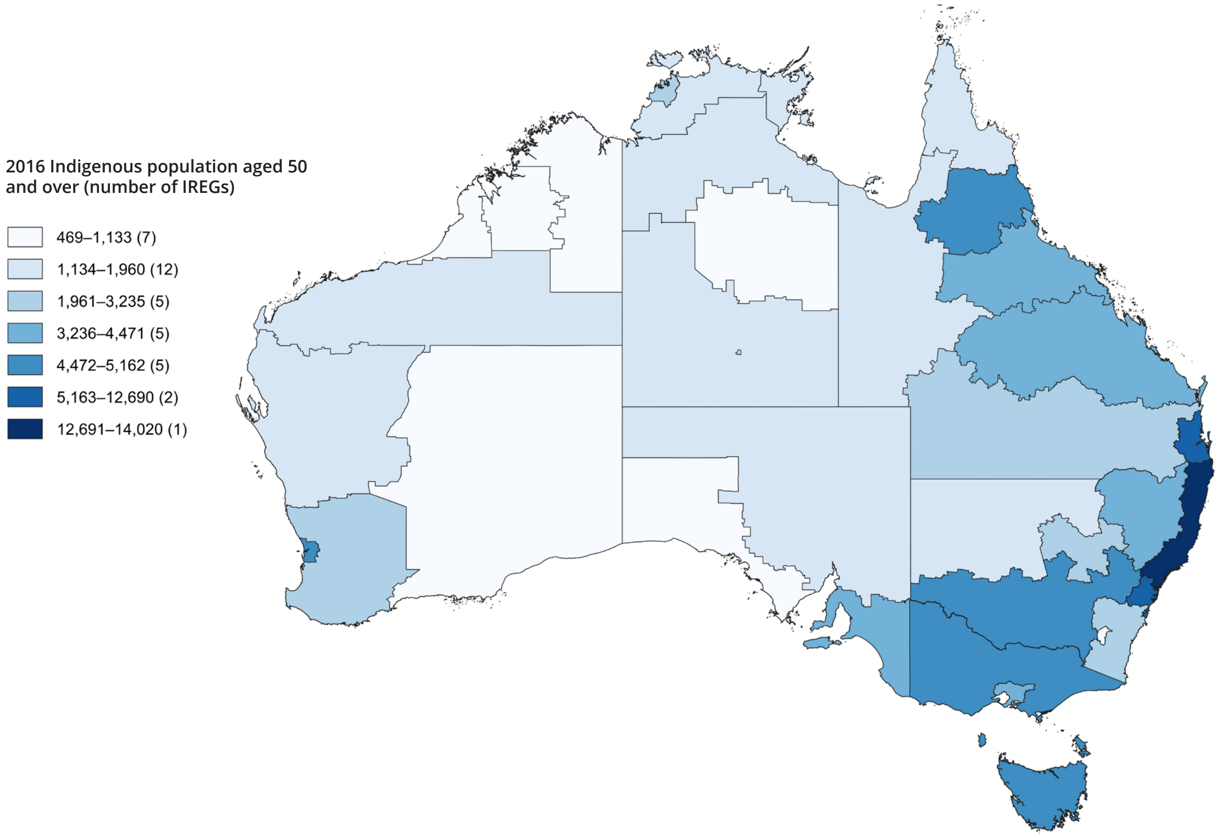
Source: AIHW analysis of ABS Estimates of Aboriginal and Torres Strait Islander Australians, June 2016 (ABS 2018a).

2.2.2 Indigenous regions

Indigenous Regions (IREGs) are geographical units based on the former Aboriginal and Torres Strait Islander Commission boundaries (ABS 2018b). Figure 2.3 shows the distribution of Indigenous Australians aged 50 and over by IREG. Within the 37 IREGs:

- all had at least 469 Indigenous Australian residents aged 50 and over
- about half (19 IREGs, or 51%) had between 469 and 1,960 Indigenous Australian residents aged 50 and over
- 8 (22%) had more than 4,471 Indigenous Australian residents aged 50 and over, with 51% of the total Indigenous Australian population aged 50 and over in these 8 IREGs
- the IREGs with the largest numbers of Indigenous Australians aged 50 and over were New South Wales Central and North Coast (14,020 Indigenous Australians aged 50 and over), Wollongong (12,690), and Brisbane (11,657) (Figure 2.3; Table S2.1).

Figure 2.3 Indigenous Australian population aged 50 and over, by 37 IREGs, 30 June 2016



Notes

1. Data are estimates based on the 2016 Census.

2. Data for this figure and notes about the analysis are shown in Table S2.1.

Source: AIHW analysis of ABS Estimates of Aboriginal and Torres Strait Islander Australians, June 2016 (using Table Builder) (ABS 2018a).

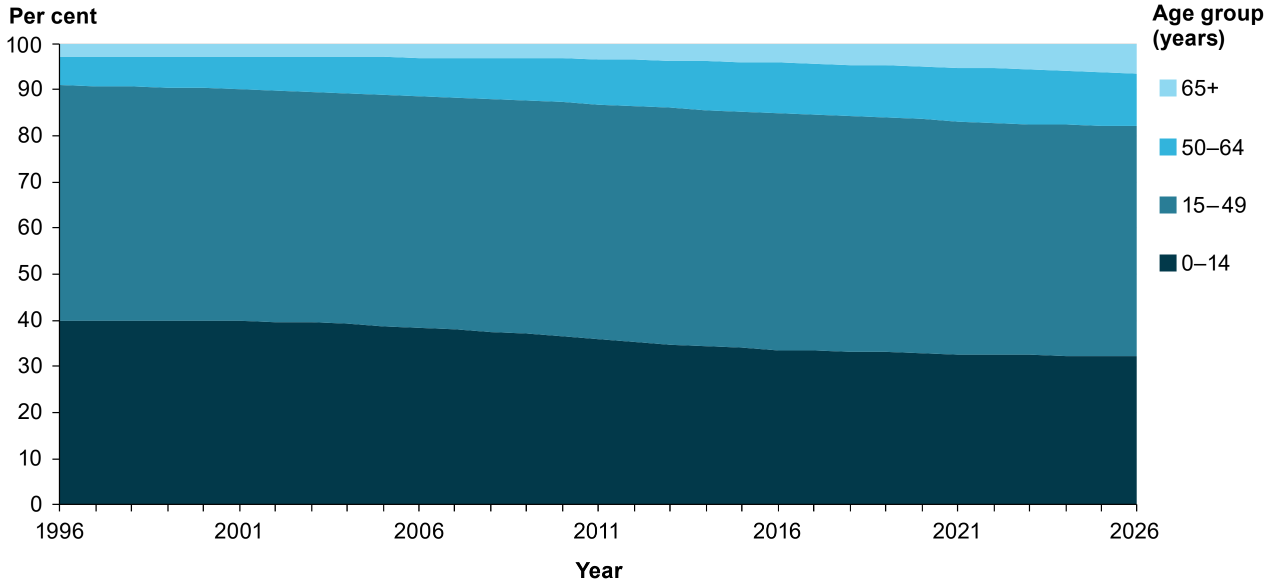
2.3 Population over time

An analysis of change over time in the size of the older Indigenous Australian population is possible using 2011 Census-based data (2016 Census-based time series data were not available at the time of writing this report—see Box 2.1).

Based on the 2011 Census, the ABS produced back cast estimates from 1996 to 2011, as well as projections forward to 2026. These data indicate that the Indigenous Australian population is growing and gradually ageing. For example:

- the number of Indigenous Australians aged 50 and over is projected to reach nearly 166,000 by 2026—almost double the 2011 estimate of 88,000 people
- based on back cast estimates for 30 June 1996, an estimated 9% of the Indigenous Australian population was aged 50 and over—in 2011, this proportion was 13%, and is projected to reach 18% by 2026 (based on medium-level population growth) (Figure 2.4).

Figure 2.4: Historical and projected Indigenous Australian population, by age, June 1996 to June 2026



Notes

1. Data are estimates and projections based on the 2011 Census. Projected population data are shown from 2012 onwards and are based on ABS medium-level growth assumptions (Series B).
2. Data for this figure and notes about the analysis are shown in Table S2.2.

Source: AIHW analysis of ABS 2014b.

2.4 Selected characteristics

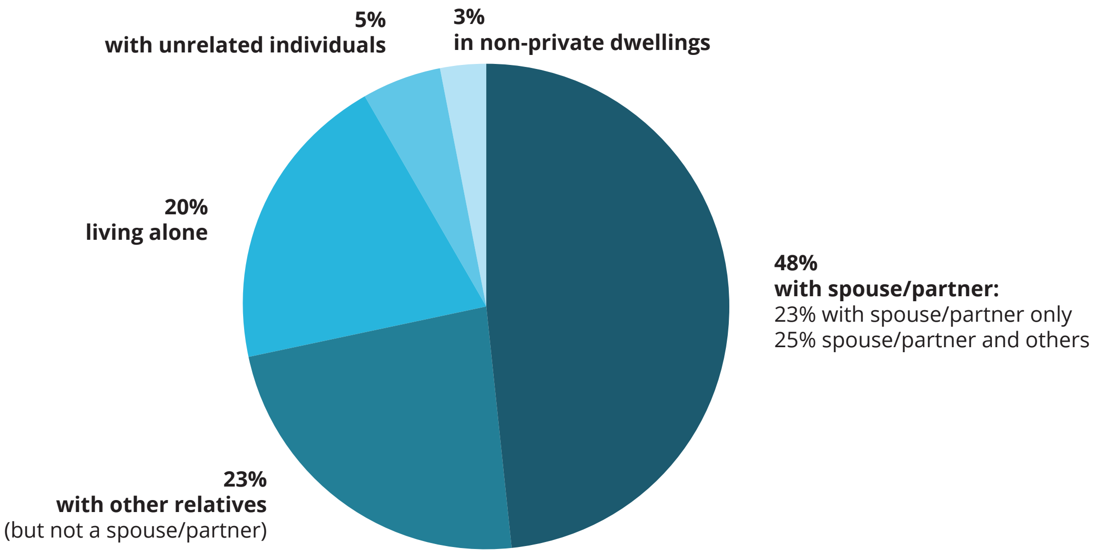
2.4.1 Living situation

Living arrangement information on older Indigenous Australians in this section are based on 2016 Census data. Data relate to Indigenous Australians aged 50 and over who were at their usual address on Census night—99,971 people, or 93% of all Indigenous Australians aged 50 and over enumerated in the Census.

In 2016, among Indigenous Australians aged 50 and over who were at their usual address on Census night:

- 97% (96,600) lived in private dwellings:
  - 48% lived with a spouse or a partner—consisting of 23% who lived with their spouse/partner only, and 25% who also lived with other family or unrelated people.
  - 23% lived with other relatives, 20% lived alone and 5% lived with unrelated individuals (either in a group household or as an unrelated individual).
- 3% (3,370) lived in a non-private dwelling—a communal accommodation type; examples include aged care facilities, hospitals, corrective facilities and hotels/motels (Figure 2.5).

Figure 2.5: Living arrangements of Indigenous Australians aged 50 and over, 2016



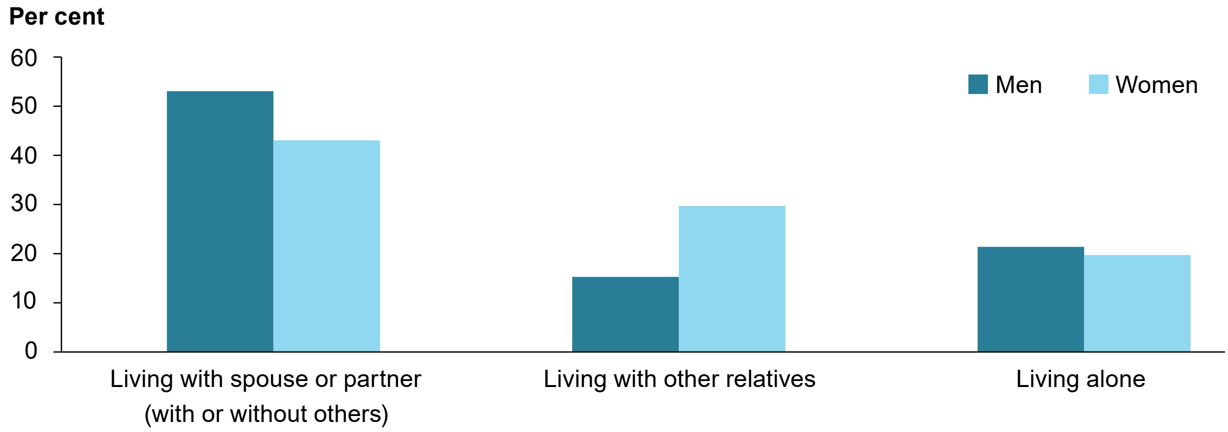
Notes

1. Data relate to people who were at home on Census night in private or non-private dwellings. All categories except 'in non-private dwellings' pertain to people living in private dwellings.
2. Components may not sum to total due to rounding.
3. Data for this figure and notes about the analysis are shown in Table S2.3.

Source: AIHW analysis of ABS Census of Population and Housing, 2016 (using Table Builder) (ABS 2017a).

Among Indigenous Australians aged 50 and over in 2016, men were more likely than women to be living with a spouse or partner (53% compared with 43%), women were more likely to be living with other relatives (30% compared with 15%), while the proportion who lived alone was similar for men and women (21% and 20%, respectively) (Figure 2.6).

Figure 2.6: Selected living arrangements of Indigenous Australians aged 50 and over, by sex, 2016



Notes

1. Denominator for the proportions is the number of men or women (as applicable) enumerated in a private or non-private dwelling who were at home on Census night.
2. Data for this figure and notes about the analysis are shown in Table S2.3.

Source: AIHW analysis of ABS Census of Population and Housing, 2016 (using Table Builder) (ABS 2017a).

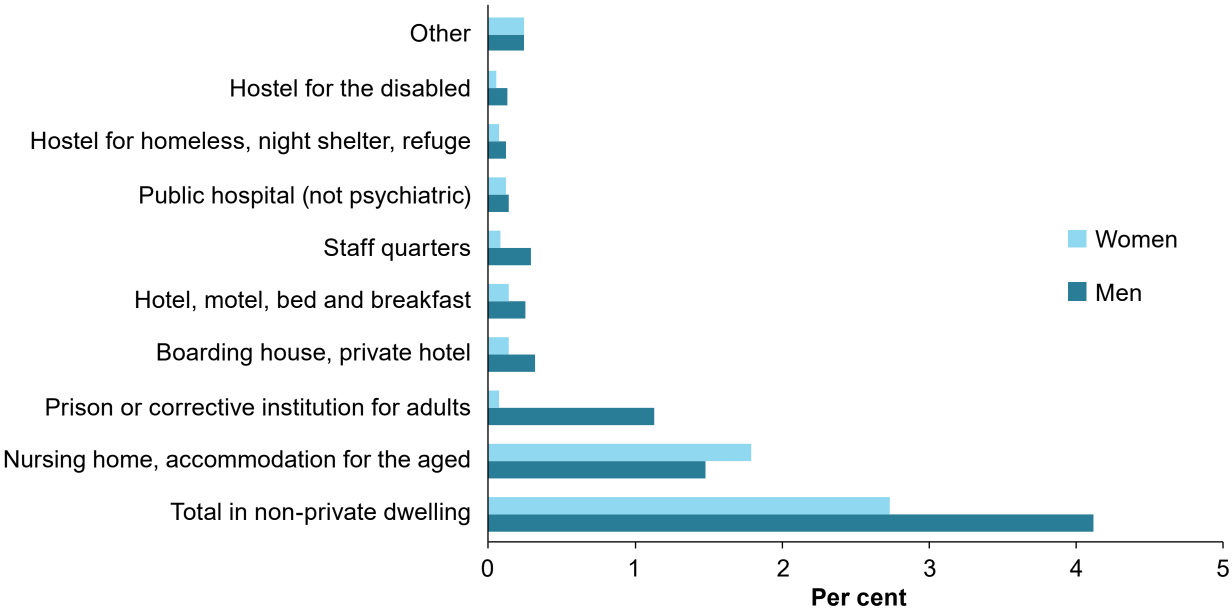
People living in non-private dwellings

Among Indigenous Australians aged 50 and over at home on Census night, 3,400 (3%) were living in a non-private dwelling. Among those in non-private dwellings, 49% were in a nursing home, or accommodation for the aged with common facilities—1.6% of the total Indigenous Australian population aged 50 and over.

Among Indigenous Australians aged 50 and over, estimates showed that in 2016:

- men were more likely than women to live in a non-private dwelling (4.1% compared with 2.7%)
- women were slightly more likely than men to be in a nursing home or accommodation for the aged (1.8% compared with 1.5%) (Figure 2.7).

Figure 2.7: Proportion of Indigenous Australians aged 50 and over living in a non-private dwelling, by sex and type of non-private dwelling, 2016



Notes

1. Denominator for the proportions is the number of men or women (as applicable) enumerated in a private or non-private dwelling who were at home on Census night.
2. Data for this figure and notes about the analysis are shown in Table S2.4.

Source: AIHW analysis of ABS Census of Population and Housing, 2016 (using Table Builder) (ABS 2017a).

2.4.2 Marital status

Data from the 2016 Census provide information on 2 types of marital status:

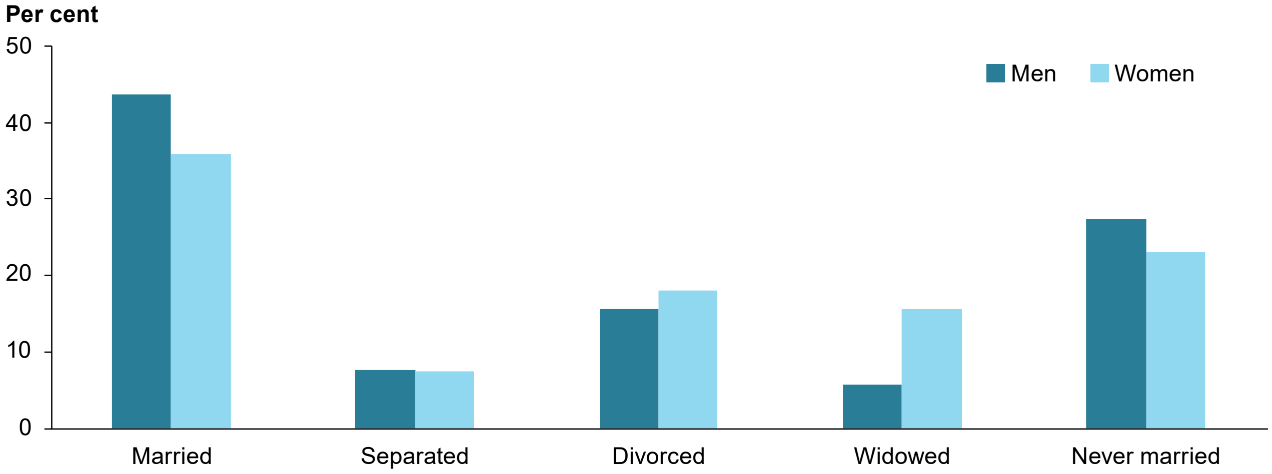
- registered marital status—records an individual's formal registered marriage status. Registered marital status is collected for everyone aged 15 and over
- social marital status—the relationship status based on whether he or she forms a couple relationship with another person living in the same usual residence, and the nature of that relationship. Social marital status is collected for everyone aged 15 and over in their usual residence on Census night (ABS 2016a).

Based on registered marital status, among Indigenous Australians aged 50 and over in 2016:

- 40% were married
- 17% were divorced
- 8% were separated
- 11% were widowed
- 25% had never married (Table S2.5).

Among Indigenous Australians aged 50 and over, men were more likely than women to be married (44% compared with 36%), while women were more likely than men to be widowed (16% compared with 6%) (Figure 2.8).

Figure 2.8: Registered marital status, Indigenous Australians aged 50 and over, 2016



Note: Data for this figure and notes about the analysis are shown in Table S2.5.

Source: AIHW analysis of ABS Census of Population and Housing, 2016 (using Table Builder) (ABS 2017a).

In relation to social marital status, data from the 2016 Census indicates that, among Indigenous Australians aged 50 and over, 49% were married—either in a registered or *de facto* marriage. Of these, 99.4% (47,400 people) were in an opposite-sex relationship and 0.6% (300 people) were in a same-sex relationship (tables S2.6, S2.7).

2.4.3 Unpaid child care

Information is available from the 2016 Census on time spent caring for children aged under 15 years in the previous 2 weeks without pay. Among Indigenous Australians aged 50 and over:

- 22% reported that they cared for their own children and/or other children:
  - 6% (6,300) reported that they cared only for their own children
  - 15% (15,200) cared for other children (but not their own)
  - fewer than 1% (800) cared for both their own children and other children
- 78% (77,400) reported that they did not provide any child care (Table S2.8).

2.4.4 Unpaid assistance to those with disability, long-term condition, or the aged

The 2016 Census collected information on those providing help or assistance in the previous 2 weeks to another person with daily activities due to disability, long-term health conditions or problems related to old age. Of Indigenous Australians aged 50 and over who responded to this question (about 98,000 people), 18% reported providing assistance, with the rate higher among women than men (21% compared with 15%) (Table S2.9).

2.4.5 Grandparent families

The 2016 Census collected information on people living in grandparent families—households in which at least one grandparent and grandchild, either dependent or not, were part of the same family unit, and in which there was no parent–child relationship.

The following information relates to grandparent families with an Indigenous Australian aged 50 and over who was part of that family. It is not possible to ascertain whether the older person was the grandparent of the grandchild, or if the grandparent was caring for the grandchild.

In 2016 among Indigenous Australians aged 50 and over 7% (about 7,800) were living in grandparent families; of those:

- 67% were women
- 49% were in lone grandparent families
- 71% lived in families with a grandchild who was aged under 15 or a dependent student
- 29% lived with a non-dependent grandchild (Table S2.10).

2.5 Connection to culture

For Indigenous Australians, factors such as family and community connectedness, supportiveness, sharing and leadership are all interrelated with culture and important in building resilience and strength (McLennan 2015, Parker & Milroy 2014). Aboriginal and Torres Strait Islander culture includes both traditional and contemporary practices. Traditional principles and practices—respect, generosity, collective benefit, collective ownership—are part of contemporary expressions of Indigenous Australian culture and identity.

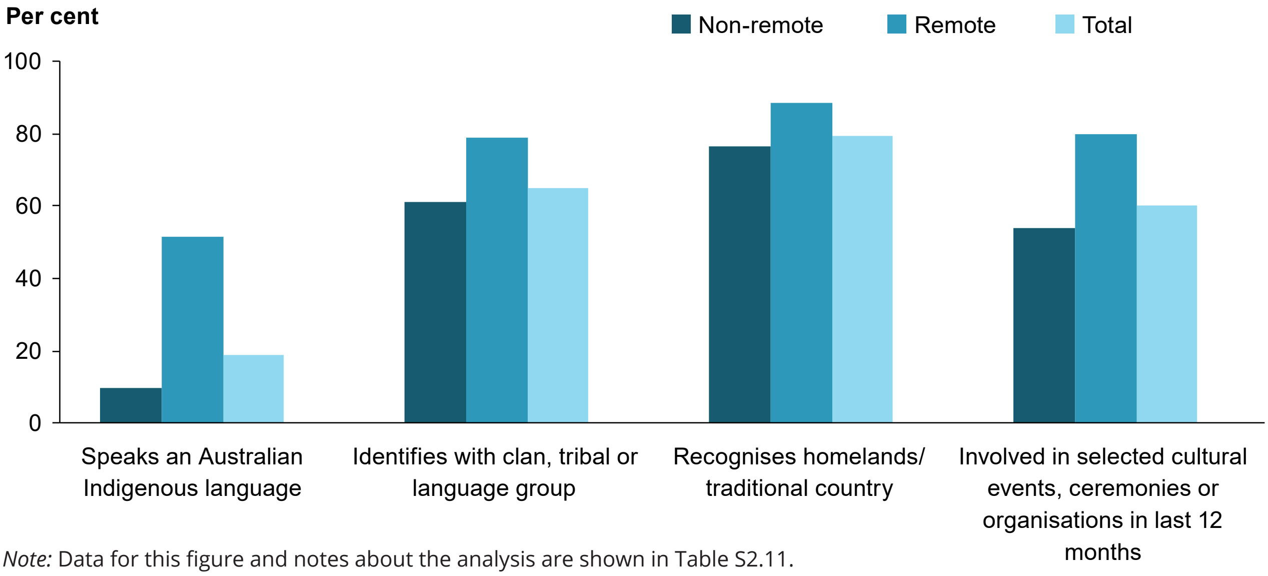
Culture is an important aspect of wellbeing among Indigenous people—both in knowing and observing it, and in the broader community's understanding of and respect for it. Indigenous perceptions of health and wellbeing are holistic and include a range of life factors or social determinants, such as physical health, cultural dislocation, social disadvantage and identity (Ganesharajah 2009). According to the Department of Health, wellbeing for Aboriginal and Torres Strait Islander people incorporates broader issues of social justice, equity and rights (DoH 2018a).

2.5.1 Selected measures of cultural connectedness

In the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), Indigenous Australians self-reported on their connection to country and land. In 2014–15, among Indigenous Australians aged 50 and over:

- 79% recognised an area as homelands or traditional country—with a higher proportion in remote areas than in non-remote areas (89% and 76%)
- 65% identified with a clan, tribal or language group—with a higher proportion in remote areas than in non-remote areas (79% and 61%)
- 60% were involved in selected cultural events, ceremonies or organisations in the previous 12 months—with a considerably higher proportion in remote areas than in non-remote areas (80% and 54%) (Figure 2.9).

Figure 2.9: Selected measures of cultural connectedness among Indigenous Australians aged 50 and over, by remoteness, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S2.11.

Source: AIHW analysis of ABS 2016c.

2.5.2 Australian Indigenous languages

Although English is the main language in Australia, several hundred unique Indigenous languages have been spoken here over tens of thousands of years. Culture and language are means by which law, ceremony and knowledge are passed between generations, and by which connection to country is maintained within generations (House of Representatives 2012).

The NATSISS collected information on whether people spoke any Australian Indigenous languages. In 2014–15, among Indigenous Australians aged 50 and over:

- 19% (an estimated 18,800 people) spoke an Australian Indigenous language
- 19% (18,700) spoke some Australian Indigenous words only
- 62% (61,200) did not speak an Australian Indigenous language (Table 2.3).

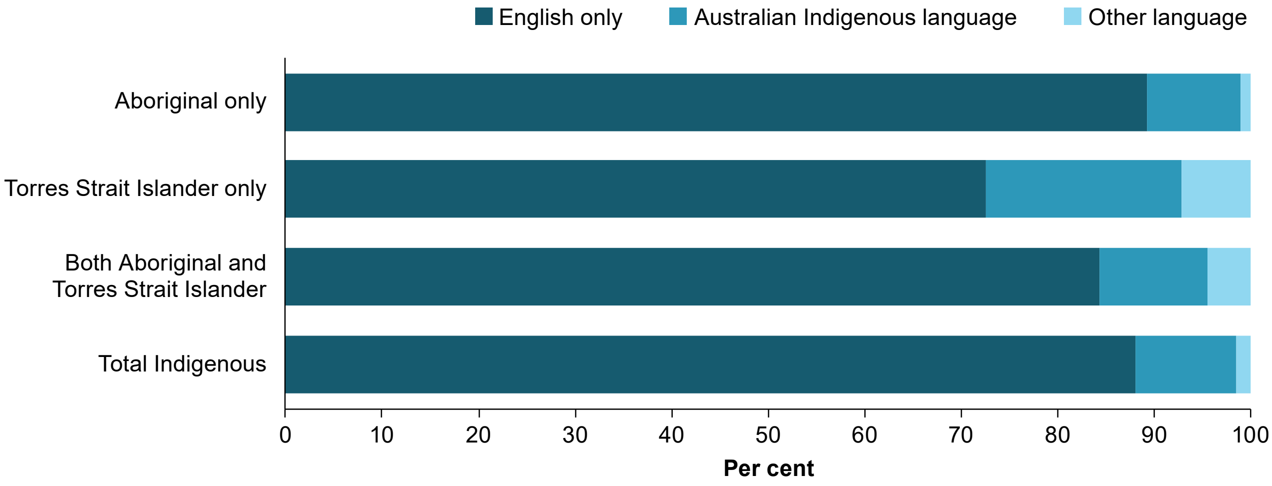
For those who did not speak an Australian Indigenous language, the NATSISS collected information on whether they understood an Australian Indigenous language. In 2014–15, among Indigenous Australians aged 50 and over:

- 2% (an estimated 1,500 people) understood but did not speak an Indigenous language
- 13% (13,300) understood some words but did not speak an Indigenous language
- 47% (46,000) did not understand an Australian Indigenous language (AIHW analysis of ABS 2016c).

2.5.3 Language spoken at home

The 2016 Census collected detailed information on main language spoken at home. In 2016, among Indigenous Australians aged 50 and over, 88% spoke only English at home, 10% spoke an Australian Indigenous language at home, while 1% spoke another language at home (Figure 2.10). People of Torres Strait Islander origin only were more likely to speak an Australian Indigenous language at home than those who were of Aboriginal origin only, or of both Aboriginal and Torres Strait Islander origin.

Figure 2.10: Indigenous Australians aged 50 and over, by language spoken at home (broad categories) and Indigenous status, 2016

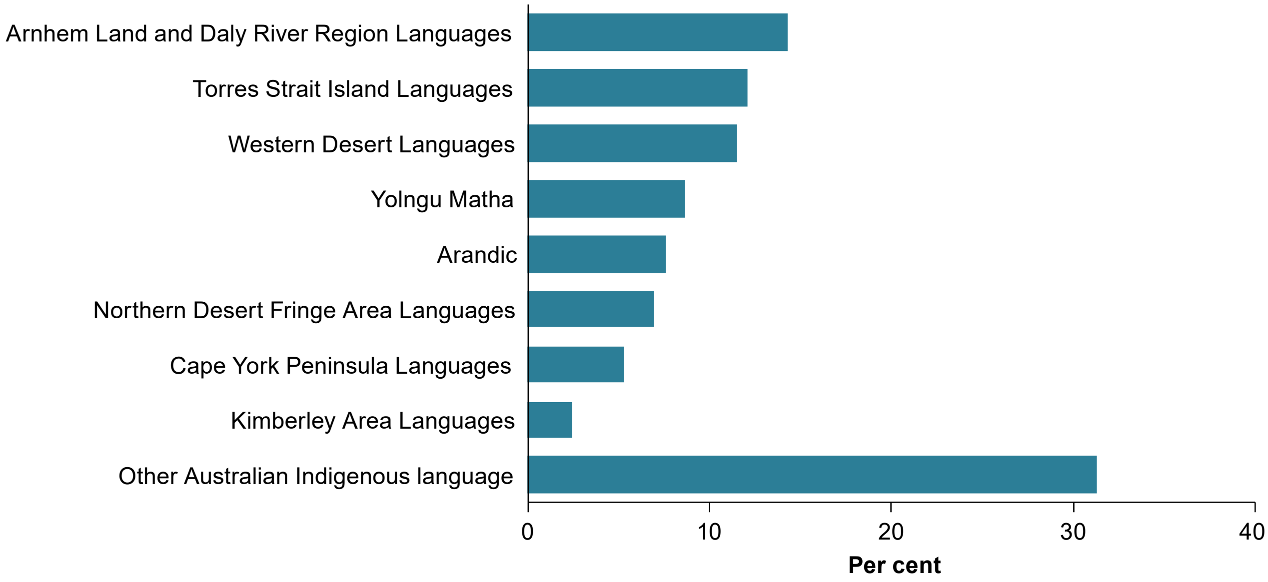


Note: Data for this figure and notes about the analysis are shown in Table S2.12.

Source: AIHW analysis of ABS 2017a.

The most widely spoken language group was the Arnhem Land and Daly River Region Languages—spoken by 14% of Indigenous Australians aged 50 and over who spoke an Australian Indigenous language at home (Figure 2.11).

Figure 2.11: Indigenous Australians aged 50 and over who speak an Australian Indigenous language at home, by language group, 2016



Notes

1. Denominator for proportions is the number of people aged 50 and over who reported speaking an Australian Indigenous language at home.
2. Data for this figure and notes about the analysis are shown in Table S2.13.

Source: AIHW analysis of ABS 2017a.

Among Indigenous Australians aged 50 and over, there were over 140 Australian Indigenous languages spoken at home, including 10 with over 200 speakers. The most common language spoken was Yumplatok, spoken by 8% of Indigenous Australians aged 50 and over who reported speaking an Indigenous language at home (see Appendix B for detailed information on Australian Indigenous languages spoken by Australians aged 50 and over).

2.6 Living as you get older—access to aged care

In Australia, the aged care system offers a range of options to meet the different care needs of each individual (see Box 2.2). While aged care is often thought of as referring primarily to residential care, only a small proportion of older Australians access this care type in a given year, with most using community-based care.

The use of aged care services is often considered in terms of a progression of care—from low-level or temporary care, to high-level permanent care—but this is not necessarily the case. People may enter and exit the aged care system at any level. All programs can be accessed by Indigenous Australians, while one (a type of flexible aged care—the National Aboriginal and Torres Strait Islander Flexible Aged Care Program) is specifically targeted at Indigenous Australians.

Box 2.2: Government-subsidised aged care programs

Community aged care

The following programs provide care in the community for people living at home:

- Commonwealth Home Support Programme (CHSP)—provides entry-level support services (such as personal care, transport, and assistance with food preparation and meals) to help people stay independent and in their homes and communities for longer.
- Home Care Packages Program (Home Care)—offers packages of services at 4 levels of care to enable people to live at home for as long as possible, with care needs increasing with each increment of level and including clinical services.

Residential aged care

Residential aged care services provide care in residential facilities, both for permanent and short-term respite stays, for people who are unable to continue living independently in their own homes.

Flexible aged care

In addition to the mainstream community and residential aged care, various flexible care programs are available to provide care for special groups or circumstances in a range of settings. There are 5 types of flexible care (DoH 2017):

- Transition Care—the largest of the flexible aged care programs, this provides support for people to return home after a hospitalisation.
- Short-Term Restorative Care—an early intervention program for anyone whose capacity to live independently is at risk; it aims to improve an individual's wellbeing and delay admission into residential or home care.
- Multi-purpose services—offers aged care alongside health and community services in regional and remote areas.
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program—provides culturally appropriate aged care (in either residential or home care settings) to older Indigenous Australians close to home and community.
- Innovative Care—pilots new approaches to providing aged care.

Access to aged care services is determined by need, rather than age. However, the aged care target population typically used for planning purposes is that aged 65 and over, or 50 and over for Indigenous Australians (DoH 2017).

Use of aged care services is common among the older Indigenous Australian population. An AIHW study involving linkage of data for the major aged care programs with deaths data suggested that 60% of Indigenous Australians aged 50 and over who died in 2012–14 had used aged care before their death (AIHW 2018l: Table B1). This may be an underestimate due to programs that were out of scope for the analysis (notably the National Aboriginal and Torres Strait Islander Flexible Aged Care Program).

In the following section, information is presented on assessments for government-subsidised aged care services, followed by information on the use of various aged care services. Data are primarily sourced from the National Aged Care Data Clearinghouse (see Appendix A).

2.6.1 Assessments for aged care

Before people can access most government-subsidised aged care services, they must undergo an assessment (see Box 2.3). Access to Home Care, residential aged care (permanent or respite), Transition Care and Short Term Restorative Care is through a comprehensive assessment performed by an Aged Care Assessment Team (ACAT) through the Aged Care Assessment Program (ACAP).

Box 2.3: Assessments for aged care

Aged Care Assessments Teams (ACATs) conduct assessments through the Aged Care Assessment Program (ACAP) and approve people for entry into Home Care, residential aged care (permanent or respite), Transition Care and Short Term Restorative Care.

As at 30 June 2016, 80 ACATs operated across Australia (AIHW 2017c). The teams are based in hospitals or in the local community, and they are generally made up of—or consult with—a range of health professionals. ACATs carry out comprehensive assessments of people's circumstances and care needs and identify the most appropriate ongoing supports.

Care provided through the Commonwealth Home Support Programme (CHSP) is accessed through a separate Regional Assessment Service. Information on the CHSP is reported in the next section of this chapter, though the Regional Assessment Service is not.

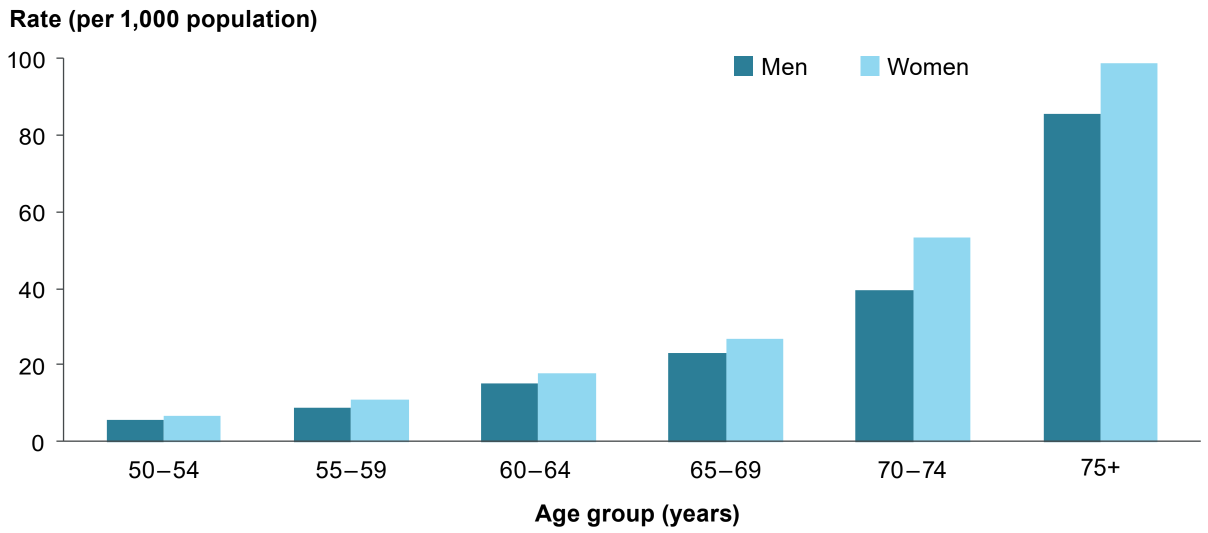
In 2015–16:

- 1.4% (2,309) of all ACAP clients aged 50 and over with completed assessments during this period were Indigenous (Table S1.1)
- considered as a population rate among Indigenous Australians aged 50 and over—21 people per 1,000 population had at least 1 completed ACAT assessment—that is, 2.1% of the Indigenous Australian population aged 50 and over (Table S2.14).

Among Indigenous Australians aged 50 and over in 2015–16:

- the rate of ACAT assessments for women was 1.3 times the rate for men—24 compared with 18 per 1,000 population
- the rate of ACAT assessments increased with age for both women and men (Figure 2.12; Table S2.14).

Figure 2.12: Age-specific rates of completed ACAT assessments among Indigenous Australians aged 50 and over, by sex, 2015–16

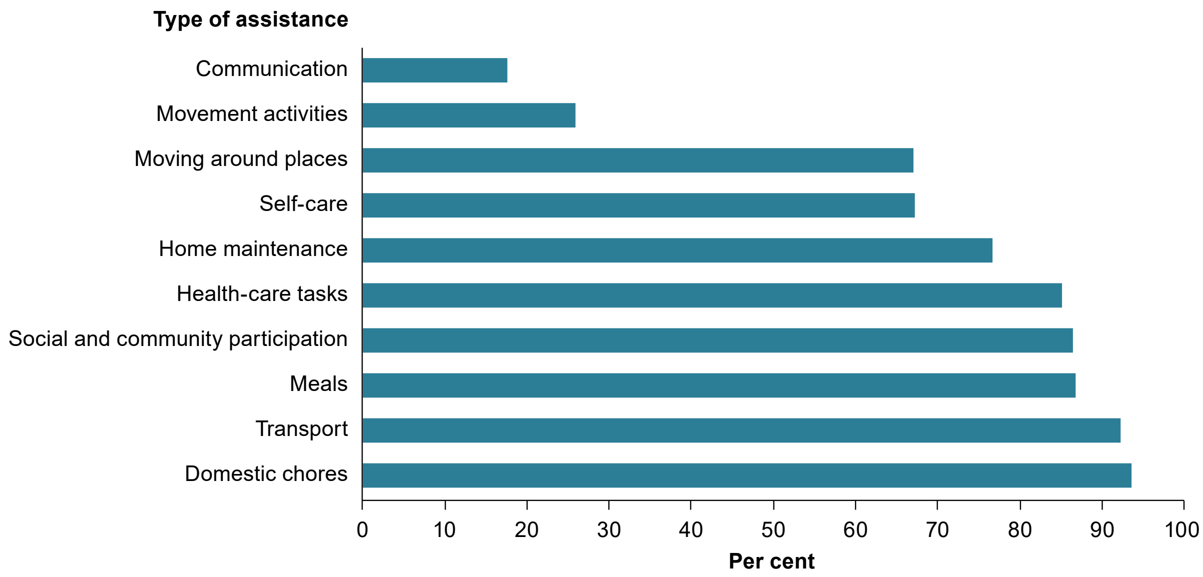


Note: Data for this figure and notes about the analysis are shown in Table S2.14.

Source: AIHW National Aged Care Data Clearinghouse.

During an ACAT assessment, a person's care needs are assessed in relation to 10 specific activities (Figure 2.13). Among Indigenous Australians aged 50 and over with an ACAT assessment in 2015–16, the majority (94%) needed the help or support of another person with domestic chores, while a similarly high proportion needed help with transport (92%). The next most common areas in which Indigenous Australian clients aged 50 and over needed help or support were meals (87%), social and community participation (87%) and health-care tasks (85%).

Figure 2.13: Indigenous Australians aged 50 and over with a completed ACAT assessment, by type of assistance needed, 2015–16



Note: Data for this figure and notes about the analysis are shown in Table S2.15.

Source: AIHW National Aged Care Data Clearinghouse.

2.6.2 Aged care programs

Table 2.3 shows a summary of the use of aged care programs among Indigenous Australians aged 50 and over. The majority of Indigenous people receiving assistance were receiving care in their own home.

Table 2.3: Indigenous Australians aged 50 and over, by use of aged care programs

Aged care type	Reference period	Number of Indigenous clients	% of total clients aged 50 and over	% of Indigenous population aged 50 and over
Commonwealth Home Support Programme	2016–17	20,102	3.1%	18%
Home Care Packages Program	30 June 2017	2,196	3.9%	1.9%
Residential aged care	30 June 2017	1,679	0.9%	1.4%

Source: AIHW analysis of the National Aged Care Data Clearinghouse.

Entry-level support at home—Commonwealth Home Support Programme

In 2016–17:

- 20,102 Indigenous Australians aged 50 and over received basic aged care support services through the Commonwealth Home Support Programme (CHSP)—representing 3.1% of all CHSP clients aged 50 and over (Table S1.1)
- considered as a population rate among Indigenous Australians aged 50 and over—175 people per 1,000 population received support through the CHSP—that is, 18% of the Indigenous Australian population aged 50 and over (Table 2.4).

The rate of CHSP use was higher among women than men—212 compared with 133 per 1,000 population (Table 2.4).

Table 2.4: Indigenous Australian CHSP recipients aged 50 and over, by sex and age group, 2016–17

	Number			Rate (per 1,000 population)[a]		
Age group	Men	Women	People[b]	Men	Women	People[b]
50–64	2,827	4,928	7,804	70.8	115.2	94.3
65+	4,426	7,811	12,298	300.0	451.9	383.8
Total 50+	7,253	12,739	20,102	*132.6*	*212.1*	175.2

(a) Rates are crude rates and were calculated using ABS back cast population estimates and projections based on the 2011 Census.

(b) Includes people for whom sex was not stated.

Source: AIHW National Aged Care Data Clearinghouse.

More complex support at home—Home Care Packages Program

The Home Care Packages Program (Home Care) assists older people with complex care needs who wish to remain at home, are able to do so with assistance, and might otherwise require care in a residential facility.

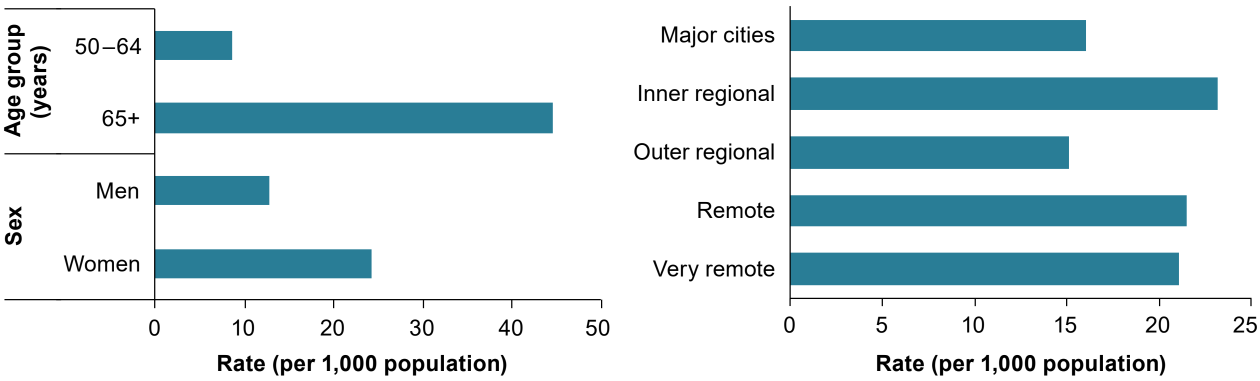
As at 30 June 2017, there were 2,196 Indigenous Australians aged 50 and over receiving Home Care—including 720 aged 50–64 and 1,476 aged 65 and over—representing 3.9% of all clients aged 50 and over (tables S1.1 and S2.16).

Considered as a population rate, as at 30 June 2017, among Indigenous Australians aged 50 and over, 19 per 1,000 population were receiving Home Care—that is, 1.9% of the Indigenous Australian population in this age group.

As at 30 June 2017, among Indigenous Australians aged 50 and over:

- women received Home Care at a higher rate than men—24 compared with 13 per 1,000 population
- those aged 65 and over received Home Care at a considerably higher rate than those aged 50–64—45 per 1,000 population compared with 9 per 1,000
- the rate of Home Care use was lower in *Major cities* and *Outer regional* areas than in *Inner regional*, *Remote* or *Very remote* areas (Figure 2.14).

Figure 2.14: Indigenous Australians aged 50 and over receiving Home Care, by sex, age and remoteness, 30 June 2017



Notes

1. Remoteness is based on the location at which the Aged Care Assessment was conducted. This is used as a proxy for service delivery location (which is not recorded).
2. Data for this figure and notes about the analysis are shown in Table S2.16.

Source: AIHW National Aged Care Data Clearinghouse.

As at 30 June 2017, 10% (228 people) of Indigenous Home Care recipients aged 50 and over reported that an Australian Indigenous language was their preferred language (Table S2.17).

Residential aged care

Residential aged care is subsidised by the Australian Government and provides accommodation and other support services such as personal care and nursing care.

As at 30 June 2017:

- 1,679 people in residential aged care identified as being Indigenous Australian, accounting for 0.9% of all residents aged 50 and over (Table S1.1)
- 14 Indigenous Australians aged 50 and over per 1,000 population in residential aged care—that is, 1.4% of the Indigenous Australian population aged 50 and over (Table S2.18).

As at 30 June 2017, among Indigenous Australians aged 50 and over:

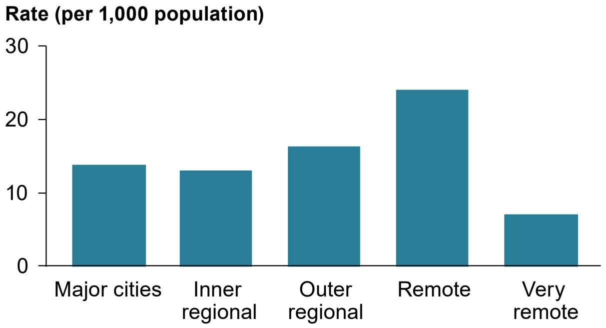
- 95% (1,595 people) of those in residential aged care were in permanent residential care, with the remaining 5% there for a respite stay (84 people)
- 11% of those in residential aged care reported that an Australian Indigenous language was their preferred language (Figure 2.15).

The rate of residential aged care use among Indigenous Australians aged 50 and over was:

- higher with increased age, ranging from 2.1 per 1,000 population among those aged 75 and over
- higher for women than men (17 compared with 12 per 1,000 population). This was mainly due to a higher rate for women than men aged 75 and over; in younger age groups, the rates were more similar for men and women
- highest in *Remote* areas compared with the other areas (Figure 2.15).

Figure 2.15: Indigenous Australian residents aged 50 and over in residential aged care, by various characteristics, 30 June 2017

By remoteness



By preferred language

Preferred language	Per cent
English	86.6
Australian Indigenous languages	11.3
Other languages	0.9
Not stated	1.3
Total	**100.0**

By sex

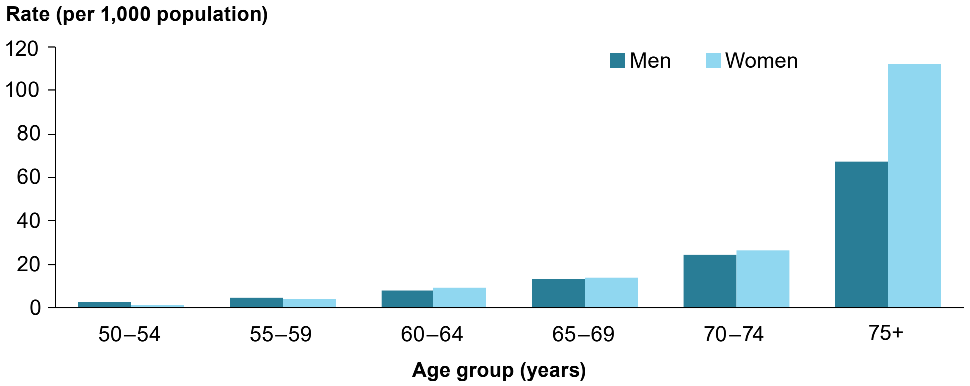
Men: 659
Women: 1,020

1,679 Indigenous Australians aged 50 and over in residential aged care

By care type

Permanent: 1,595
Respite: 84

By sex and age group



Notes

1. Data for this figure and notes about the analysis are shown in tables S2.18, S2.19, S2.20.
2. Percentages may not total 100% due to rounding.

Source: AIHW National Aged Care Data Clearinghouse.

Care needs of people in permanent residential aged care

People in permanent residential aged care require assistance with most activities. Their needs are assessed through the Aged Care Funding Instrument (ACFI), an assessment tool that looks at 3 broad areas (or 'domains') of care to determine the subsidy level—activities of daily living, cognition and behaviour, and complex health care (see Box 2.4).

Box 2.4: Aged Care Funding Instrument

The ACFI is a tool used to assess the needs of people in permanent residential aged care as a means to determine the subsidy level. It consists of questions about care needs that affect the cost of care delivery across 3 broad domains:

- activities of daily living—the areas of nutrition, personal hygiene, toileting and continence
- cognition and behaviour—the areas of cognitive skills, wandering, verbal behaviour, physical behaviour and depression
- complex health care—the areas of medication and complex health care procedures, including palliative care.

The ACFI also includes 2 sections where medical conditions that affect care needs are recorded:

- mental and behavioural disorders—diagnosed mental and behavioural disorders that have an impact on current care needs for support and assistance
- other medical diagnoses—up to 3 other diagnosed medical conditions (that is, in addition to any mental and behavioural disorders) that have an impact on care needs. Where a resident has more than 3 other medical diagnoses, the assessment guidelines state that the 3 most significant in terms of impact on care needs should be recorded.

The ACFI is not a comprehensive assessment tool; rather, it is designed to capture basic information on fundamental care areas to determine the overall relative care needs profile of all residents in a residential aged care facility, and thus the level of funding.

Source: DoH 2018b.

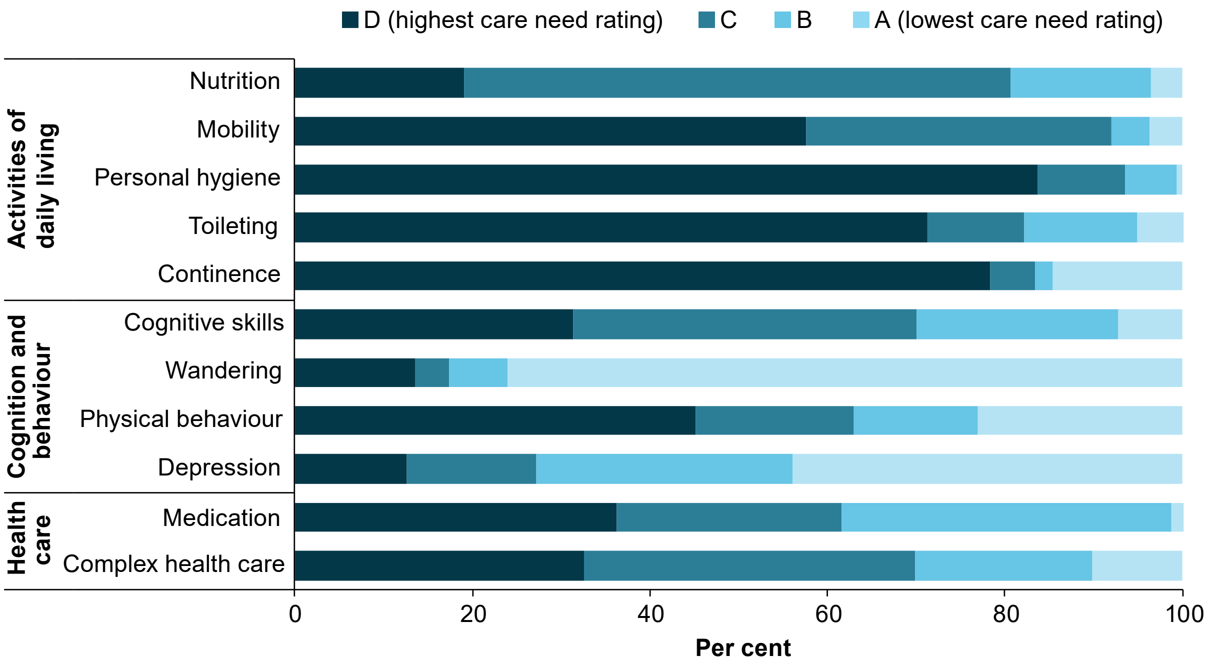
As at 30 June 2017, almost all (98.7%) Indigenous Australian residents aged 50 and over in permanent residential aged care had a current ACFI assessment. Figure 2.16 shows the assessed care needs of these residents in specific areas within each ACFI domain. For example, among Indigenous Australian residents aged 50 and over:

- in the *activities of daily living* domain—84% (1,317 people) were assessed as having the highest care need rating for personal hygiene, 78% (1,233 people) for continence, and 71% (1,120 people) for toileting
- in the *cognition and behaviour* domain—45% (710 people) had the highest care need rating for physical behaviour, and 31% (495 people) for cognitive skills
- in the *health care* domain—36% (571 people) had the highest care need rating for medications (Figure 2.16).

As at 30 June 2017, in relation to cognitive skills, 7 in 10 (70% or 1,102) Indigenous Australians aged 50 and over in permanent residential aged care were assessed as having moderate or severe cognitive impairment:

- 39% (607 people) of residents were assessed as having moderate cognitive impairment, indicating that they have significant problems with everyday activities, and require supervision and some assistance (rating 'C' for 'cognitive skills' in Figure 2.16)
- 31% (495) were assessed as having a severe cognitive impairment, indicating that they have severe problems with everyday activities and require full assistance as they are unable to respond to prompts and directions (rating 'D' for 'cognitive skills' in Figure 2.16).

Figure 2.16: Assessed need for care among Indigenous Australians aged 50 and over in permanent residential aged care, by ACFI domain and specific area, 30 June 2017



Note: Data for this figure and notes about the analysis are shown in Table S2.21.

Source: AIHW National Aged Care Data Clearinghouse.

As part of the ACFI assessment, diagnosed health conditions that have an impact on current care needs are recorded (see Box 2.4). Among Indigenous Australian residents aged 50 and over in permanent residential aged care as at 30 June 2017:

- about half (49%) had dementia, most commonly Alzheimer disease (35% of all residents)
- 39% had depression, bi-polar disorder or another mood disorder
- 32% had arthritis (including rheumatoid as well as other types of arthritis)
- 1 in 4 (25%) had a diagnosis of type 2 diabetes (tables S2.22, S2.23).

Reasons for leaving permanent residential aged care

Once people have finished using residential aged care they are ‘discharged’ and information on their reasons for leaving care and how long they were in care are recorded.

In 2016–17, there were 508 exits from permanent residential aged care for an Indigenous Australian aged 50 and over. Of these:

- half (50%) involved stays of under 1 year. Just over one-quarter (23%) of stays were for 3 years or more, while 11% were for 5 years or more
- 69% ended due to the death of the person
- 10% ended due to discharge to another residential aged care service, and 3% ended due to discharge to hospital
- 13% ended due to the person’s returning home (or with family) (Table S2.24).

Flexible care

Flexible aged care acknowledges that, in some circumstances an alternative to mainstream residential and home care is required (DoH 2017). There are 5 types of flexible care (see Box 2.2), 2 of which are discussed in this section—the Transition Care Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Transition Care Program—support for people leaving hospital

The Transition Care Program provides short-term care aimed at restoring independent living after a hospital stay. As at 30 June 2017, there were 31 Indigenous Australians aged 50 and over who were using the program (0.9% of all clients aged 50 and over) (Table S1.1).

As people use this program only for short periods, the number using it over 1 year is much larger than the number at a single point in time. During 2016–17, for Indigenous Australians aged 50 and over to the Transition Care Program and 219 exits from it.

Of these 219 exits:

- 21% ended with the person’s returning home with no formal aged care services
- 32% ended with the person’s returning home with support through the CHSP or Home Care, or transferring to another transitional care provider
- 28% ended with discharge to hospital
- 9% ended as a result of discharge to residential care
- the remaining 11% had other discharge destinations (analysis of AIHW National Aged Care Data Clearinghouse).

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Indigenous people can also access more flexible care through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This program provides culturally appropriate aged care to older Indigenous people close to home and community, and services are located mainly in remote areas. Services delivered through this program can be in a residential or home care setting. As at 30 June 2017, 32 aged care services were funded to deliver 820 aged care places though this program (DoH 2017).

3

Health and functioning

Declines in health and functioning mean that some older people may have a diminished capacity for self-care or self-protection, leaving them vulnerable to abuse or mistreatment (Bonnie & Wallace 2003). In considering Aboriginal and Torres Strait Islander people, this is important, as they have poorer health outcomes than the broader population.

Abuse of older people may involve intentional actions that cause harm or serious risk of harm by a person who stands in a relationship of trust, or by such a person's failing to prevent some injury, deprivation or dangerous condition.

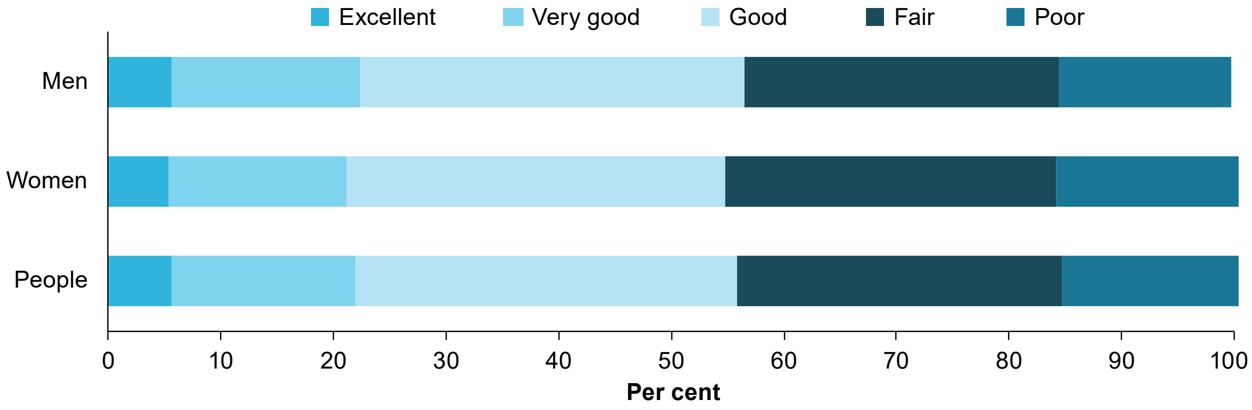
This chapter first outlines self-assessed health status to give context on how Aboriginal and Torres Strait Islander people view their own health. It then provides information on use of health services and disability services as these may provide important touchpoints for older Indigenous Australians who may be vulnerable. Finally, the chapter looks at overall prevalence and burden of ill health.

3.1 Self-assessed health

In 2014–15, among Indigenous Australians aged 50 and over:

- 56% (55,100) reported that their health was good, very good or excellent
- 29% (28,500) reported that their health was fair
- 16% (15,500) reported that their health was poor (Figure 3.1).

Figure 3.1: Self-assessed health status among Indigenous Australians aged 50 and over, by sex, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S3.1.

Source: AIHW analysis of 2014–15 NATSISS (Using Table Builder) (ABS 2016c).

When asked to compare their general health at the time of the interview to 1 year prior, among Indigenous Australians aged 50 and over:

- nearly half (48%) indicated that their health was about the same as 1 year ago
- one-quarter (25%) indicated that their health was better
- just over one-quarter (28%) indicated their health was worse (Table S3.2).

Indigenous Australians aged 50 and over who said they currently had fair/poor health were more likely to report that their health was worse than 1 year ago than those with better self-assessed health. Of those with fair/poor health in 2014–15, 47% said that their health was worse than 1 year ago, compared with 18% of those with good self-assessed health, and 6% of those with very good or excellent self-assessed health (Table S3.3).

3.2 Health and disability services

This section provides information on the use of selected services among Indigenous Australians aged 50 and over (mental health service use is presented in Chapter 4).

Access to and use of health and disability services should be viewed from the perspective of Indigenous Australians having access to culturally safe services. They are more likely to access services they regard as being culturally safe.

Box 3.1: What is cultural safety?

Cultural safety is about the experience of the care recipient—allowing the individual to feel safe in health-care interactions. It goes beyond cultural awareness as it explicitly acknowledges the experience of the recipient of care. It requires a genuine partnership between caregiver and recipient—where power is shared between the 2 individuals and/or cultural groups.

Among Indigenous Australians aged 45 and over in 2012–13, 22% reported that they needed to go to a doctor in the previous 12 months but did not. Of these people, more than one-fifth (23%) said that the reason for their non-attendance was a perceived lack of cultural appropriateness of the service (including, for example, due to discrimination, language problems or lack of trust in the service provider) (AIHW 2018a).

3.2.1 Primary health care

In 2014–15, among Indigenous Australians aged 50 and over, 90% (an estimated 89,100 people) reported that they had seen a doctor in the previous 12 months for their own health. Women reported a higher rate than men (94% compared with 86%) as did those in non-remote areas compared with remote areas (90% compared with 88%).

In 2016–17, among the 196 organisations that provided Indigenous primary health-care data, 82% (364,100) of clients identified as Indigenous. Two-thirds of organisations were Aboriginal Community Controlled Health Organisations, which saw around 84% of clients (AIHW 2018c).

3.2.2 Disability services

Information in this section is based on data from the 2016–17 Disability Services National Minimum Data Set relating to the provision of services to people with disability under the National Disability Agreement (NDA).

The National Disability Insurance Scheme (NDIS) is being progressively rolled out and is expected to largely replace services provided under the NDA. Many people, however, are still receiving services under the NDA, and existing service users aged 65 and over (who are not already participants) are not eligible to enter the NDIS.

Under the NDA, the Australian Government is responsible for the provision of employment services for people with disability, and the states and territories for the provision of all other services.

The Australian Capital Territory Government did not collect data for the Disability Services National Minimum Data Set in 2016–17; as a result, data in this section exclude services provided in the Australian Capital Territory.

In 2016–17, there were 2,918 Indigenous Australians aged 50 and over who used disability support services under the NDA. Among these users:

- the proportion of men and women was similar (51% and 49% of the total respectively)
- 70% were aged between 50 and 59, 20% between 60–64, and 10% were aged 65 and over (Table S3.4).

Type of services provided

In 2016–17, among the 2,918 Indigenous Australians aged 50 and over using disability support services, 45% (1,324) had accessed at least 1 type of state- or territory-provided service, and 57% had accessed an Australian Government-provided service. In terms of specific services:

- 57% used employment services—these provide employment assistance and opportunities
- 31% used community support services—these provide the support needed for a person with disability to live in a non-institutional setting
- 15% used accommodation support services—these provide accommodation to people with disability, and support services to enable a person with disability to remain in their existing accommodation
- 12% used community access services—these are designed to provide opportunities for social independence
- 6.3% used respite—these provide a short-term break for families and other caregivers (Table 3.1).

Table 3.1: Indigenous Australian disability service users aged 50 and over, by service group 2016–17

Service group	Number	%
State and territory services		
Community support[(a)]	893	30.6
Accommodation support[(a)]	450	15.4
Community access[(a)]	336	11.5
Respite[(a)]	183	6.3
Total (unique) users[(a)(b)]	*1,324*	*45.4*
Australian Government services		
Employment	1,672	57.3
Total (unique) service users[(b)]	**2,918**	**100.0**

(a) Excludes services provided by the Australian Capital Territory Government, as it did not collect Disability Services National Minimum Data Set data in 2016–17.

(b) Total service users might not be the sum of service group components because individuals might have used more than 1 service group over the 12-month period.

Note: Data pertain to people who received disability support services provided under the NDA.

Source: AIHW 2018f.

Characteristics of service users

Disability group

Disability service users are asked to record their primary disability group—that is, the one that most clearly reflects their experience of disability, and which causes them the most difficulty in everyday life. In 2016–17, among Indigenous Australian disability service users aged 50 and over who reported their primary disability:

- 44% reported a physical disability
- 21% reported a psychiatric disability
- 16% reported an intellectual disability (Figure 3.2).

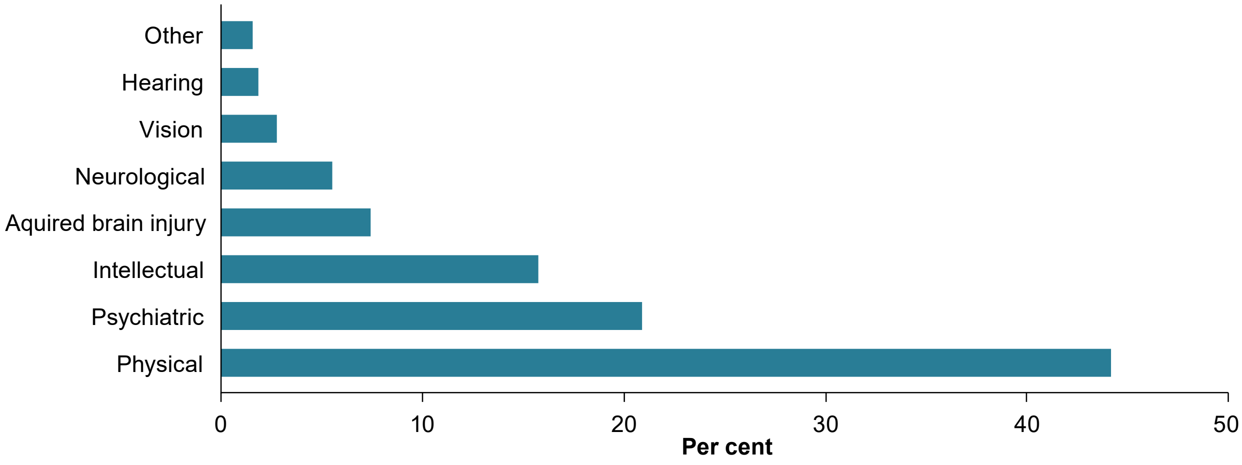
Functional need

People with disability might require assistance to perform activities in different areas of their lives. Information is available on the functional needs of service users, where need is evaluated relative to that of a person of the same age without disability.

In 2016–17, the majority of Indigenous Australian disability service users aged 50 and over needed assistance in 1 or more broad life areas, with:

- 58% always or sometimes needing assistance with activities of daily living
- 71% always or sometimes needing assistance with activities of independent living
- 80% always or sometimes needing assistance with activities of work, education and community living (Figure 3.3).

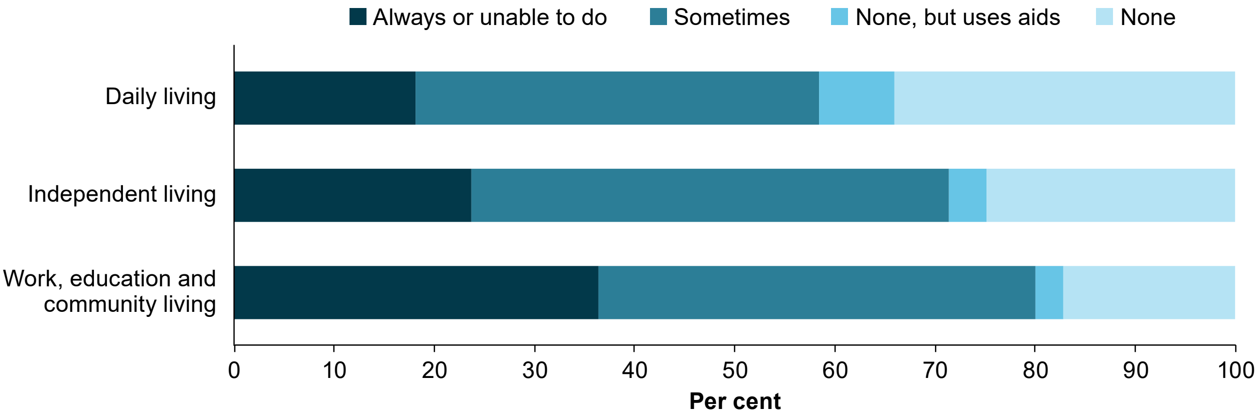
Figure 3.2: Indigenous Australian disability service users aged 50 and over, by primary disability group, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S3.5.

Source: AIHW 2018f.

Figure 3.3: Functional need for assistance among Indigenous Australian disability service users, aged 50 and over, by broad life area, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S3.6.

Source: AIHW 2018f.

Living arrangement

In 2016–17, among Indigenous Australians aged 50 and over who were using disability services, 45% lived alone, 32% lived with others (such as sharing with a friend or a non-related carer) and 23% lived with family (AIHW 2018f).

Informal carers

Informal carers play an important role in the lives of many people with disability. An informal carer is a person—such as a family member, friend or neighbour—who provides regular and sustained care and assistance to the person requiring support. This includes those people who might receive a pension or benefit associated with their caring role, but does not include those whose caring services are arranged by a formal service organisation.

In 2016–17, 40% reported that they had an informal carer. This proportion should be interpreted with caution as information on whether the person had an informal carer was missing for 49% of Indigenous Australians aged 50 and over who used disability support services; these people were excluded prior to calculating proportions.

Among Indigenous Australians aged 50 and over who used disability support services with an informal carer:

- 34% were cared for by a spouse or partner
- 15% were cared for by a parent
- 43% were cared for by another type of relative
- 8% were cared for by a friend or neighbour (Table S3.8).

Of those who reported having an informal carer, 78% reported that this carer was also their primary carer—that is an informal carer who helps with 1 or more activities of daily living (self-care, mobility or communication) (analysis of AIHW 2018f).

3.2.3 Hospital service use

This section provides an overview of hospital service use among Indigenous Australians aged 50 and over, both for admitted patient care hospitalisations and emergency department presentations. (For hospital service use specific to alcohol and substance use, see Section 7.3.)

Admitted hospital patient care

Drawing on data from the National Hospital Morbidity Database (NHMD), this section presents information on episodes of admitted patient care—referred to as 'hospitalisations' in this report—for Indigenous Australians aged 50 and over (see Box 3.2). Data include both public and private hospitals. (For detailed information on data quality, see Appendix A.)

Box 3.2: Admitted patient care—key concepts and terms

Separation: an episode of admitted patient care. It can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). In this report, the term hospitalisation is used in place of separation.

Principal diagnosis: the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care.

Additional diagnosis: a condition or complaint that either coexists with the principal diagnosis or arises during the episode of care. An additional diagnosis is reported if the condition affects patient management.

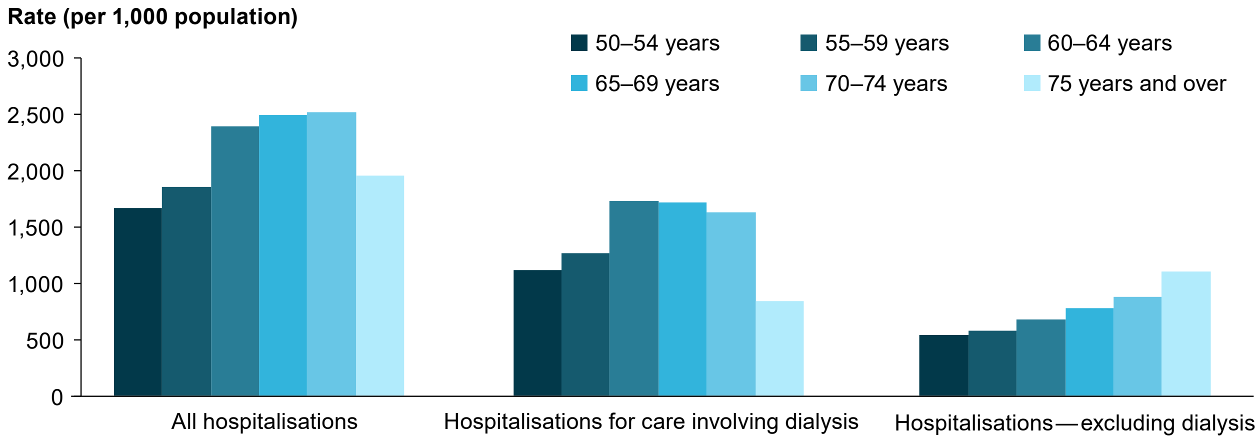
Care type: the overall nature of a clinical care provided to an admitted patient during an episode of care. Care types reported in this chapter include acute care (for example, to cure or treat illness or injury), subacute care (including rehabilitation care, palliative care), non-acute care (relates to maintenance care) and mental health care.

Among hospitalisations for Indigenous Australians aged 50 and over in the 2-year period 2014–16:

- there were more than 430,000 hospitalisations—representing 3.4% of hospitalisations for the total Australian population aged 50 and over
- there were 2,023 hospitalisations for every 1,000 Indigenous Australians aged 50 and over—that is, on average—that is, on average, 2 hospitalisations for every Indigenous Australian aged 50 and over (Table S3.9)
- 67% of total hospitalisations (more than 290,000) were due to dialysis—based on principal diagnosis. The high proportion of hospitalisations for care involving dialysis reflects the high rates of end-stage renal disease among Indigenous Australians, requiring frequent dialysis treatment. On average, dialysis patients attend 3 sessions per week
- overall, 98% of hospitalisations were for acute care, and 1.4% were for rehabilitation, palliative care and mental health care combined (Table S3.10).

In 2014–16, among Indigenous Australians aged 50 and over, those aged 50 to 74 were hospitalised at a higher rate than those aged 75 and over (Figure 3.4). This partly reflects higher rates of hospitalisations for care involving dialysis among those aged 50 to 74. When dialysis sessions are excluded, the hospitalisation rate was highest for those aged 75 and over.

Figure 3.4: Age-specific hospitalisation rates, including and excluding hospital care involving dialysis, 2014–16



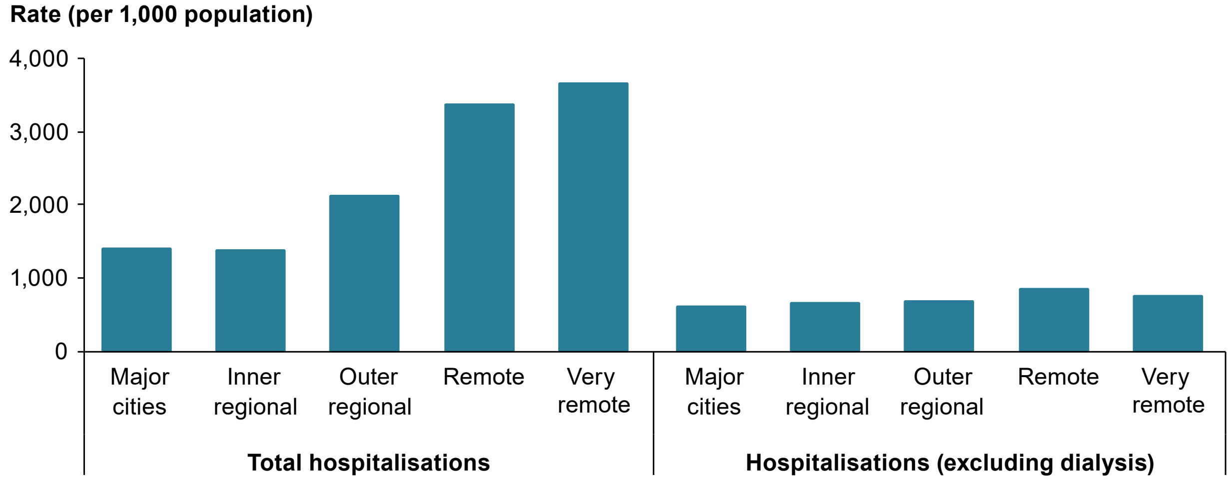
Note: Data for this figure and notes about the analysis are shown in Table S3.11.

Source: AIHW NHMD.

The rate of hospitalisations among Indigenous Australians aged 50 and over in 2014–16 varied by remoteness of usual residence. The rate of total hospitalisations for Indigenous Australians aged 50 and over generally increased with remoteness—the rate for *Very remote* areas was 2.6 times as high as the rate for *Major cities* (Figure 3.5).

The contribution of care involving dialysis to overall hospitalisation rates varied by remoteness of usual residence. Among Indigenous Australians aged 50 and over, the proportion of hospitalisations for dialysis in 2014–16 ranged from 53% for *Inner regional* areas to 80% for *Very remote* areas (Table S3.13).

Figure 3.5: Hospitalisation rates for Indigenous Australians aged 50 and over, including and excluding care involving dialysis, by remoteness, 2014–16



Note: Data for this figure and notes about the analysis are shown in Table S3.12.

Source: AIHW NHMD.

The proportion of hospitalisation for dialysis care in more remote areas is relatively high; when this is excluded, the rate difference by remoteness is less marked (see Figure 3.5).

When care involving dialysis is excluded among Indigenous Australians aged 50 and over, in the 2-year period 2014–16:

- there were nearly 144,000 hospitalisations—representing 1.4% of all hospitalisations (excluding dialysis) for the total Australian population aged 50 and over (tables S1.1 and S3.11)
- there were 670 hospitalisations for every 1,000 Indigenous Australians aged 50 and over (Table S3.12).

Emergency department presentations

Emergency departments are a critical component of Australia's health care system. This section provides information on care provided in public hospital emergency departments, based on data from the AIHW National Non-admitted Patient Emergency Department Care Database (NNAPEDCD).

The quality of the data reported for Indigenous status in emergency departments has not been formally assessed; therefore, caution should be exercised when interpreting these data (see Appendix A for more detailed information on data quality).

Box 3.3: Emergency department—key concepts and terms

An **emergency department presentation** occurs following the arrival of a patient at the emergency department and is the earliest occasion of being registered clinically or triaged. Presentation refers to attendance for an actual or suspected condition that is sufficiently serious to require acute unscheduled care.

A **major diagnostic block** is a classification that groups emergency presentations based on diagnosis information.

The **principal diagnosis** is the diagnosis established at the conclusion of the patient's attendance in an emergency department to be mainly responsible for occasioning the attendance.

An **additional diagnosis** is a condition or complaint that either coexists with the principal diagnosis or arises during the episode of care. An additional diagnosis is reported if the condition affects patient management.

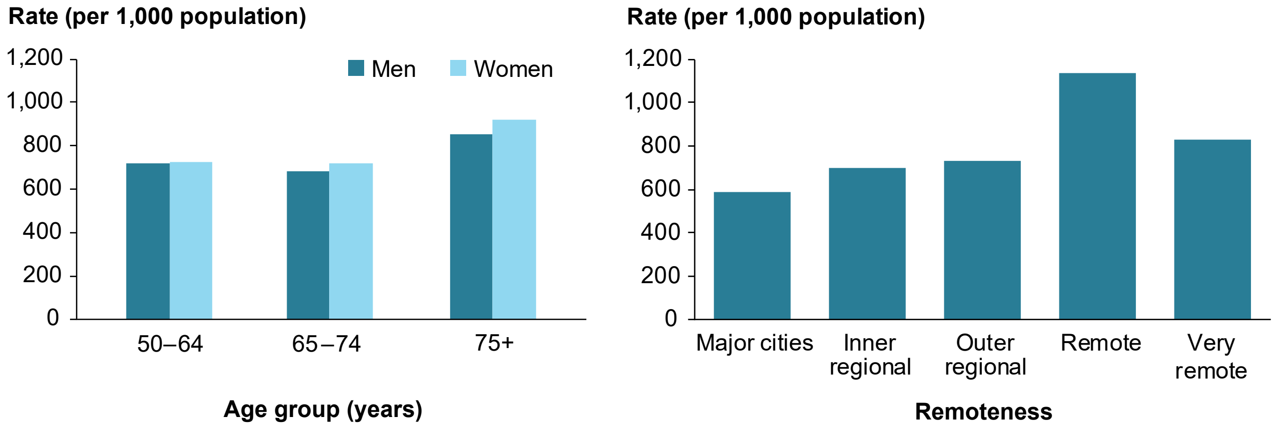
Over the 2-year period combined, 2015–17:

- there were just over 164,000 emergency department presentations in public hospitals for Indigenous Australians aged 50 and over—representing 3.1% of emergency presentations for the total Australian population aged 50 and over (Table S1.1)
- there were 731 emergency department presentations for every 1,000 Indigenous Australians aged 50 and over (Table S3.14).

The rate of emergency presentations for Indigenous Australians aged 50 and over in 2015–17 was:

- broadly similar for men and women (722 and 739 per 1,000 population, respectively)
- highest among those aged 75 and over (890 per 1,000 population) and lowest for those aged 65–74 years (702 per 1,000)
- highest for those residing in *Remote* areas (1,140 per 1,000 population), and lowest in *Major cities* (587 per 1,000) (Figure 3.6).

Figure 3.6: Rate of emergency department presentations among Indigenous Australians aged 50 and over, by sex and age group, and by remoteness, 2015–17



Note: Data for this figure and notes about the analysis are shown in tables S3.14 and S3.15.

Source: AIHW Non-admitted Patient Emergency Department Care Database.

Data are available on the number of emergency department presentations for people who 'left at their own risk' or who 'did not wait to be seen'.

Over the 2-year period 2015–17:

- there were around 9,600 emergency department presentations where Indigenous Australian patients aged 50 and over either 'left at their own risk' or 'did not wait to be seen'—representing 6.3% of all presentations where a person left at own risk or did not wait to be seen among the total Australian population aged 50 and over
- there were 43 per 1,000 Indigenous Australians aged over 50 who left at their own risk or did not wait to be seen (Table S3.16).

Two-thirds (66%) of the presentations for people who left at their own risk or did not wait to be seen were in the category of 'did not wait to be seen'.

Further information on emergency department presentations related to mental health issues is in Section 4.4.

3.3 Burden of disease

This section reports on the overall impact of health problems for older Indigenous Australians, including the effects of both premature death and living with poor health. Burden of disease analysis estimates the number of years of healthy life lost due to the diseases and injuries causing premature death and poor health in a particular population—see Box 3.4.

Box 3.4: What is burden of disease analysis?

Burden of disease analysis compares the impact of different diseases, conditions, injuries and risk factors on a population. More than merely counting deaths or disease prevalence, it takes into account age at death and severity of disease.

It uses information from a range of sources to quantify the fatal and non-fatal effects of these diseases and injuries in a consistent manner so they can then be combined into a summary measure of health called 'disability-adjusted life years', or DALYs.

Simply put, a DALY combines the impact of dying early and living with illness, by counting the number of:

- years of life lost (YLL) due to premature death (for example, dying early due to cancer). YLL represent fatal burden.
- years of life lived with disability (YLD)—that is, the years that could have been a healthy life but were instead spent in states of less than full health. YLD represent non-fatal burden.

Burden of disease estimates capture the quantity and quality of life, and reflect the magnitude, severity and impact of different diseases and injuries within a population.

The burden of disease analysis also estimates the contribution of various risk factors (for example, tobacco smoking) to the overall burden of disease (DALYs), known as the 'attributable burden'.

Burden of disease data in this report are from the 2011 Australian Burden of Disease Study (ABDS)—see Appendix A for details.

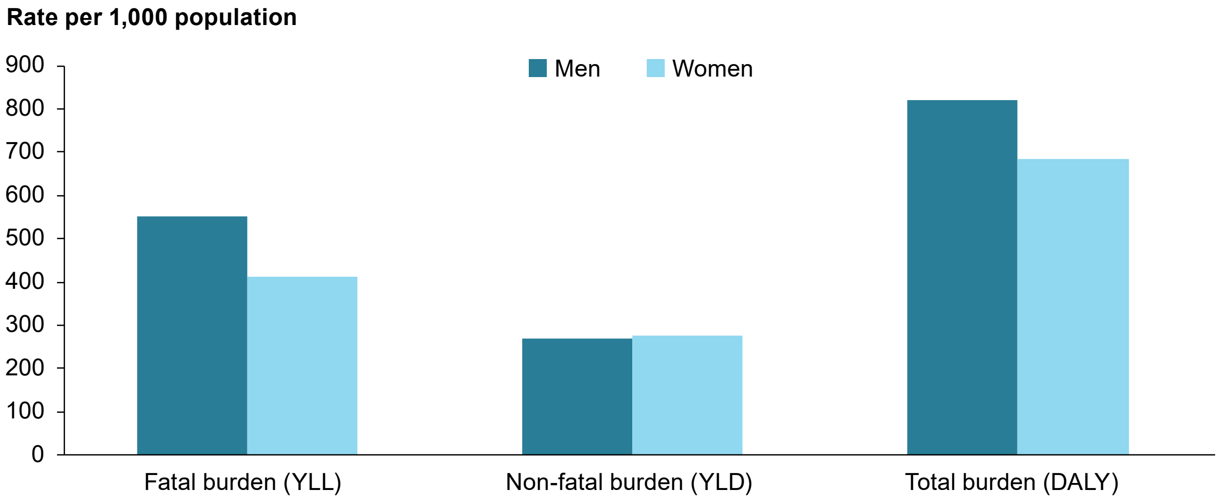
3.3.1 Overall burden

In 2011, among Indigenous Australians aged 50 and over, there were around 66,100 years of healthy life lost due to premature death or living with disease or injury (that is, 66,100 DALYs)—this equates to a rate of around 750 years of healthy life lost for every 1,000 Indigenous Australians aged 50 and over.

Among Indigenous Australians aged 50 and over in 2011:

- dying early caused more years of life lost (64% of the total) than living with poor health (36%)
- the disease burden was higher for men than for women (822 compared with 685 per 1,000 population). This was due to a higher rate of fatal burden (that is, dying early) among men (Figure 3.7; Table S3.17).

Figure 3.7: Rate of disease burden among Indigenous Australians aged 50 and over, by sex, 2011



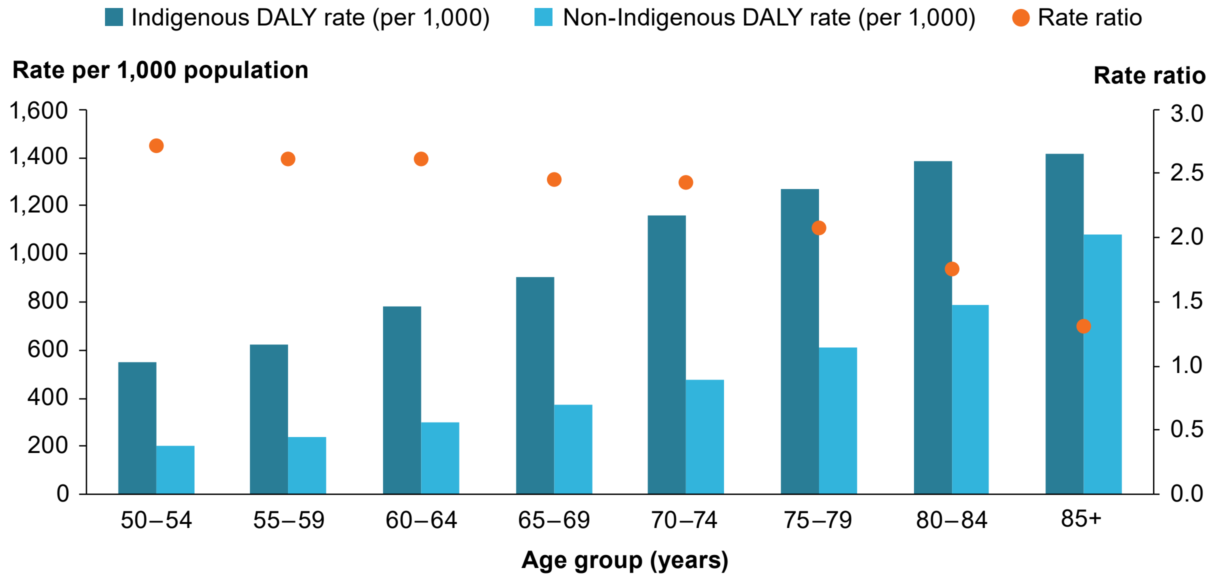
Note: Data for this figure and notes about the analysis are shown in Table S3.17.

Source: ABDS 2011.

In 2011, the rate of disease burden among Indigenous Australians aged 50 and over was higher than for non-Indigenous Australians of the same age (Table S3.18):

- the relative gap between older Indigenous and non-Indigenous Australians—as measured by the rate ratio—was highest for those aged 50–54, and then decreased:
  - among those aged 50–54, the rate of disease burden among Indigenous Australians was 2.7 times as high as for non-Indigenous Australians of the same age
  - for those in the age range 55–79, the rate of disease burden among Indigenous Australians was between 2.1 and 2.6 times as high as for non-Indigenous Australians of the same age
- the absolute gap between older Indigenous and non-Indigenous Australians—as measured by the rate difference—increased between ages 50–54 and 70–74 (from 347 to 681 per 1,000 population). The rate difference then declined in subsequent age groups, to 335 per 1,000 among those aged 85 and over (Figure 3.8).

Figure 3.8: Rate of disease burden among people aged 50 and over, by Indigenous status and age group, 2011



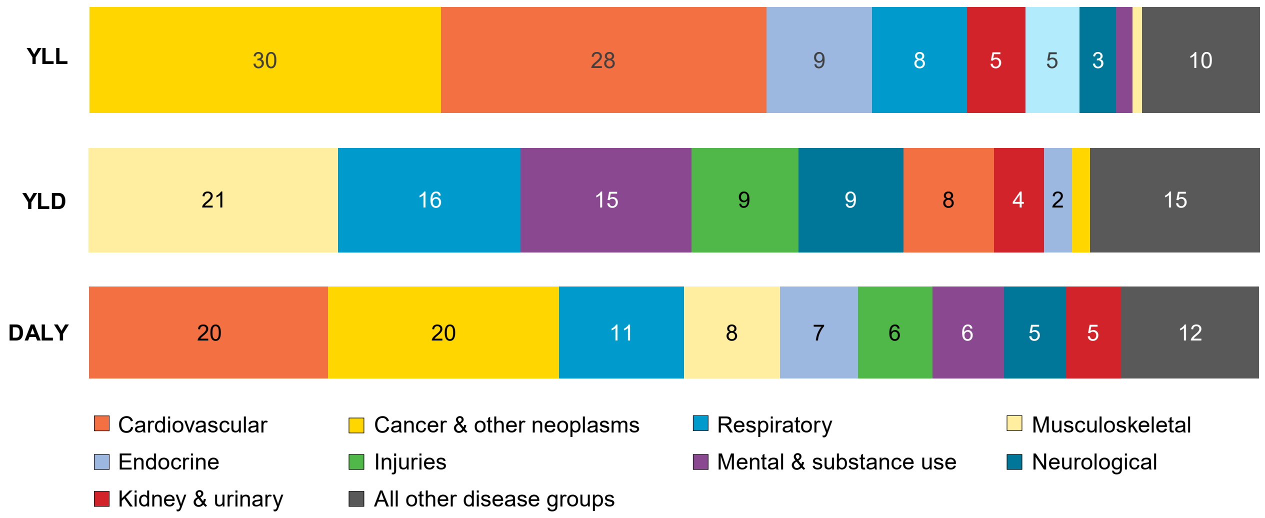
Note: Data for this figure and notes about the analysis are shown in Table S3.18.

Source: AIHW 2016a.

3.3.2 Leading causes of disease burden

In 2011, cardiovascular diseases were the leading cause of total disease burden among Indigenous Australians aged 50 and over (20.4% of the total burden), followed closely by cancer and other neoplasms (19.6%) (Figure 3.9).

Figure 3.9: Contribution (per cent) of disease groups to fatal (YLL), non-fatal (YLD) and total burden (DALYs), Indigenous Australians aged 50 and over, 2011



Notes

1. The 'all other disease groups' category includes the 'gastrointestinal', 'infectious diseases', 'hearing & vision', 'oral', 'blood & metabolic', 'skin', 'infant & congenital' and 'maternal & reproductive' disease groups.
2. Data for this figure and notes about the analysis are shown in Table S3.19.

Source: ABDS 2011.

In terms of specific diseases, coronary heart disease was the leading cause of disease burden among older Indigenous Australians in 2011 (12% of total disease burden), followed by chronic obstructive pulmonary disease (COPD) (7.3%) and diabetes (6.6%) (AIHW 2016a).

3.3.3 Contribution of risk factors to burden

In addition to estimating burden of disease, the ABDS 2011 also looked at some of the risks to health and how these contributed to the overall disease burden (DALYs) among Indigenous Australians (called the 'attributable burden'; see also Box 3.4). The study looked at 29 different risk factors. Taking into account the effects of simultaneously having more than 1 risk factor, these 29 risk factors, together, explained about half (52%) of total burden for Indigenous Australians aged 50 and over.

The ABDS study found that the risk factors contributing most to the burden of disease experienced by Indigenous Australians aged 50 and over were:

- tobacco use (which caused 24% of the disease burden)
- too much body weight (based on high body mass index, or BMI) (14%)
- high blood pressure (8.9%)
- physical inactivity (8.8%)
- high blood sugar (based on a high fasting plasma glucose levels) (8.4%) (AIHW analysis of (AIHW 2016a)).

3.4 Disability

Disability is an umbrella term for any or all of the following components, all of which may also be influenced by environmental and personal factors: impairment (problems in body function or structure), activity limitation (difficulties in executing activities) and participation restriction (problems an individual may experience in involvement in life situations). This can have varying effects on a person's level of functioning and need for support in daily activities.

Disability prevalence among Indigenous Australians is available from 3 ABS collections:

- 2015 ABS Survey of Disability, Ageing and Carers—this survey includes the most comprehensive measure of disability of the 3 collections. It uses detailed screening questions to identify those people with disability. However, the 2015 survey excluded people living in *Very remote* areas and in discrete Indigenous communities. In addition to private dwellings, data were also collected from people living in certain non-private dwellings, but these are not available by Indigenous status
- 2016 ABS Census of Population and Housing—the Census provides national data on people living in non-private dwellings. Census data are based on limited questions and capture only those with more severe levels of disability
- 2014–15 ABS NATSISS—this survey includes a nationally representative sample of Indigenous Australian people living in private dwellings in remote and non-remote areas of Australia, including discrete Indigenous communities.

Data from these 3 sources are shown in Table 3.2. The remainder of this section presents information on disability from the 2014–15 NATSISS only.

Table 3.2: Disability prevalence, selected data sources, among Indigenous Australians aged 50 and over (per cent)[(a)]

	2014–15 NATSISS	2015 SDAC	2016 Census
Severe or profound disability	13.5	15.8	18.1
All with disability	64.4	53.1	n.a.

n.a. = not available.

(a) Data from the 2014–15 NATSISS and 2015 SDAC pertain to people living in private dwellings, while data from the 2016 Census include people living in both private and non-private dwellings.

Sources: AIHW analysis of ABS 2013f, 2016c and 2017f.

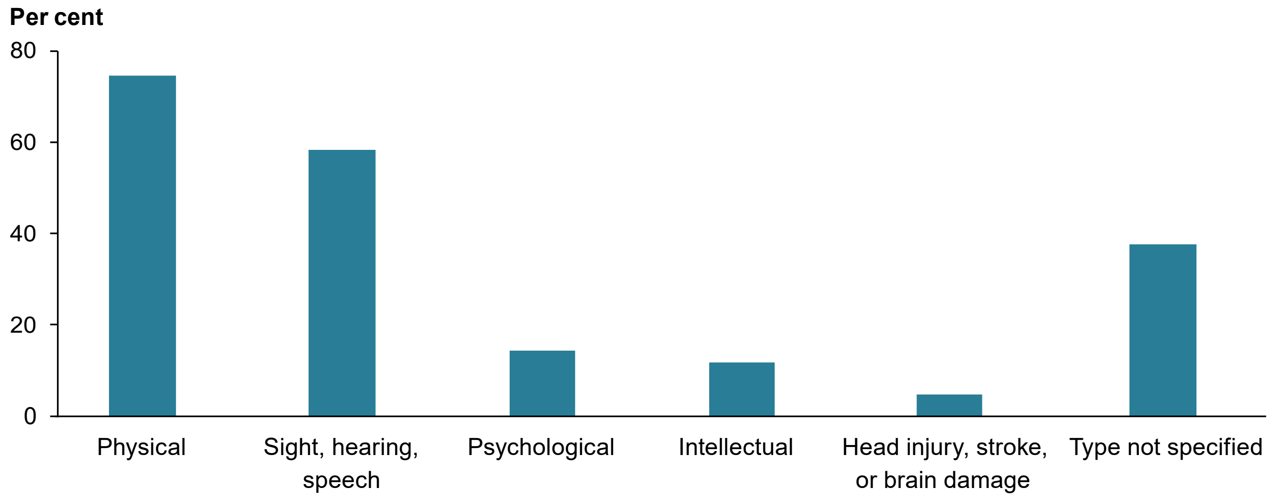
According to estimates calculated from the weighted number of responses to the 2014–15 NATSISS, among Indigenous Australians aged 50 and over:

- 64% (an estimated 63,600 people) reported that they had some form of disability—that is, a limitation, restriction, impairment, disease or disorder, that has lasted, or is expected to last, for 6 months or more and restricts everyday activities
- 13% (13,300 people) reported that they had a severe or profound core activity limitation—these are people who need help with communication, mobility and/or self-care
- the proportion reporting a severe or profound core activity limitation was similar in remote (15%) and non-remote areas (13%) and among men and women (both 14%) (Table S3.20).

In the 2014–15 NATSISS, among Indigenous Australians aged 50 and over reporting that they had disability:

- 74% (an estimated 47,300 people) reported a physical disability
- 58% (37,000 people) reported a sight, hearing or speech disability
- 14% (9,200 people) reported a psychological disability
- 12% (7,500) reported an intellectual disability (Figure 3.10).

Figure 3.10: Indigenous Australians aged 50 and over with disability, by type of disability, 2014–15



Notes

1. Multiple responses were possible; some people reported more than 1 type of disability.
2. Data for this figure and notes about the analysis are shown in Table S3.21.

Source: AIHW analysis of ABS 2016c.

3.5 Causes of ill health

3.5.1 Common long-term health conditions

This section presents information on long-term health conditions as derived from the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) (see Box 3.5 for information about this data source).

Box 3.5: Long-term health conditions—data sources

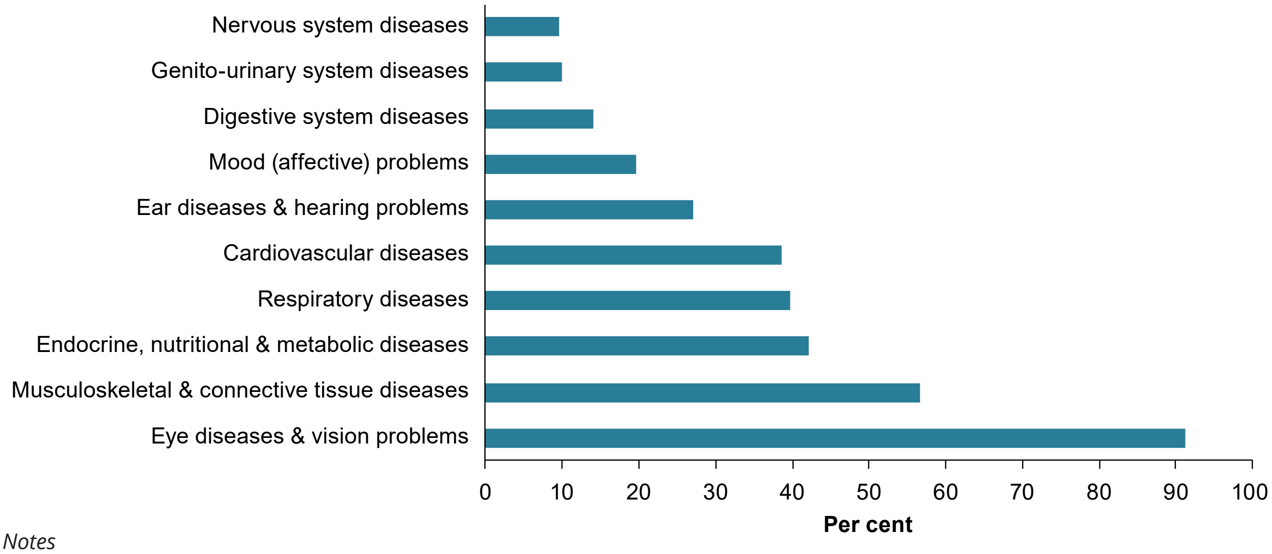
Detailed data on long-term health conditions were collected in the 2012–13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)—a component of the 2012–13 AATSIHS (see also Appendix A). The NATSIHS is based on a sample of about 9,300 Indigenous Australians of all ages. While some data on long-term health conditions are available from the 2014–15 NATSISS, the ABS considers that the 2012–13 NATSIHS to be the better source of prevalence estimates (ABS 2016d).

For selected conditions, the 2012–13 AATSIHS collected information in the NATSIHS component, as well as in the National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey. The combined sample of these two surveys—consisting of about 12,900 people aged 2 and over—is referred to as the 'core sample' (ABS 2013f). In this subsection (Section 3.5.1), for consistency and comparability of data, data for all conditions are based on the NATSIHS sample only. In Section 3.5.2, core sample data are used where available—namely, for prevalence estimates for diabetes, chronic kidney disease, and cardiovascular disease.

Considering broad categories of conditions, in 2012–13, the most commonly reported health conditions among Indigenous Australians aged 50 and over were:

- eye diseases and vision problems (an estimated 91% of those aged 50 and over)—most commonly long-sightedness (67% of those aged 50 and over)
- diseases of musculoskeletal system and connective tissues (57%)—most commonly, osteoarthritis (21%)
- endocrine, nutritional and metabolic diseases (42%)—most commonly type 2 diabetes (25%)
- respiratory diseases (40%)—most commonly asthma (21%)
- cardiovascular diseases (39%)—most commonly hypertensive disease (18% of those aged 50 and over) (Figure 3.11; Table S3.22).

Figure 3.11: Most common long-term health conditions (broad categories) among Indigenous Australians aged 50 and over, 2012–13



Notes

1. The figure shows the 10 most common broad types of conditions for Indigenous Australians aged 50 and over, excluding 'symptoms, signs and conditions not elsewhere classified'.
2. Data for this figure and notes about the analysis are shown in Table S3.22.

Source: AIHW analysis of ABS 2014c.

Among Indigenous Australians aged 50 and over, women were more likely than men to report endocrine, nutritional and metabolic diseases (49% compared with 36%), and diseases of the respiratory system (47% compared with 33%) (Table S3.22).

3.5.2 Selected conditions

This section presents information on selected health conditions causing the greatest disease burden among Indigenous Australians aged 50 and over. It provides detailed information on the occurrence of ill health and use of hospital services for these selected conditions.

Although mental health-related conditions and substance use disorders make a substantial contribution to the burden of disease among Indigenous Australians aged 50 and over, these are not reported in this chapter. Information on these topics is included in Chapters 4 and 7, respectively.

Cardiovascular disease

Cardiovascular disease (also known as circulatory system disease) covers diseases and conditions of the heart and blood vessels, including, for example, coronary heart disease, stroke, peripheral vascular disease, heart failure and rheumatic heart disease. Cardiovascular disease contributes substantially to poor health and reduced life expectancy among Indigenous people.

In Australia, the main cause of cardiovascular disease is atherosclerosis—where abnormal fat deposits, cholesterol and other substances build up in the arteries. This is a slow and complex process, often starting in childhood and progressing with age (AIHW 2014).

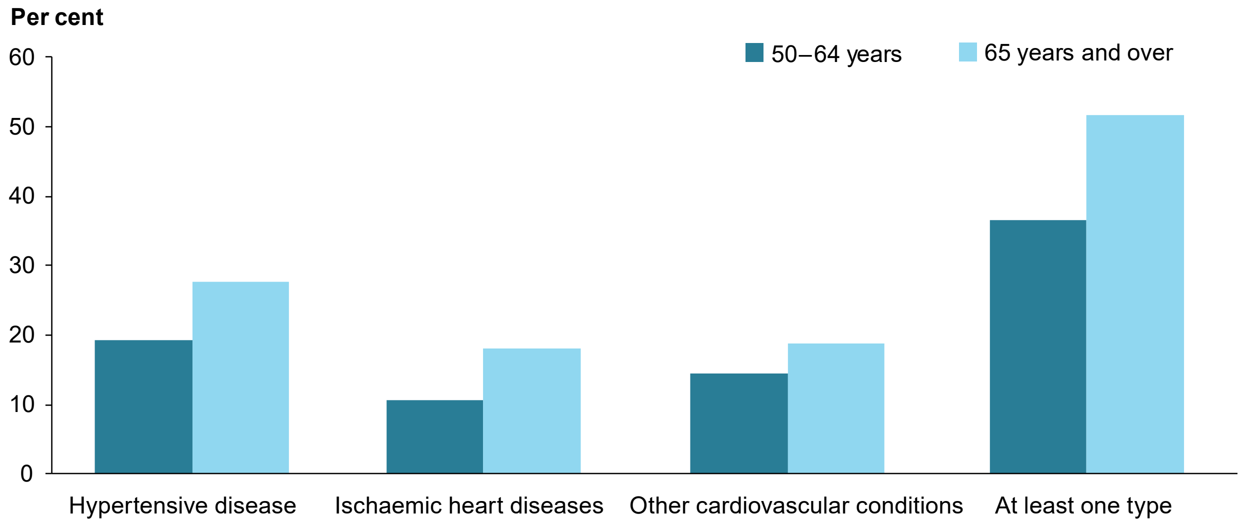
Cardiovascular disease was the leading cause of disease burden among Indigenous Australians aged 50 and over in 2011, accounting for just over 20% of total burden.

Prevalence

Based on self-reported data from the 2012–13 AATSIHS (core sample; see Box 3.5), among Indigenous Australians aged 50 and over 40% had some form of cardiovascular disease. Prevalence was higher among those aged 65 and over than among those aged 50–64—52% compared with 36% (Figure 3.12).

The most common type of cardiovascular disease reported by Indigenous Australians aged 50 and over was hypertensive disease (an estimated 22% of people) (Figure 3.12). Hypertensive disease refers to heart problems caused by high blood pressure—including heart failure, thickening of the heart muscle and coronary heart disease (ABS 2014c).

Figure 3.12: Proportion of Indigenous Australians aged 50 and over who reported having cardiovascular disease, by age group and type, 2012–13



Note: Data for this figure and notes about the analysis are shown in Table S3.23.

Source: AIHW analysis of ABS 2015.

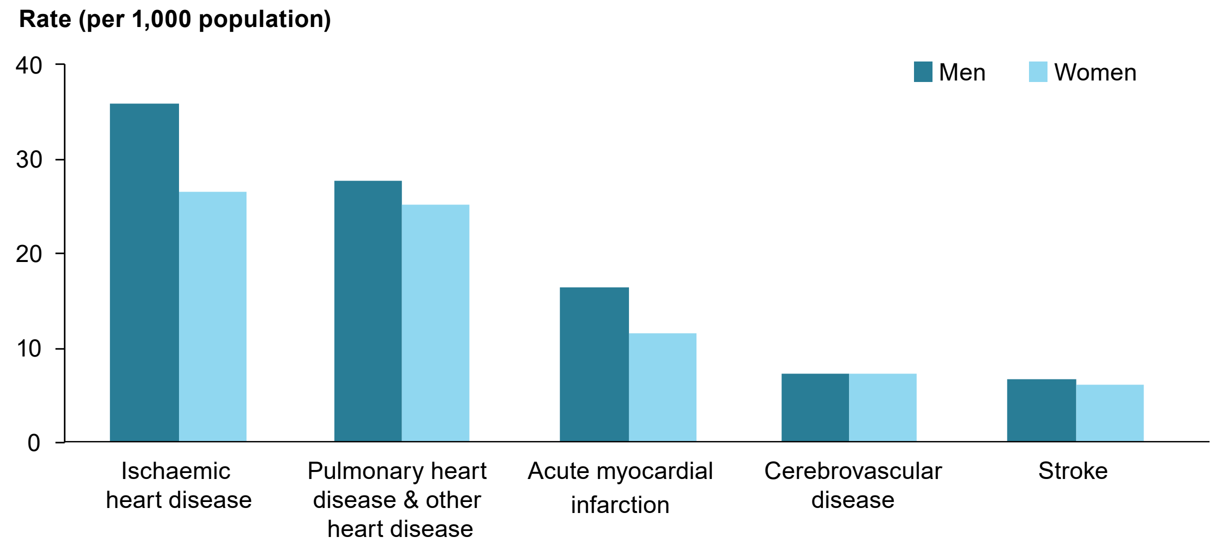
Hospitalisations

In the 2-year period 2014–16, among Indigenous Australians aged 50 and over, there were 16,300 hospitalisations due to cardiovascular disease (based on principal diagnosis)—a rate of 76 hospitalisations per 1,000 population (Table S3.24). The rate of hospitalisations due to cardiovascular disease was:

- higher among men than women (83 and 70 per 1,000 population)
- higher for those aged 75 and over (144 per 1,000 population) compared with those aged 65–74 and 50–64 (102 and 62 per 1,000) (Table S3.24).

Among Indigenous Australians aged 50 and over, ischaemic heart disease was the most common cause of hospitalisation due to cardiovascular disease in 2014–16 (with a rate of 31 hospitalisations per 1,000 population), followed by pulmonary heart disease (26 hospitalisations per 1,000). For most types of cardiovascular disease considered, the rate of hospitalisations was higher for men than for women (Figure 3.13; Table S3.24).

Figure 3.13: Hospitalisation rates among Indigenous Australians aged 50 and over for selected types of cardiovascular disease, by sex, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.24 for ICD-10-AM codes included in the analysis).
2. Data for this figure and some notes about the analysis are shown in Table S3.24.

Source: AIHW analysis of National Hospital Morbidity Database.

Cancer

As a disease group, cancer and other neoplasms accounted for almost 20% of the overall disease burden among Indigenous Australians aged 50 and over in 2011; this disease group was the second leading cause of disease burden.

Incidence and prevalence

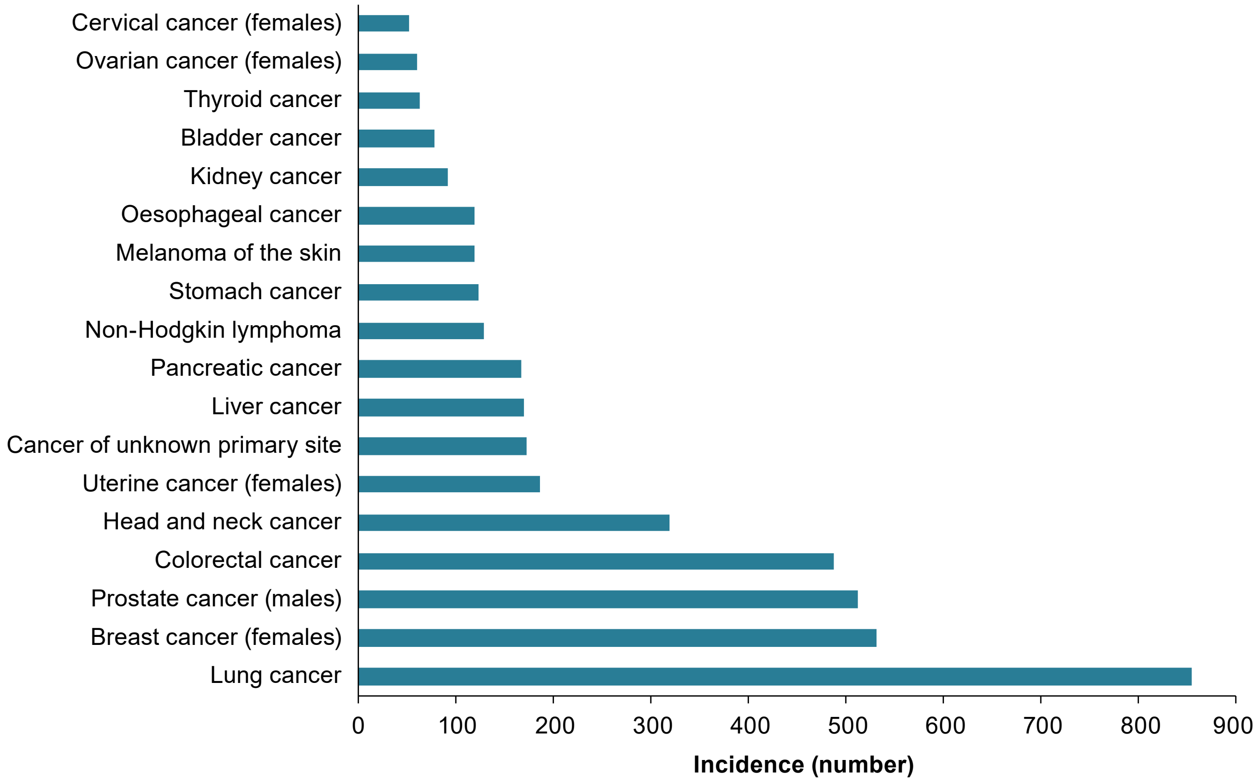
Incidence and prevalence data for cancer are sourced from the Australian Cancer Database. The quality of Indigenous status is considered to be of sufficient completeness for reporting only for New South Wales, Victoria, Queensland, Western Australia and the Northern Territory, so the data presented in this section related to these 5 jurisdictions combined.

Over the 5-year period 2009–2013 there were 4,804 new cancer diagnoses among Indigenous Australians aged 50 and over (12 per 1,000 population). The incidence rate was higher among:

- men than women (13 and 11 per 1,000 population)
- those aged 75 and over (28 per 1,000 population) compared with those aged 65–74 and 50–64 (20 and 9 per 1,000) (Table S3.25).

In 2009–2013, lung cancer was the most commonly diagnosed cancer among Indigenous Australians aged 50 and over (with 854 new diagnoses), followed by breast cancer (532), prostate cancer (513) and colorectal cancer (488) (Figure 3.14).

Figure 3.14: Cancer incidence among Indigenous Australians aged 50 and over, by type of cancer, 2009–2013



Notes

1. Cancer incidence relates to the number of new primary cancers over the 5-year period and not a recurrence of a previous primary cancer cases.
2. Data for this figure and notes about the analysis are shown in Table S3.26.
3. Data reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined.

Source: AIHW analysis of AIHW 2018k.

At the end of 2013 there were nearly 2,500 surviving Indigenous Australians aged 50 and over who had been diagnosed with cancer during the previous 5 years, corresponding to a 5year prevalence rate of 30 per 1,000 population (Table S3.27). The cancers with the highest prevalence rates among Indigenous Australians aged 50 and over were prostate cancer and breast cancer (11 per 1,000 men and women, respectively) (Table S3.28).

Hospitalisations

In the 2-year period 2014–16 among Indigenous Australians aged 50 and over, there were around 8,500 hospitalisations due to neoplasms (based on principal diagnosis), including around 6,500 for cancer (that is, malignant neoplasms).

The hospitalisation rate due to cancer among the Indigenous Australian population aged 50 and over was 30 per 1,000 population. The rate was higher among:

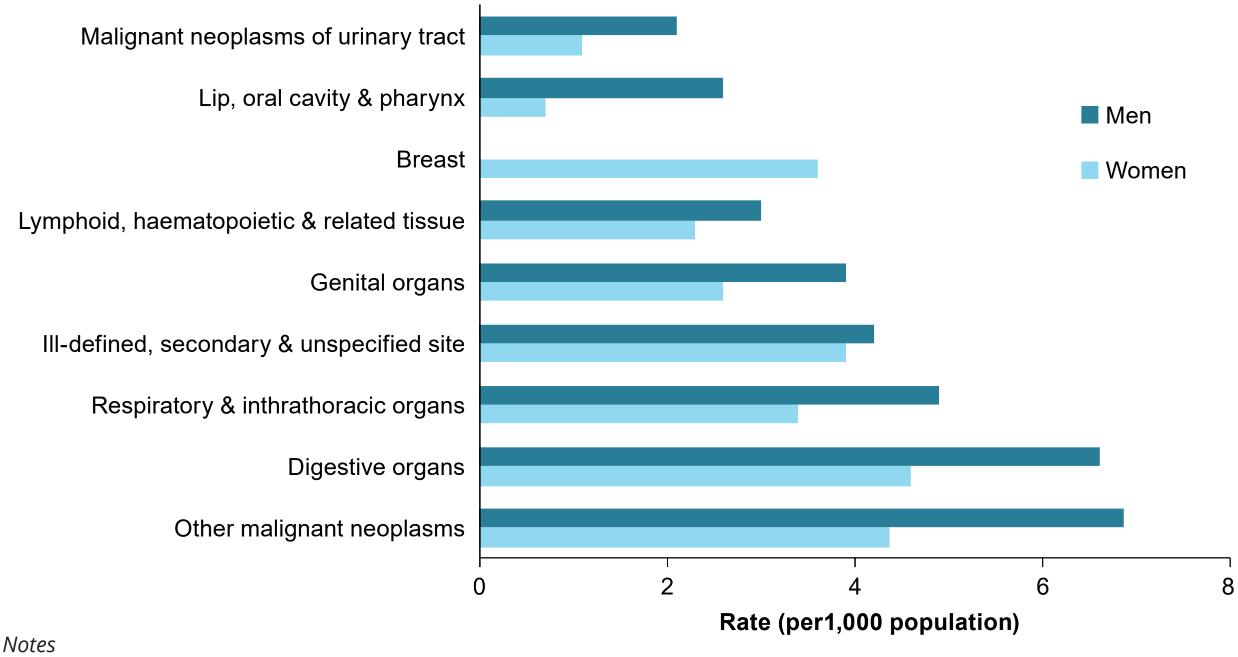
- men than women (34 and 27 per 1,000 population)
- those aged 75 and over (66 per 1,000 population), than those aged 65–74 (46 per 1,000) and those aged 50–64 (23 per 1,000) (Table S3.29).

Of the 6,501 hospitalisations due to cancer among Indigenous Australians aged 50 and over in 2014–16:

- 18% were due to cancer of the digestive organs
- 14% were due to cancer of the respiratory and intrathoracic organs
- 11% were due to cancers of the genital organs (for example, cervical cancer and prostate cancer) (Table S3.29).

In 2014–16, hospitalisation rates due to cancer among Indigenous Australians aged 50 and over were higher for men than women across the majority of cancer types (Figure 3.15).

Figure 3.15: Hospitalisation rates among Indigenous Australians aged 50 and over for selected types of cancer, by sex, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.34 for ICD-10-AM codes included in the analysis).
2. Categories are ordered according to the most common type for all people combined.
3. Data for this figure and notes about the analysis are shown in Table S3.29.

Source: AIHW NHMD.

Respiratory diseases

Respiratory diseases accounted for 11% of the disease burden among Indigenous Australians aged 50 and over in 2011. This disease group includes conditions such as asthma, chronic obstructive pulmonary disease (COPD, including chronic bronchitis and emphysema), chronic sinusitis, and hay fever.

Prevalence

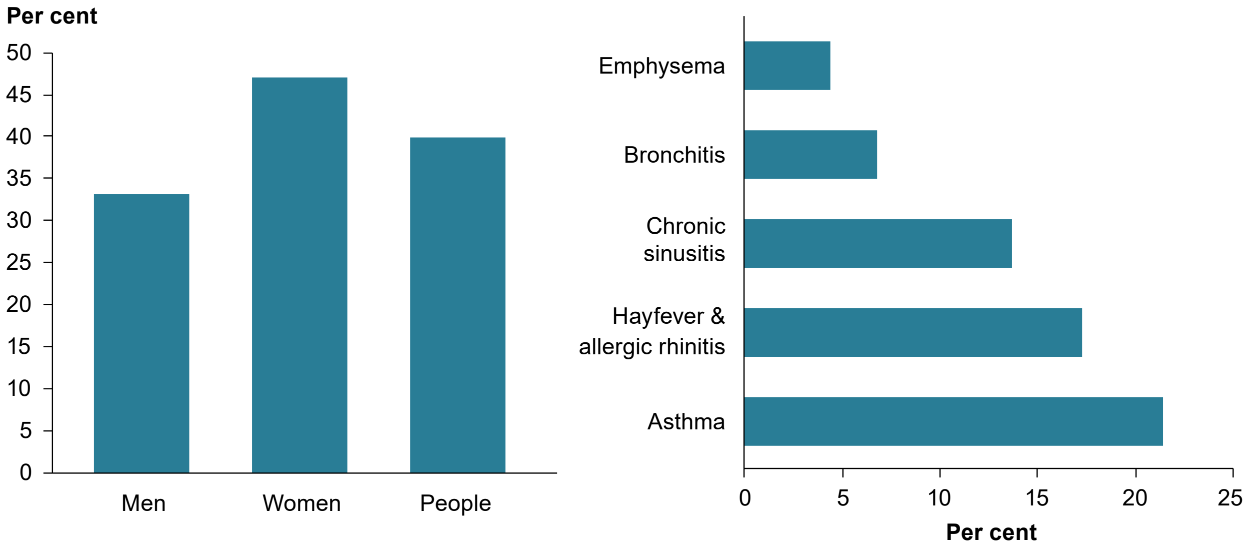
Based on self-reported data from the AATSIHS (NATSIHS component; see Box 3.5), in 2012–13, among Indigenous Australians aged 50 and over, 40% (an estimated 33,500 people) had some form of long-term respiratory disease. In terms of specific conditions (multiple responses possible), an estimated:

- 21% had asthma
- 17% had hayfever or allergic rhinitis

- 14% had chronic sinusitis
- 7% had bronchitis
- 4% had emphysema.

Women were more likely than men to have a long-term respiratory disease—47% compared with 33% (Figure 3.16).

Figure 3.16: Proportion of Indigenous Australians aged 50 and over who reported having respiratory system diseases, by sex and selected conditions, 2012–13



Note: Data for this figure and notes about the analysis are shown in Table S3.30.

Source: AIHW analysis of ABS 2015.

Hospitalisations

In 2014–16 among Indigenous Australians aged 50 and over, there were 15,122 hospitalisations due to respiratory diseases (based on principal diagnosis)—a rate of 70 hospitalisations per 1,000 population (Table S3.31).

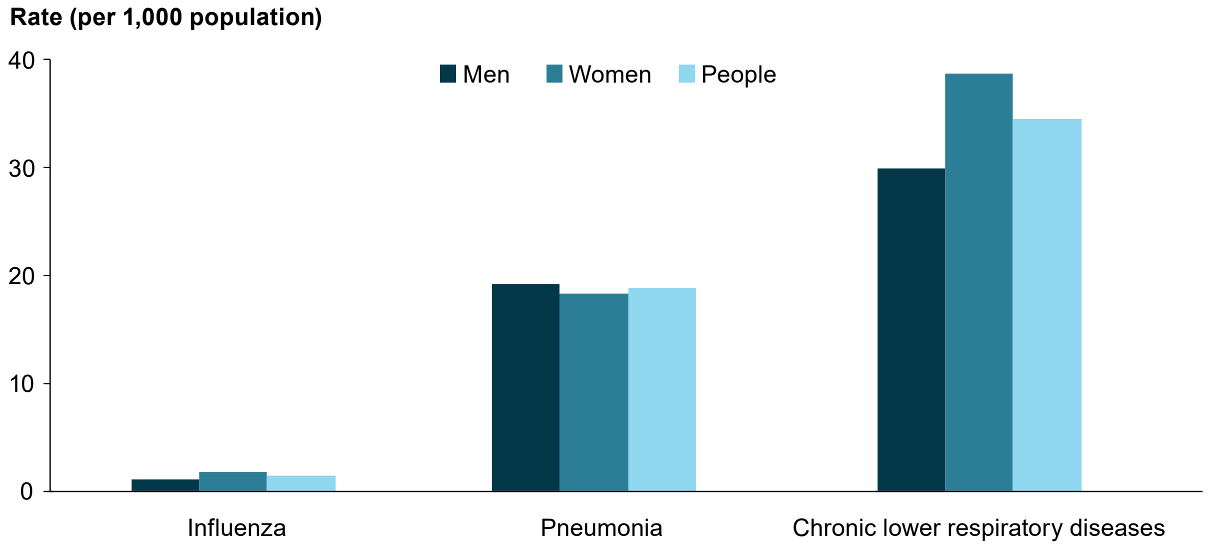
The hospitalisation rates for respiratory conditions among Indigenous Australians aged 50 and over were higher:

- for women than men (75 and 65 per 1,000 population)
- for those aged 75 and over (137 per 1,000 population), followed by those aged 65–74 and those aged 50–64 (95 and 57 per 1,000, respectively) (Table S3.31).

In 2014–16, among Indigenous Australians aged 50 and over, the most common form of respiratory disease causing hospitalisation was chronic lower respiratory diseases (a rate of 35 per 1,000 population) (Figure 3.17).

Bronchitis and emphysema, together, accounted for the vast majority of hospitalisations due to chronic lower respiratory diseases (91% of chronic lower respiratory disease hospitalisations; or a rate of 32 per 1,000 population).

Figure 3.17: Hospitalisation rates among Indigenous Australians aged 50 and over for selected types of respiratory disease, by sex, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.31 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S3.31.

Source: AIHW NHMD.

Musculoskeletal conditions

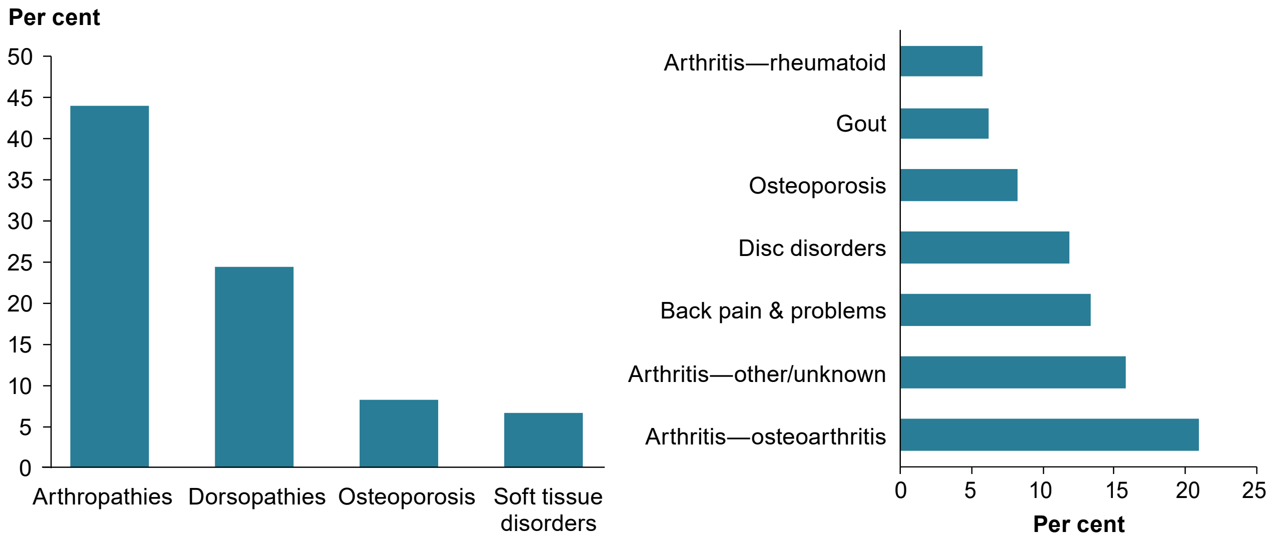
In 2011, musculoskeletal conditions accounted for 8.2% of the disease burden experienced by Indigenous Australians aged 50 and over. This disease group includes conditions such as osteoarthritis, rheumatoid arthritis, back pain and disc disorders, gout, sciatica, osteoporosis and lupus.

Prevalence

Based on self-reported data from the AATSIHS (NATSIHS component; see Box 3.5), among Indigenous Australians aged 50 and over in 2012–13, an estimated 57% had a disease of the musculoskeletal system or connective tissue (Table S3.32). In terms of the specific types of conditions, an estimated:

- 44% had an arthropathy—that is, a disease of the joint, such as arthritis or gout:
  - osteoarthritis was the most common, reported by 21% of those aged 50 and over
- 24% had a dorsopathy—defined as one of the following conditions: sciatica, disc disorders, back pain or curvature of the spine:
  - 13% had back pain, and 12% had disc disorders
- 8% had osteoporosis
- 7% had soft tissue disorders (Figure 3.18).

Figure 3.18: Proportion of Indigenous Australians aged 50 and over with musculoskeletal system or connective tissue diseases, by selected broad categories and specific conditions, 2012–13



Note: Data for this figure and notes about the analysis are shown in Table S3.32.

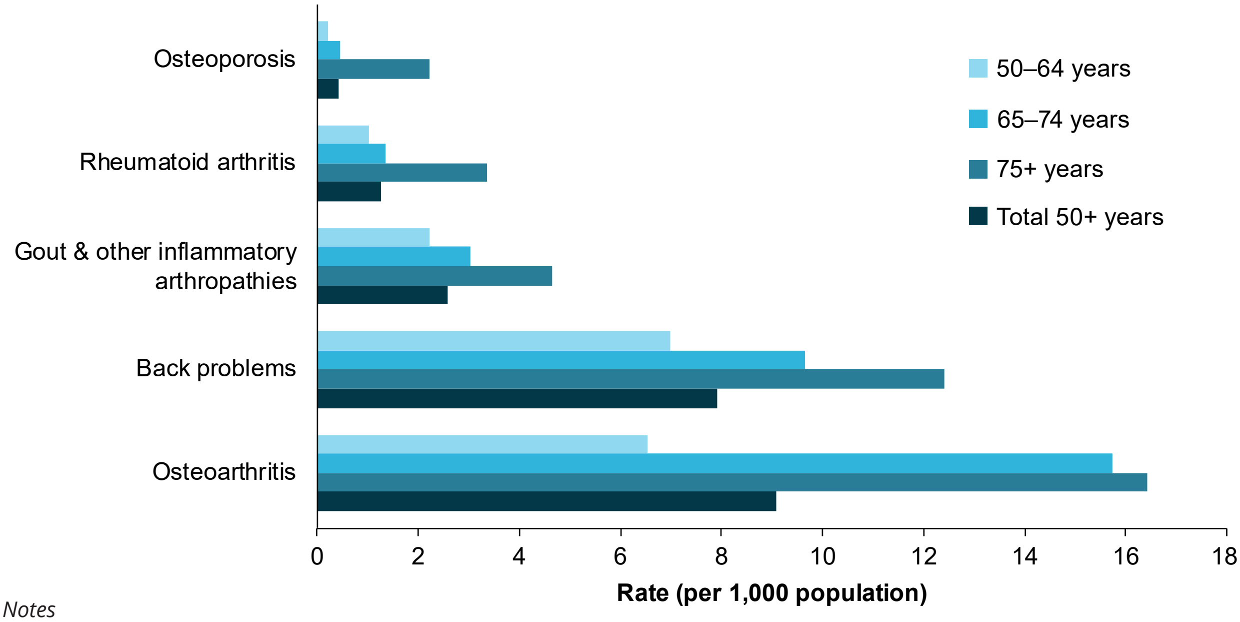
Source: AIHW analysis of ABS 2015.

Hospitalisations

In 2014–16 among Indigenous Australians aged 50 and over, there were around 8,100 hospitalisations due to musculoskeletal conditions (based on principal diagnosis)—corresponding to a rate of 38 per 1,000 population (Table S3.33). The hospitalisation rate for musculoskeletal conditions among Indigenous Australians aged 50 and over was highest for those aged 75 and over (55 per 1,000), followed by those aged 65–74, and those aged 50–64 (49 and 33 per 1,000).

Figure 3.19 shows hospitalisation rates among Indigenous Australians aged 50 and over, for selected types of musculoskeletal conditions. For these selected conditions, the rate of hospitalisation was higher for those aged 75 and over than for those in the younger age groups. Overall, among those aged 50 and over, the hospitalisation rate was highest for conditions due to osteoarthritis (9 per 1,000 population), followed by back problems (8 per 1,000) and gout and other inflammatory arthropathies (2.6 per 1,000).

Figure 3.19: Hospitalisation rates for selected musculoskeletal conditions among Indigenous Australians aged 50 and over, by age group, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.33 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S3.33.

Source: AIHW NHMD.

Diabetes

In 2011, endocrine disorders contributed almost 7% of the total burden of disease among Indigenous Australians aged 50 and over. Diabetes accounted for almost all (99%) of this burden. Diabetes is a chronic condition marked by high glucose levels in the blood. It is caused by the body's inability to produce insulin (a hormone produced by the pancreas to control blood glucose levels), use insulin effectively, or both. There are several types of diabetes, with the most common form being type 2 diabetes, which is largely preventable. Type 2 diabetes is usually associated with lifestyle factors and a later onset than type 1 diabetes.

Prevalence

Based on self-reported data from the AATSIHS (core sample; see Box 3.5), among Indigenous Australians aged 50 and over in 2012–13:

- 35% had diabetes
- of those for whom information on type of diabetes was available (97% of those with diabetes)—81% had type 2 diabetes
- the rate of diabetes was higher among those aged 65 and over than among those aged 50–64 (40% and 33%) (Table S3.34).

Information on the prevalence of diabetes was also collected in the biomedical component of the 2012–13 AATSIHS—called the National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS) (see Appendix A under the Aboriginal and Torres Strait Islander Health Survey heading)—which determined prevalence using blood test results and self-reported information. Based on these data, in 2012–13, 35% of Indigenous Australians aged 50 and over had diabetes—33% with known diabetes, and 2% who were newly diagnosed (Table S3.34).

Hospitalisations

In the 2-year period 2014–16 among Indigenous Australians aged 50 and over:

- there were nearly 3,000 hospitalisations due to diabetes (based on principal diagnosis)—corresponding to a rate of 14 per 1,000 population
- of hospitalisations due to diabetes, the vast majority (94%, or 2,784 hospitalisations) were for type 2 diabetes—a rate of 13 hospitalisations for type 2 diabetes per 1,000 population (Table S3.35).

The hospitalisation rate for diabetes (any type) among Indigenous Australians aged 50 and over:

- was broadly similar for men and women (15 and 13 per 1,000 population respectively)
- was slightly higher for those aged 65–74 (at 18 per 1,000 population) than for those aged 50–64 or 75 and over (both 13 per 1,000) (Table S3.35).

Injury and poisoning

Injuries and poisoning (including assault, self-harm and unintentional injuries) accounted for just over 6% of the total burden of disease among Indigenous Australians aged 50 and over in 2011. Homicide and violence accounted for 8% of the total injury burden in this population group, or just over 0.5% of the total burden of disease. (For further information on homicide and violence, see Chapter 8.)

Prevalence

In the 2012–13 AATSIHS, information was collected on whether people had any accidents, had hurt themselves, or had been hurt by someone or something in the 4 weeks prior to the survey.
In 2012–13, among Indigenous Australians aged 50 and over:

- an estimated 11% had been injured in the previous 4 weeks. Falls (54% of injury events) were the most common event causing injury
- 45% of those injured in the previous 4 weeks took some kind of action for the injury—22% went to a community clinic or hospital, 15% treated the injury at home, and the remaining 8% took some other form of action (AIHW analysis of ABS 2014c).

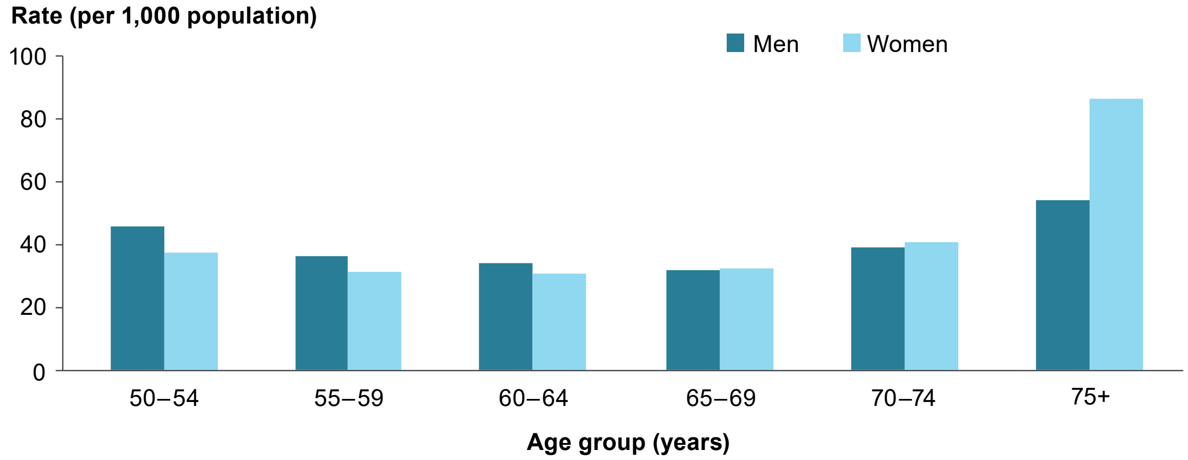
Hospitalisations

Hospitalised injuries can range from single fractures to catastrophic injuries such as spinal cord injury or traumatic brain injury, which may result in life-long disability.

Among Indigenous Australians aged 50 and over, in the 2-year period 2014–16:

- there were nearly 8,400 hospitalisations due to injury and poisoning (based on principal diagnosis), corresponding to a rate of 39 per 1,000 population
- the rate of hospitalisation due to injury and poisoning was higher for men than women in the younger age groups (50–54 to 60–64); while in the older age groups the rate was higher for women
- for both men and women, the rate of hospitalisation for injury and poisoning was highest among those aged 75 and over—likely due to the fact that prevalence of falls increases with age and frailty (Figure 3.20).

Figure 3.20: Hospitalisation rates for injury and poisoning among Indigenous Australians aged 50 and over, by sex and age group, 2014–16



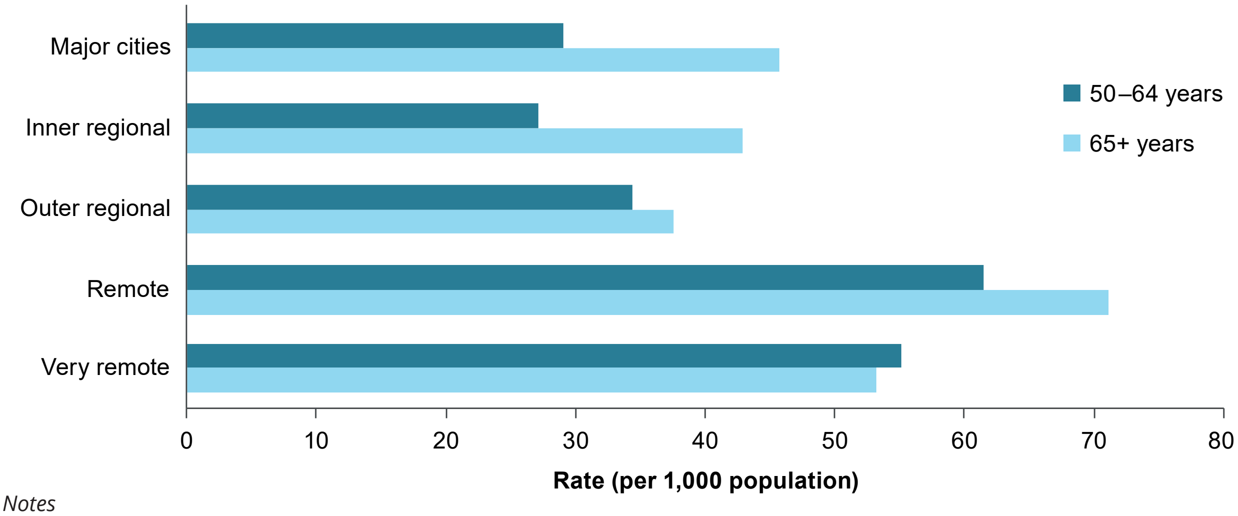
Notes

1. Data are based on principal diagnosis (see Table S3.36 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S3.36.

Source: AIHW NHMD.

In 2014–16, among Indigenous Australians aged 50 and over, those living in *Remote* and *Very remote* areas had higher rates of hospitalisation for injury than those in the non-remote areas (Figure 3.21).

Figure 3.21: Hospitalisation rates for injury and poisoning among Indigenous Australians aged 50 and over, by remoteness and age group, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.37 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S3.37.

Source: AIHW NHMD.

Causes of injury hospitalisations

Data on hospitalised injuries can be viewed in terms of the damage sustained to the body (for example, broken bones and head injuries), or by the external cause of the injury (for example, falls, poisoning and drowning).

In the 2-year period 2014–16, the most common causes of injury hospitalisations among Indigenous Australians were falls (46% of injury hospitalisations) (Table 3.3).

In 2014–16, 18% of injury hospitalisations among Indigenous Australians aged 50 and over were caused by intentional injuries—that is, either self-inflicted with intent to self-harm, or assault. There were a small proportion of injury hospitalisations for Indigenous Australians aged 50 and over where intent could not be determined (1.6%), or where there was no external cause recorded (4.3%) (Table 3.3).

In 2014–16, among Indigenous Australians aged 50 and over there were 3,882 injury hospitalisations due to falls, accounting for 51% of injury hospitalisations for women, and 41% for men. The most common cause of fall injury hospitalisations was falling on the same level due to slips, trips and stumbles (29% of hospitalised fall injuries) (Table S3.38).

Table 3.3: Hospitalisations of people aged 50 and over for a principal diagnosis of injury and poisoning[(a)], by first reported external causes, and Indigenous status, 2014–16

External cause (ICD-10-AM codes)(b)	Number	% of injury hospitalisations
Accidental injuries		
Falls (W00–W19)	3,882	46.2
Inanimate mechanical forces (W20–W49)	741	8.8
Transport accidents (V01–V99)	620	7.4
Accidental poisoning (X40–X49)	275	3.3
Animate mechanical forces (W50–W64)	273	3.3
Smoke, fire, flames, heat hot substances (X00–X19)	157	1.9
Other accidental injuries(c)	720	8.6
Total unintentional	*6,668*	*79.4*
Intentional injuries		
Assault (X85–Y09, Y35–Y36)	1,033	12.3
Intentional self-harm (X60–X84)	440	5.2
Total intentional	*1,473*	*17.5*
Intent unknown		
Events of undetermined intent (Y10–Y34)	131	1.6
Other/missing		
Other external cause(d)	87	1.0
External cause not reported	35	0.4
Total	**8,394**	**100.0**

(a) Based on principal diagnosis, classified using the ICD-10-AM (9th edition for 2015–16 data and 8th edition for 2014–15 data). Includes the following ICD-10-AM codes: S00–T75 or T79.

(b) Based on first reported external cause (ICD-10-AM, 9th edition codes).

(c) Includes accidental drowning and submersion (W65–W74); other accidental threats to breathing (W75–W84), exposure to electric current, radiation and extreme ambient air temperature and pressure (W85–W99); contact with venomous animals and plants (X20–X29); exposure to forces of nature (X30–X39); overexertion, travel and privation (X50–X57); accidental exposure to other and unspecified factors (X58–X59).

(d) Includes complications of medical and surgical care (Y40–Y84), and sequelae and supplementary factors (Y85–Y98).

Note: Exclude separations for Newborns without qualified days, Hospital boarders and Posthumous organ procurement.

Source: AIHW NHMD.

Dementia

In 2011, neurological disorders accounted for just over 5% of the total burden of disease among Indigenous Australians aged 50 and over, of which the majority (59%) was due to dementia.

Prevalence

Australia lacks reliable national data on the prevalence of dementia. Consequently, recent estimates of dementia prevalence among the total Australian population have been based on rates derived from local and international studies, with these rates applied to estimates of the Australian population (see AIHW 2012a).

For the Indigenous population, information on the prevalence of dementia is particularly limited, with studies on prevalence limited to specific regions (see Box 3.6).

Box 3.6: Dementia prevalence studies among Indigenous Australians

Studies on the prevalence of dementia among Indigenous Australians have been limited to specific geographic regions:

- A study of 336 Indigenous Australians aged 60 and over across 5 urban/regional Aboriginal communities in New South Wales found that 13.4% had dementia (Radford et al. 2015).
- A study of 363 Indigenous Australians aged 45 and over from remote communities in the Kimberly region of Western Australia found that 12.4% had dementia (Smith et al. 2008).
- A study of dementia among Indigenous Australians aged 45 and over in the Northern Territory—using diagnosis data from hospital admissions, aged care services, primary care, and death registrations from 2008 to 2011—found that 3.7% had dementia, compared with 1.1% of the corresponding non-Indigenous population (Li et al. 2014). After adjusting for differences in age structures, the prevalence rate for Indigenous Australians aged 45 and over in this study was 6.5%, compared with 2.6% for the non-Indigenous population.

The rates in these studies may differ due not only to different regions, but also to other aspects of study design such how dementia is identified. For example, in the 2014 study by Li and others, diagnosis information was used (Li et al. 2014), while Smith and others used a cognitive screening tool (Smith et al. 2008).

Dementia tends to be under-diagnosed, particularly in the earlier stages (AIHW 2012a). A review of Australian and international studies among Indigenous populations found that retrospective studies relying on medical records for diagnosis had much lower prevalence rates than prospective studies that used cognitive assessment tools (Warren et al. 2015).

Hospitalisations

In the 2-year period 2014–16, among Indigenous Australians aged 50 and over, there were around 300 hospitalisations due to dementia (based on principal diagnosis)—corresponding to a rate of 1.4 hospitalisations per 1,000 population (Table 3.4).

For each hospitalisation, in addition to principal diagnoses, additional diagnoses that affect patient management can also be recorded. In 2014–16, there were 2,130 hospitalisations among Indigenous

Australians aged 50 and over where dementia was recorded as either the principal or an additional diagnosis (a rate of 9.9 per 1,000 population).

Among Indigenous Australians aged 50 and over, the hospitalisation rates with dementia as a principal and/or additional diagnosis were broadly similar for men and women (Table 3.4).

Table 3.4: Hospitalisations among Indigenous Australians aged 50 and over, with a diagnosis of dementia, by sex, 2014–16

	Principal diagnosis[(a)]			Principal or additional diagnosis[(b)]		
	Number	%	Rate (per 1,000)	Number	%	Rate (per 1,000)
Men	139	45.1	1.4	935	43.9	9.2
Women	169	54.9	1.5	1,195	56.1	10.6
Total	**308**	**100.0**	**1.4**	**2,130**	**100.0**	**9.9**

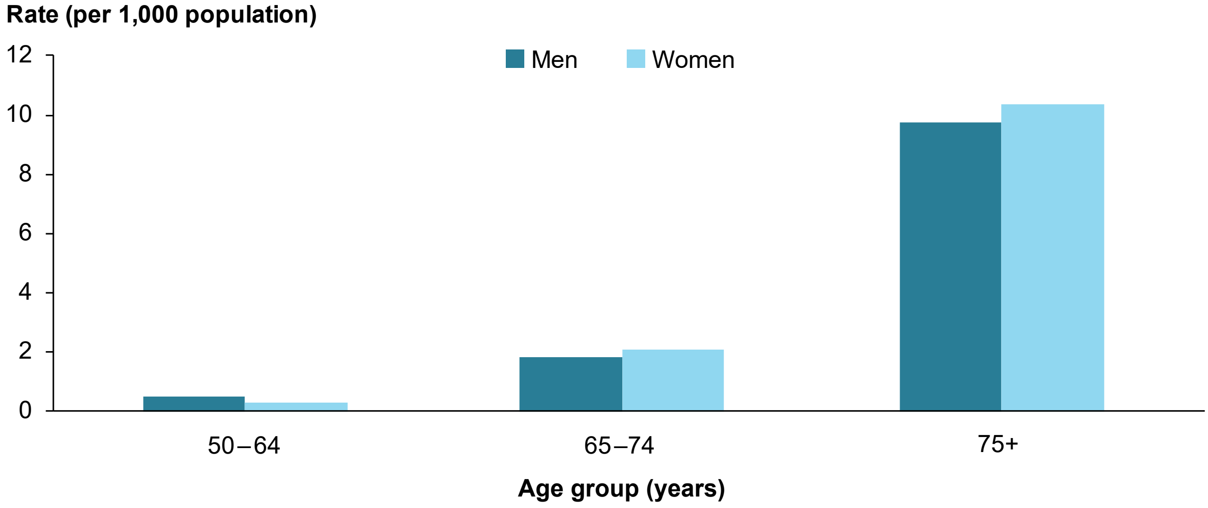
(a) Includes hospitalisations with a principal diagnosis of dementia in Alzheimer disease (ICD-10-AM code F00), Vascular dementia (F01), Dementia in other diseases (F02), Unspecified dementia (F03), Delirium superimposed on dementia (F05.1) or Alzheimer disease (G30). Also includes hospitalisations with a principal diagnosis of 'Other degenerative diseases of nervous system, not elsewhere classified' (G31) where the additional diagnosis was recorded as one of the dementia codes listed previously (that is, F00, F01, F02, F03, F05.1 or G30).

(b) Includes hospitalisations with a principal and/or additional diagnosis of one of the following: dementia in Alzheimer disease (ICD-10-AM code F00), Vascular dementia (F01), Dementia in other diseases (F02), Unspecified dementia (F03), Delirium superimposed on dementia (F05.1) and Alzheimer disease (G30).

Source: AIHW National Hospital Morbidity Database.

The rate of hospitalisation with a principal diagnosis of dementia was highest for those aged 75 and over (10.2 per 1,000 population) followed by those aged 65–74 (2.0 per 1,000) and those aged 50–64 (0.4 per 1,000) (Figure 3.22). A similar trend was observed where dementia was recorded as the principal or additional diagnosis.

Figure 3.22: Hospitalisation rates among Indigenous Australians aged 50 and over due to dementia, by age and sex, 2014–16



Notes

1. Hospitalisations data are based on principal diagnosis (see Table S3.39 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S3.39.

Source: AIHW NHMD.

In 2014–16, of hospitalisations for Indigenous Australians aged 50 and over where the principal diagnosis was dementia, the most commonly recorded diagnosis was unspecified dementia (41%), followed by Alzheimer disease (22%), and delirium superimposed on dementia (20%) (Table 3.5).

Table 3.5: Hospitalisations with a principal diagnosis of dementia[(a)] among Indigenous Australians aged 50 and over, by type of dementia, 2014–16

Principal diagnosis (ICD–10–AM code)	Number	%
Unspecified dementia (F03)	125	40.6
Alzheimer disease (F00, G30)	68	22.1
Delirium superimposed on dementia (F05.1)	60	19.5
Dementia in other diseases (F02)	37	12.0
Vascular dementia (F01)	12	3.9
Other degenerative diseases of nervous system, not elsewhere classified (G31), with an additional diagnosis of one of the dementia codes listed above	6	1.9
Total	**308**	**100.0**

(a) Based on principal diagnosis, classified using the ICD-10-AM (9th edition for 2015–16 data and 8th edition for 2014–15 data).

Notes

1. Data are for the 2-year period 1 July 2014 to 30 June 2016.
2. Data exclude separations for Newborns without qualified days, Hospital boarders and Posthumous organ procurement.

Source: AIHW National Hospital Morbidity Database.

Chronic kidney disease

Chronic kidney disease (CKD) is defined as the presence of impaired or reduced kidney function lasting at least 3 months. The kidneys can be permanently damaged by various acute illnesses or by progressive damage from chronic conditions such as long-standing untreated diabetes. In 2011, kidney and urinary disorders accounted for almost 5% of the total burden of disease among Indigenous Australians aged 50 and over, of which the majority (80%) was due to CKD.

Prevalence

In the 2012–13 AATSIHS (core sample; see Box 3.5), an estimated 6.8% of Indigenous Australians aged 50 and over had kidney disease that was current and that had lasted, or was expected to last, for 6 months or more.

The biomedical component of the 2012–13 AATSIHS— called the National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS) (see Appendix A)—used 2 biomedical tests to measure kidney function: glomerular filtration rate and urinary albumin creatinine ratio. While these tests cannot be used on their own to diagnose CKD (ABS 2014d), the results of these tests suggest that the self-reported data substantially underestimates the proportion of Indigenous Australians with CKD. For example, in 2012–13:

- among Indigenous Australians aged 18 and over in the NATSIHMS, 18% had indicators of CKD based on biomedical test results—however of these people, only about 11% self-reported having the condition (ABS 2014d)

- 40% of Indigenous Australians aged 55 and over in the NATSIHMS had indicators of CKD based on the biomedical tests (ABS 2014d). The ABS has not published data on the proportion of this sample who self-reported having the condition; however, data from the core sample of the AATSIHS for the same age group—that is, those aged 55 and over—suggests a self-reported prevalence rate of 7.8% (AIHW analysis of ABS 2015).

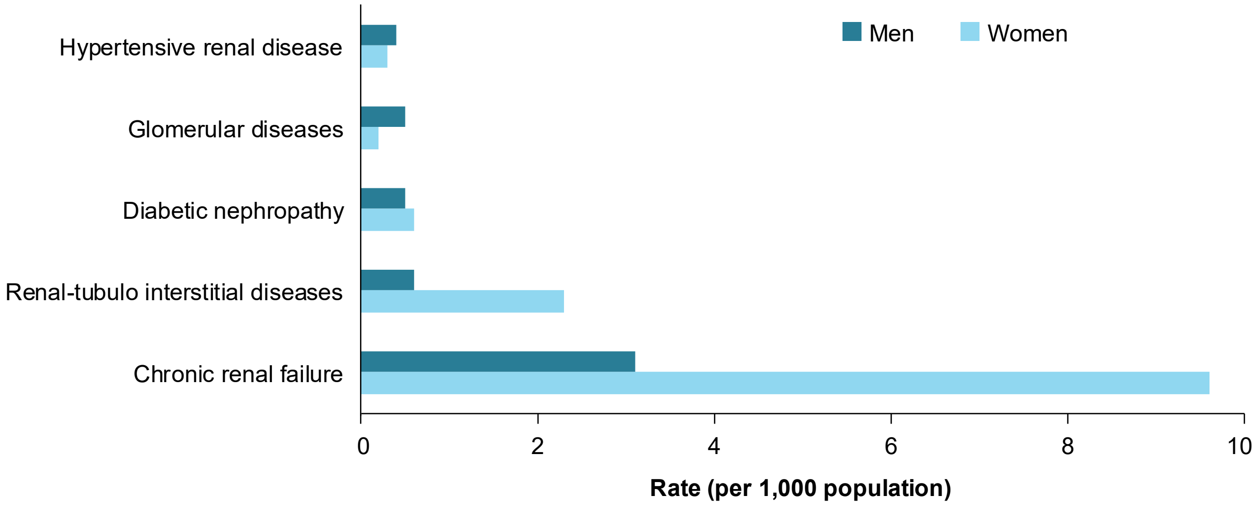
Hospitalisations

Excluding regular dialysis, there were more than 2,600 hospitalisations for CKD among Indigenous Australians aged 50 and over during 2014–16 (based on principal diagnosis); this corresponds to a rate of 12 per 1,000 population. The rate among Indigenous Australians aged 50 and over was:

- 2 times higher for women than men (16 compared with 8 per 1,000 population)
- slightly higher for those aged 50–64 (13 per 1,000 population) than for those aged 65–74 and 75 and over (both groups at 10 per 1,000). The difference between age groups was greater for women than men (Table S3.40).

In 2014–16, among Indigenous Australians aged 50 and over, the condition most commonly recorded as the primary reason for hospitalisation for CKD was chronic renal failure (a rate of 6.5 per 1,000 population) (Table S3.40). The rate for chronic renal failure was higher for women than men (9.6 and 3.1 per 1,000) (Figure 3.23).

Figure 3.23: Hospitalisations due to CKD, by selected conditions, among Indigenous Australians aged 50 and over, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S3.40 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S3.40.

Source: AIHW NHMD.

End-stage kidney disease prevalence and treatment

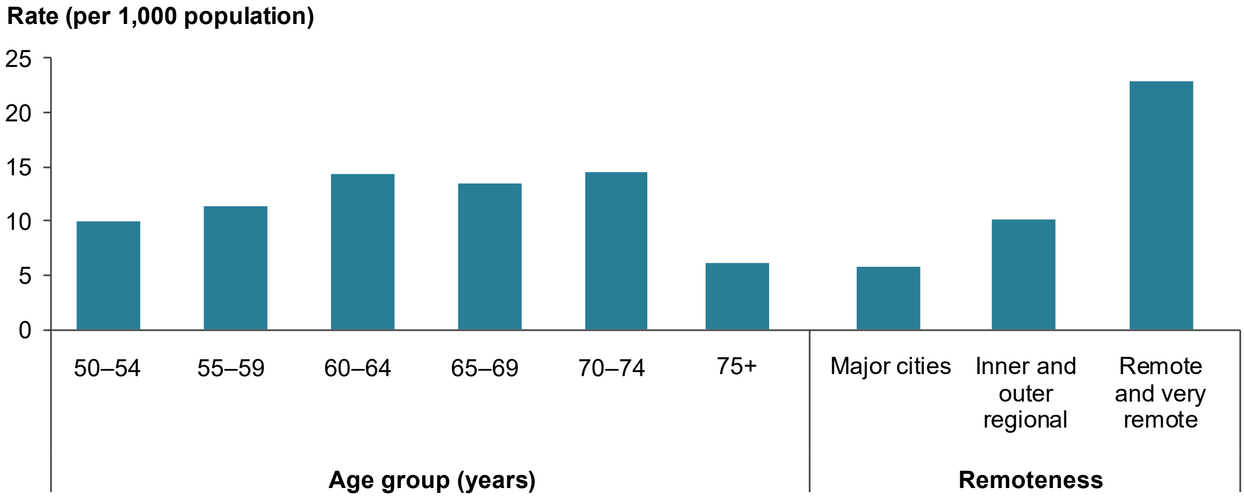
People with end-stage kidney disease (ESKD)—the most severe form of CKD—often require a kidney transplant or dialysis to survive. Information on people with treated ESKD is available from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA)—a register of people receiving kidney dialysis or a kidney transplant (see Appendix A).

Based on data from the ANZDATA, as at 31 December 2016, there were around 1,300 Indigenous Australians aged 50 and over receiving treatment for ESKD in Australia—constituting 7.6% of all Australians aged 50 and over receiving treatment for ESKD (Table S1.1).

As at 31 December 2016, among Indigenous Australians aged 50 and over:

- 12 in every 1,000 people were receiving treatment for ESKD
- people aged 60–74 had the highest prevalence rate of treated ESKD (between 13 and 15 per 1,000 population), with the lowest rate being among those aged 75 and over (6 per 1,000)
- the prevalence rate of treated ESKD was higher among people living in more remote areas. In remote and very remote areas, 23 per 1,000 population were receiving treatment for ESKD; this was 2 times as high as the prevalence rate in inner and outer regional areas (10 per 1,000) and over 3 times as high as the rate in major cities (6 per 1,000) (Figure 3.24).

Figure 3.24: Prevalence of treated ESKD among Indigenous Australians aged 50 and over, by age group and remoteness, 31 December 2016



Note: Data for this figure and notes about the analysis are shown in Table S3.41.

Source: AIHW analysis of ANZDATA data.

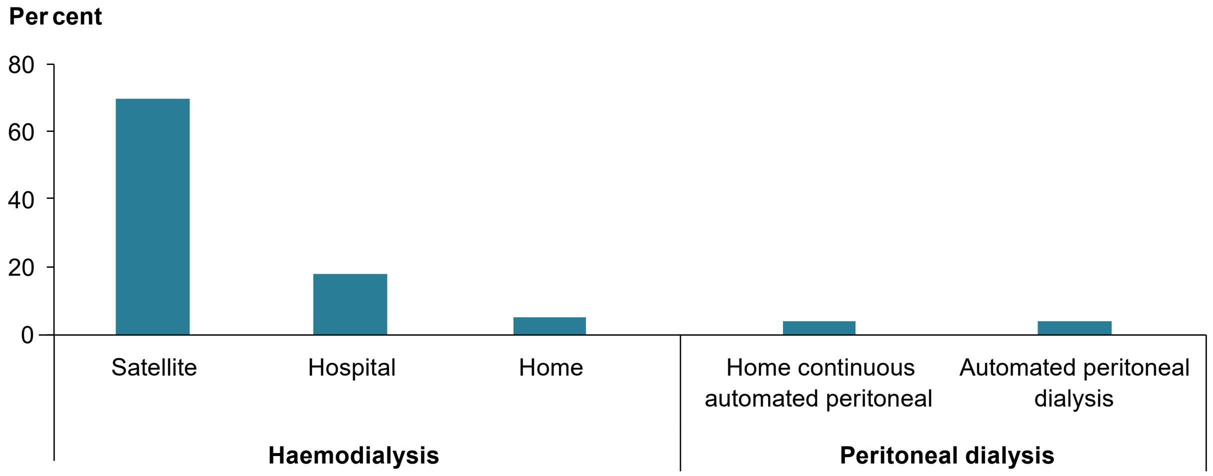
The majority of people with ESKD receive dialysis treatment, an artificial method of removing waste substances from the blood and regulating levels of circulating chemicals. There are 2 main types of dialysis treatment:

- haemodialysis: the blood is diverted from the body to a dialysis machine where it is filtered before being returned to the body—most often in a hospital or satellite (specialised community-based) setting.
- peritoneal dialysis: the abdomen is filled with sterile dialysis solution and blood is filtered through the peritoneal membrane—most often in the home setting (AIHW 2012b).

Among Indigenous Australians aged 50 and over with ESKD there were 1,166 registered patients receiving dialysis as at 31 December 2016. Of those receiving dialysis:

- 87% (1,017) received dialysis in a centre-based setting and 13% (149) at home
- 92% (1,075) received haemodialysis, with 75% (810) of these dialysed in a satellite setting, followed by 19% (207) in a hospital setting and only 5% (58) at home
- 8% (91) received peritoneal dialysis at home (Figure 3.25).

Figure 3.25: Dialysis among Indigenous Australians aged 50 and over with treated ESKD by mode of dialysis treatment received, at 31 December 2016



Note: Data for this figure and notes about the analysis are shown in Table S3.42.

Source: AIHW analysis of ANZDATA registry data.

Information on dialysis in hospital is also available from the NHMD. Over the 2-year period, 2014–16, care involving dialysis was the leading cause of hospitalisations (67%) for Indigenous Australians aged 50 and over (Table S3.13).

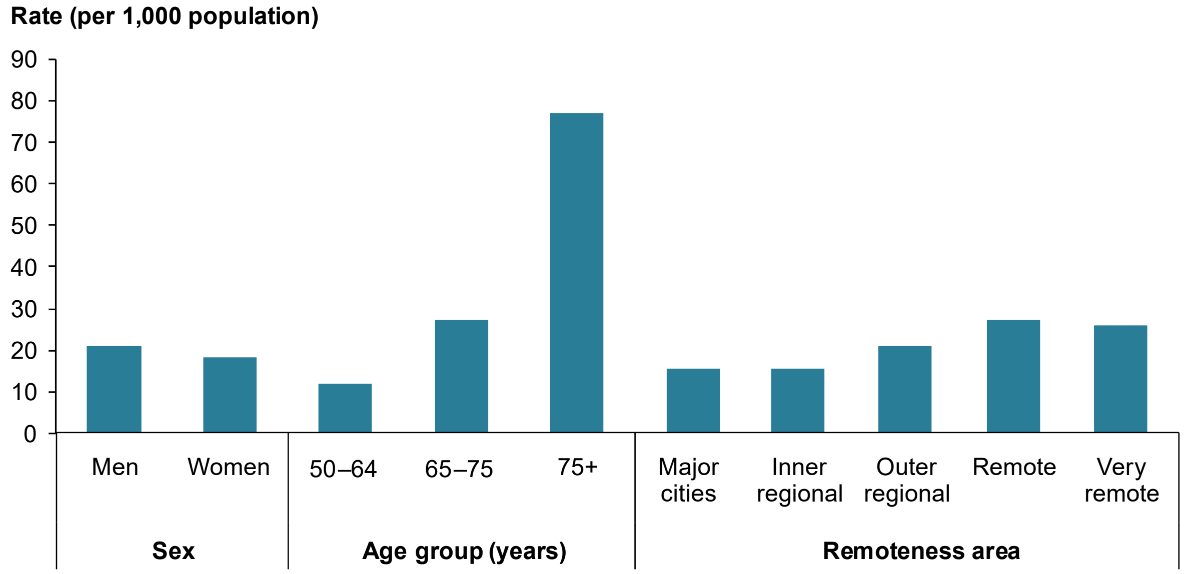
3.6 Leading causes of death

Deaths data are available from the AIHW National Mortality Database (see Appendix A). The quality of Indigenous identification is considered adequate for 5 jurisdictions—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.

In these 5 jurisdictions combined, over the 5 year period 2012–2016, there were 8,909 registered deaths of Indigenous Australians aged 50 and over—corresponding to a rate of 20 deaths per 1,000 population. Among Indigenous Australians aged 50 and over, the death rate:

- was slightly higher for men than women—21 and 18 per 1,000 population
- increased with age—from 12 per 1,000 population among those aged 50–64 to 77 per 1,000 among those aged 75 and over
- was lowest for those in *Major cities* (15 per 1,000 population) and *Inner regional* areas (16 per 1,000) and highest in *Remote* areas (27 per 1,000) (Figure 3.26).

Figure 3.26: Mortality rate among Indigenous Australians aged 50 and over, by remoteness, age and sex, 2012–2016



Notes

1. Data for this figure and notes about the analysis are shown in Table S3.43.

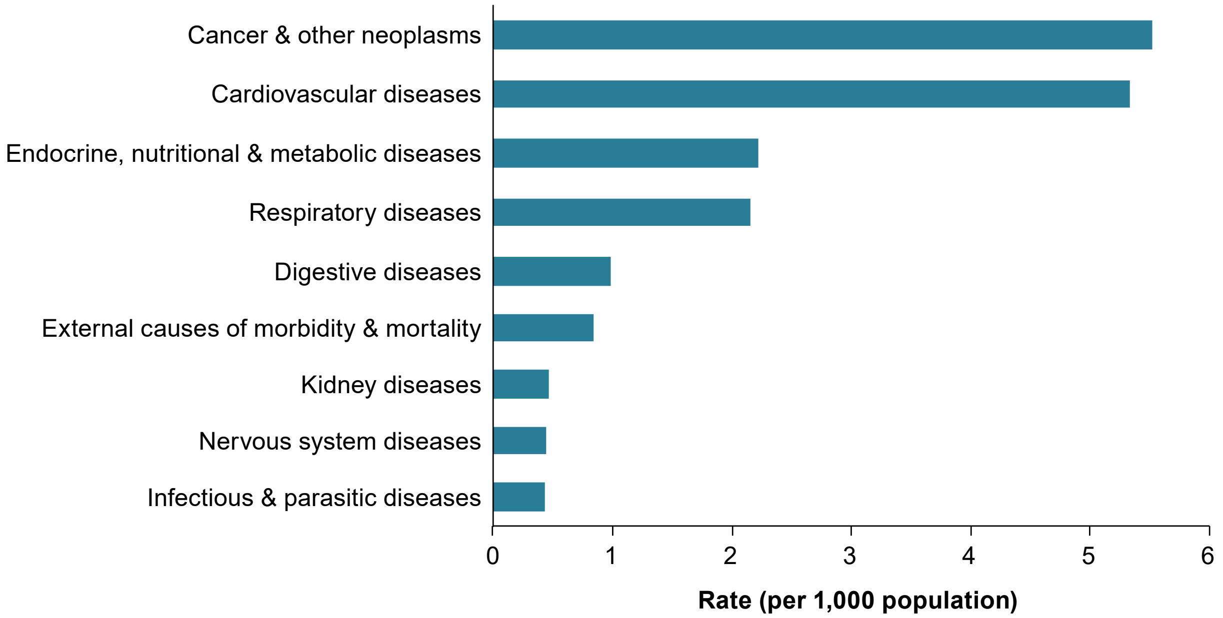
2. Data are reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined.

Source: AIHW analysis of National Mortality Database.

During the 5-year period 2012–2016, in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined, the leading broad causes of death for Indigenous Australians aged 50 and over were:

- neoplasms (cancers and benign neoplasms)—nearly 2,500 deaths, or a rate of 5.5 deaths per 1,000 population
- cardiovascular diseases—around 2,400 deaths, or a rate of 5.3 deaths per 1,000 population
- endocrine, nutritional and metabolic diseases—around 1,000 deaths, or a rate of 2.2 per 1,000 population
- respiratory diseases—nearly 1,000 deaths, also a rate of 2.2 per 1,000 population, after rounding (Figure 3.27).

Figure 3.27: Causes of death among Indigenous Australians aged 50 and over, 2012–2016



Notes

1. Data for this figure and notes about the analysis are shown in Table S3.43.
2. Data are reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined.

Source: AIHW analysis of National Mortality Database.

4

Social and emotional wellbeing

Social and emotional wellbeing is a holistic concept that results from a network of relationships between individuals, family, kin and community. For Aboriginal and Torres Strait Islander people, it also recognises the importance of connection to land, culture, spirituality and ancestry (PM&C 2017).

Declines in health and functioning, as well as mental disorders (such as depression), cognitive impairment and social isolation are some of the risk factors for abuse of older people (WHO 2015) (see Box 4.1).

Box 4.1: What is social and emotional wellbeing?

Social and emotional wellbeing includes mental health, but also considers other factors such as connections to culture, country or land, family, community and spirituality (Gee et al. 2014); (Parker & Milroy 2014). It encompasses not just the wellbeing of the individual, but also 'the social, emotional and cultural wellbeing of the whole community' (Day & Francisco 2013); (Gee et al. 2014:55–68).

It also seeks to recognise Aboriginal and Torres Strait Islander Australians' particular experiences of grief and trauma through a history of colonisation, separation from family and loss of land and culture (AIHW 2009).

This chapter presents information on the following aspects of social and emotional wellbeing: cultural and social, mental health, mental health-related service use, mental health related deaths and potential negative impacts on wellbeing.

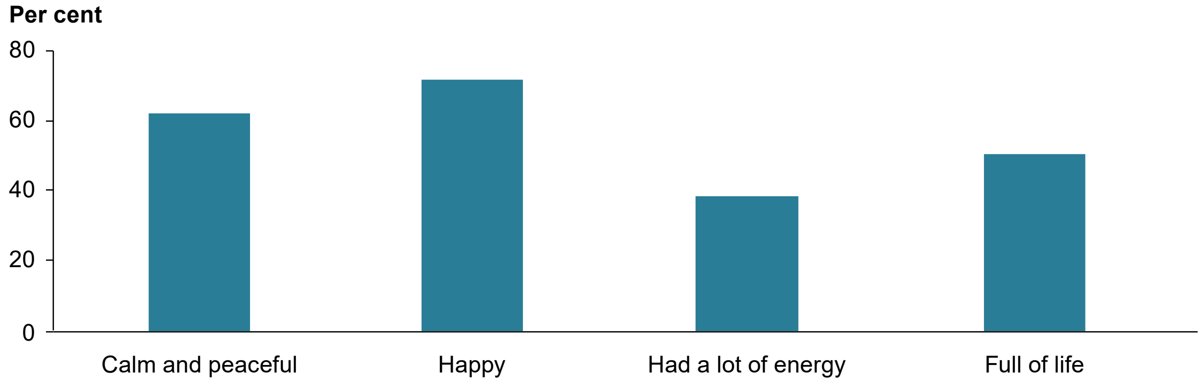
4.1 Cultural and social wellbeing

There are limited nationally comparable data on measures of cultural, spiritual and social wellbeing of older Indigenous Australians. This section focuses on a selection of self-reported data available from the ABS 2014–15 NATSISS for those aged 50 and over.

4.1.1 Positive wellbeing

The 2014–15 NATSISS asked respondents a series of questions on how they felt during the previous 4 weeks. In 2014–15, among Indigenous Australians aged 50 and over, the most common feeling reported all or most of the time was happiness (72%) (Figure 4.1).

Figure 4.1: Proportion of Indigenous Australians aged 50 and over reporting selected feelings 'all or most of the time' during the previous 4 weeks, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S4.1.

Source: AIHW analysis of ABS 2016c.

4.1.2 Connection to culture

The 2014–15 NATSISS included some questions of respondents on self-reported connection to culture:

- whether an Australian Indigenous language was spoken
- whether they identified with a clan, tribal or language group
- whether they recognised their homelands/traditional country
- whether they have been involved in selected cultural events, ceremonies or organisations in the last 12 months.

Further analysis of connection to culture data is included in Section 2.5 of this report.

The 2014–15 NATSISS also collected information on language spoken. Among Indigenous Australians aged 50 and over:

- 19% reported speaking an Australian Indigenous language—with a higher proportion in remote areas (51%) than in non-remote areas (10%)
- of those reporting their main language at home as an Australian Indigenous language, 39% stated they had a difficulty communicating with English speakers (Table S4.2).

4.2 Mental health and wellbeing

This section presents a range of mental health-related data. The terms 'mental illness' and 'mental disorder' can be used to describe a wide spectrum of mental health and behavioural disorders. These disorders, which can vary in both duration and severity, may interfere with an individual's cognitive, social and emotional abilities.

In the data presented across this report, the definitions and methods used to identify mental health-related conditions and events may vary, reflecting the availability of data and nature of different data collections. In general, for this report, the following have been considered mental health-related conditions:

- mental health conditions and substance use disorders—for example, bipolar affective disorder, anxiety, schizophrenia, and alcohol use disorders

- self-inflicted injuries and suicide—although there is no single cause or stressor that is sufficient to explain either fatal or non-fatal behaviour, not all older people who die by suicide have a diagnosable mental disorder at the time of death (AIHW 2015)
- dementia—although this can be categorised as a neurological disorder, it is reported within this section on mental health-related conditions as it is a common condition with symptoms that can have a negative impact on social and emotional wellbeing.

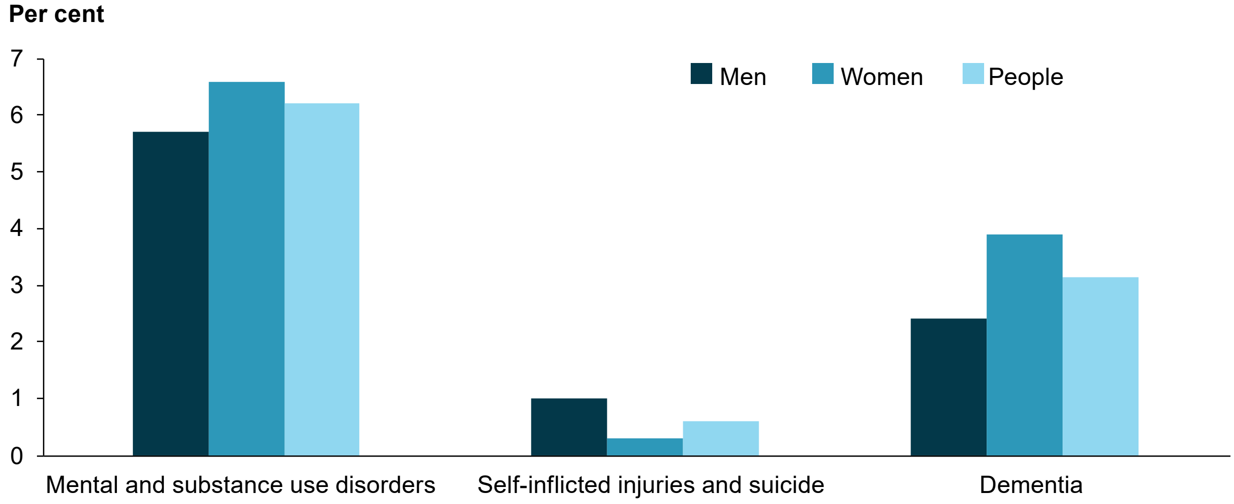
Information on specific inclusions for each analysis are available in the supplementary tables.

4.2.1 Mental health-related burden of disease

Burden of disease analysis is a way to measure the combined fatal and non-fatal impacts of diseases and injuries on a population—see (AIHW 2016a). It combines estimates of years of life lost due to premature death (YLL) and years lived in ill health or with disability (YLD) to count the total years of healthy life lost from disease and injury (disability-adjusted life years, or DALYs) (Box 3.4).

In 2011, among Indigenous Australians aged 50 and over, non-fatal burden (particularly dementia and mental and substance use disorders) contributed the majority of mental heath-related burden of disease (Figure 4.2).

Figure 4.2: Proportion of total burden of disease by selected causes among Indigenous Australians aged 50 and over, 2011[(a)]



(a) Rates are calculated using ABS population estimates based on the 2011 Census.

Notes

1. Data for this figure and notes about the analysis are shown in Table S4.3.
2. See AIHW 2016b for further information about the ABDS and the methods used.

Source: AIHW analysis of the ABDS Database 2011.

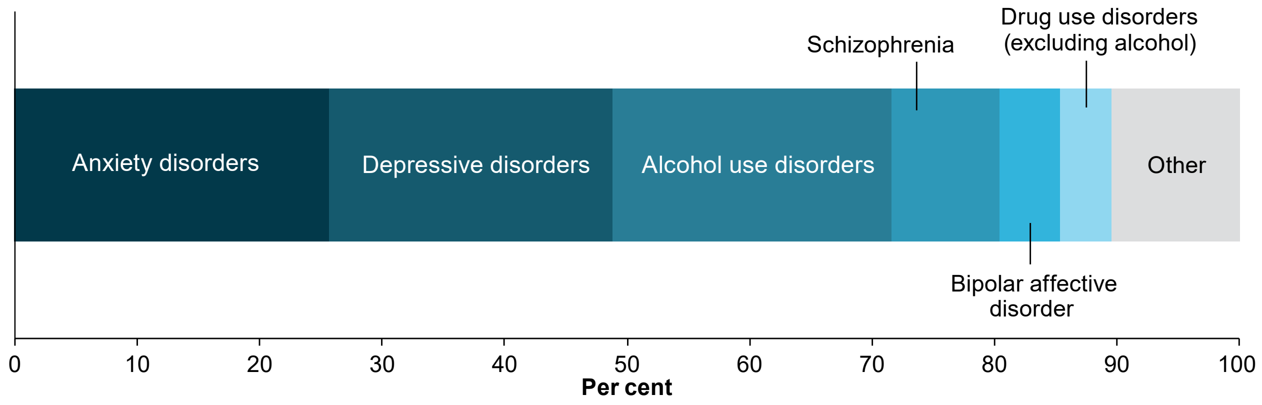
4.2.2 Mental and substance use disorders

Based on the Australian Burden of Disease Study (ABDS) 2011, among Indigenous Australians aged 50 and over, there were an estimated 4,076 years of healthy life lost (fatal and non-fatal combined; DALYs) due to mental and substance use disorders. This represents 6.2% of the total burden of all disease for those aged 50 and over (66,141 DALYs).

Among these 4,076 DALYs due to mental and substance use disorders:

- 26% (1,045 DALYs) were attributed to anxiety disorders
- 23% (947 DALYs) were due to or depressive disorders
- 23% (926 DALYs) were attributed to alcohol use disorders (Figure 4.3).

Figure 4.3: Mental and substance use disorders burden (DALYs) for Indigenous Australians aged 50 and over, by disease: proportion of disease group total, 2011



Note: Data for this figure and notes about the analysis are shown in Table S4.4.

Source: AIHW analysis of the Australian Burden of Disease Study, 2011.

In 2011, among Indigenous Australians aged 50 and over:

- there were 46 years of healthy life lost due to mental and substance use disorders per 1,000 population
- 86% of the burden due to mental and substance use disorders was due to non-fatal burden (years lived in ill health or with disability), with the remaining 14% due to fatal burden (premature death)
- the rate of non-fatal burden due to mental and substance use disorders was slightly higher for women than men (41 compared with 39 years of life lost per 1,000 population), while the rate of fatal burden was higher for men (8.4 compared with 4.8 years of life lived in ill health or with disability per 1,000 population)
- overall, the rate of disease burden (fatal and non-fatal combined) due to mental and substance use disorders was slightly higher for men than women—47 compared with 45 healthy years of life lost per 1,000 population
- the proportion of total disease burden due to mental and substance use disorders was higher among those aged 50–64 than for those aged 65 and over—8.7% compared with 2.0% (tables S4.4, S4.5).

4.2.3 Self-inflicted injuries and suicide

Based on the 2011 ABDS, among Indigenous Australians aged 50 and over the total disease burden was 66,141 DALYs—with an estimated 0.6% (427 years of healthy life) lost due to self-inflicted injuries and suicide. Considered as a population rate, among Indigenous Australians aged 50 and over in 2011:

- self-inflicted injuries and suicide caused an estimated 4.8 years of healthy life lost per 1,000 population
- those aged 50–64 had a higher rate of burden due to self-inflicted injuries and suicide than those aged 65 and over—5.5 compared with 3.0 per 1,000 population
- the rate of burden due to self-inflicted injuries and suicide was higher for men than for women—7.8 and 2.2 per 1,000 population (tables S4.3, S4.5).

4.2.4 Dementia

Dementia is a term describing a syndrome associated with more than 100 different diseases that are categorised as neurological disorders.

In the 2011 ABDS, dementia was included in the neurological conditions group. In 2011, among Indigenous Australians aged 50 and over:

- 3.1% of the total disease burden was due to dementia
- dementia caused the loss of 23 years of healthy life per 1,000 population (Table S4.5).

In contrast to the pattern seen for mental and substance use disorders and self-inflicted injuries and suicide, the burden due to dementia was higher among those aged 65 and over than for those aged 50–64 (Table S4.5). The higher burden among those aged 65 and over reflects the higher prevalence of dementia at older ages. See Section 3.5 for additional information on dementia.

4.3 Mental health service use

Mental health services can be provided in a variety of settings, including in:

- community settings: for example, care provided by general practitioners, as well as specialised mental health care provided in community and hospital-based outpatient care settings
- residential settings: residential mental health care services that provide specialised mental health care on an overnight basis in a domestic-like environment
- hospital settings: mental health-related care provided within emergency departments, as well as in an admitted patient care setting.

This section provides information on the use of health services for mental health and wellbeing, based on self-reported survey data. Information is then provided on hospital service use (both admitted patient hospitalisations and emergency department presentations), followed by information on government-funded and -operated specialised community mental health care provided by specialised community mental health care services. Due to small numbers of Indigenous Australian clients aged 50 and over, information on specialised residential mental health care is not included in this report.

4.3.1 Self-reported service use

In the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), respondents were asked if they had ever accessed or used health services for a mental health condition, and whether they had received any counselling for their own health in the previous

12 months. In 2012–13 among Indigenous Australians aged 50 and over, 24% had accessed or used health services for a mental health condition at some time in the past and 13% had been to a counselling service in the previous 12 months (Table S4.6).

The 2012–13 AATSIHS also collected data on health service use among those who experienced high/very high levels of psychological distress (based on the Kessler Psychological Distress Scale, also known as the Kessler-5 scale). Among Indigenous Australians aged 50 and over who reported high/very high levels of psychological distress in the 4 weeks prior to interview:

- 31% (7,400) said they had seen a doctor or other health professional about their feelings in the last 4 weeks
- 43% (10,300) said they had days where they were unable to work or carry out normal activities due to feelings in the last 4 weeks—of these people, about half (53%) had seen a doctor or other health professional about their feelings in the last 4 weeks (Table S4.7).

4.3.2 Hospital service use

This section provides an overview of mental health-related hospital service use among Indigenous Australians aged 50 and over, both as emergency department presentations and admitted patient care. There will be some overlap in people's receiving assistance in admitted patient care hospitalisations and emergency department presentations—for example, an individual admitted to hospital after presenting to the emergency department.

Emergency department presentations

Information on emergency department presentations for mental health-related conditions are available from the National Non-admitted Patient Emergency Department Care Database. For detailed information on data quality, see Appendix A.

Data in this section relate to emergency department presentations with a principal diagnosis falling into the category of 'mental and behavioural disorders' (see Table S4.8 for the diagnosis codes included in the analysis). Principal diagnosis indicates the main reason for the emergency department presentation.

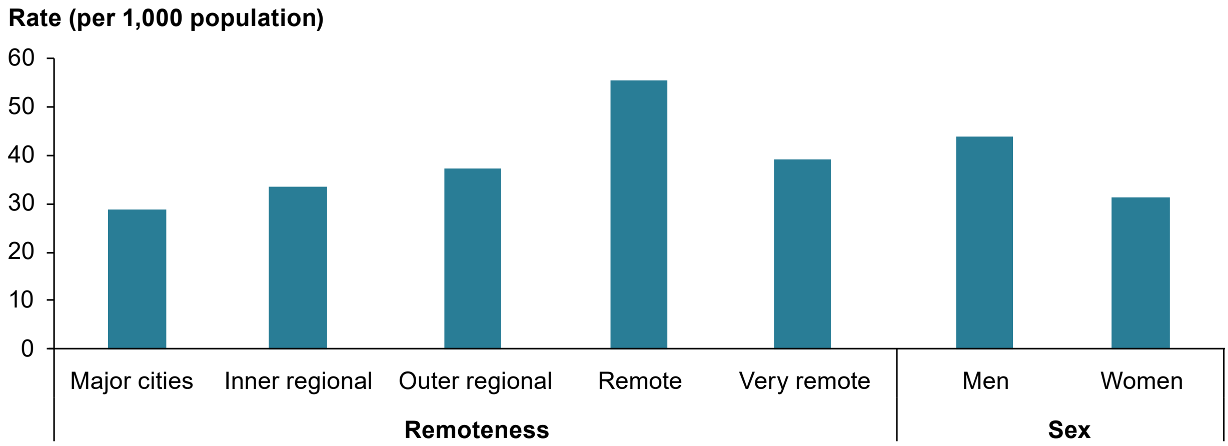
In the 2-year period 2015–17:

- there were nearly 8,400 emergency department presentations for mental and behavioural disorders among Indigenous Australians aged 50 and over—representing 6.3% of presentations for mental and behavioural disorders among the total Australian population aged 50 and over (Table S1.1)
- among Indigenous Australians aged 50 and over, there were 37 emergency department presentations for mental and behavioural disorders per 1,000 population (Table S4.9).

In 2015–17, among Indigenous Australians aged 50 and over, the rate of emergency department presentations for mental and behavioural disorders were:

- higher for men than women—44 compared with 31 per 1,000 population
- highest for people living in *Remote* areas (56 per 1,000 population) and lowest for those living in *Major cities* (29 per 1,000) (Figure 4.4).

Figure 4.4: Emergency department presentations for mental and behavioural disorders among Indigenous Australians aged 50 and over, by remoteness and sex, 2015–17



Notes

1. Principal diagnoses were reported using various ICD-10-AM editions, ICD-9-CM, and SNOMED CT-AU, and were mapped to ICD-10-AM 3-character diagnosis codes (see Table S4.8 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S4.9.

Source: AIHW analysis of the National Non-Admitted Patient Emergency Department Care Database.

Admitted patient care

Drawing on data from the National Hospital Morbidity Database, this section presents information on episodes of admitted patient care—referred to as 'hospitalisations' in this report (see Box 3.2 and Appendix A). Data include both public and private hospitals.

Overall mental health-related hospitalisations

Information reported on overall hospitalisation rates covers those instances with a mental health-related principal diagnosis (see Table S4.8 for diagnosis codes included in analysis).

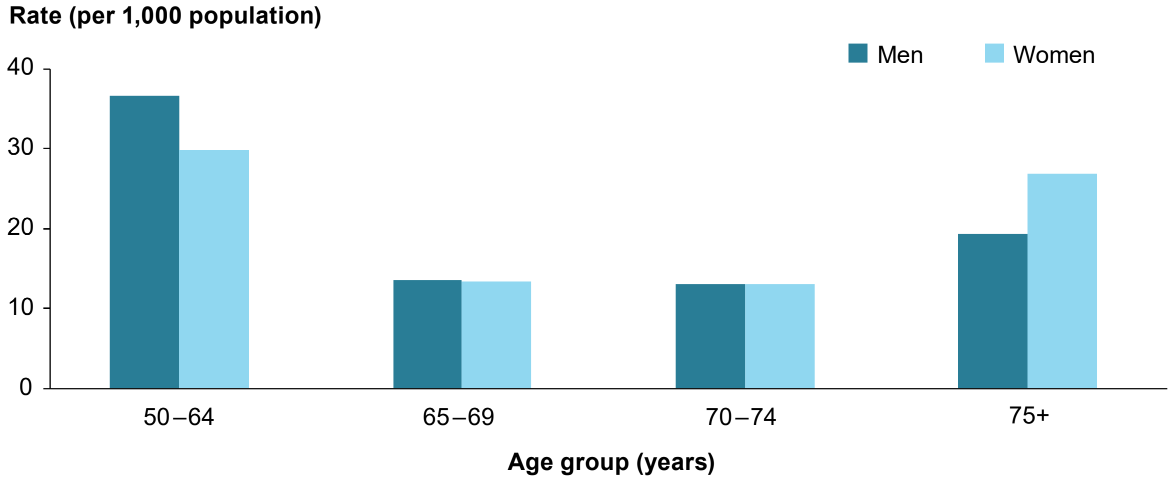
Over the 2-year period 2014–16:

- among Indigenous Australians aged 50 and over there were around 6,100 mental health-related hospitalisations—representing 1.9% of all mental health-related hospitalisations (Table S1.1)
- considered as a population rate among Indigenous Australians aged 50 and over, there were 29 mental health-related hospitalisations per 1,000 population (Table S4.10).

Over 2014–16, among Indigenous Australians aged 50 and over, the rate of mental health-related hospitalisations were:

- slightly higher for men than women—31 compared with 26 per 1,000 population (Table S4.10)
- highest in *Major cities* (33 per 1,000 population), followed by *Remote* areas (32 per 1,000), *Outer regional* areas (25 per 1,000), *Very remote* areas (24 per 1,000) and *Inner regional* areas (21 per 1,000) (Table S4.11)
- highest among those aged 50–64, followed by those aged 75 and over (33 and 24 per 1,000 population) (Figure 4.5).

Figure 4.5: Rate of mental health-related hospitalisations among Indigenous Australians aged 50 and over, by age group and sex, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S4.8 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S4.10.

Source: AIHW analysis of the National Hospital Morbidity Database.

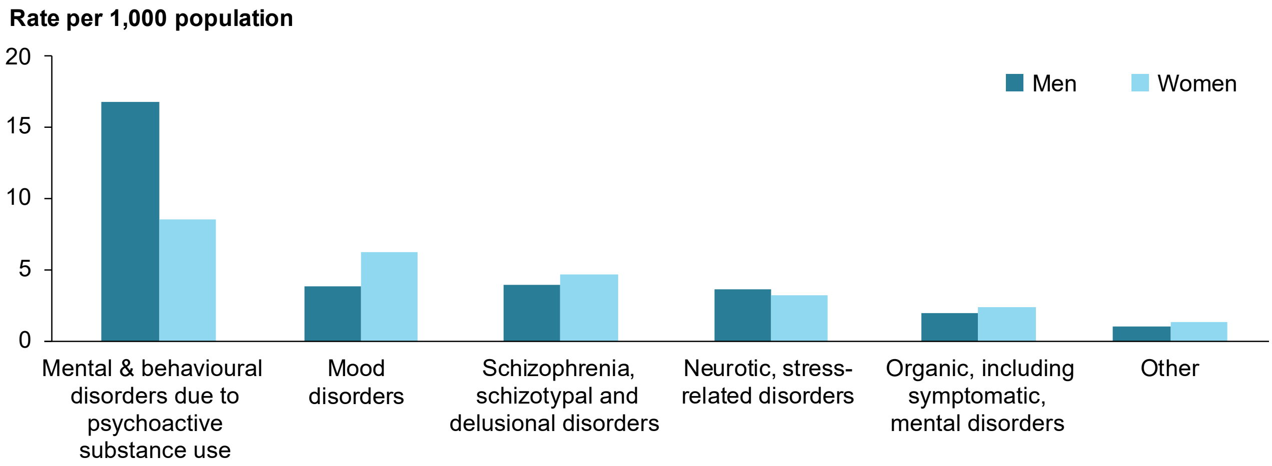
Types of mental health-related hospitalisations

Over the 2-year period 2014–16, among total mental health-related hospitalisations for Indigenous Australians aged 50 and over:

- 43% (around 2,700 hospitalisations) were for mental and behavioural disorders due to psychoactive substance use—this was largely disorders due to the use of alcohol (around 2,400 hospitalisations)
- 18% were due to mood disorders (for example, depression)
- 15% were due to schizophrenia, schizotypal and delusional disorder
- 12% were due to neurotic, stress-related disorders (for example, obsessive compulsive disorder) (Table S4.12).

For both Indigenous Australian men and women aged 50 and over, mental and behavioural disorders due to psychoactive substance use were the most common reason for mental health-related hospitalisations (Figure 4.6).

Figure 4.6: Rate of mental health-related hospitalisations among Indigenous Australians aged 50 and over, by type of condition and sex, 2014–16



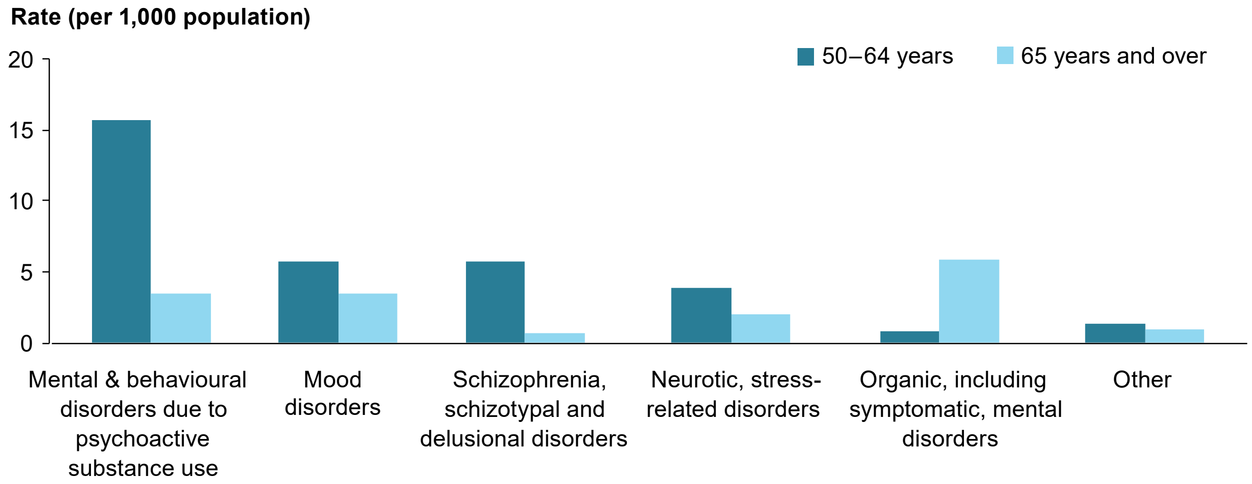
Notes

1. Data are based on principal diagnosis (see Table S4.12 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S4.12.

Source: AIHW analysis of National Hospital Morbidity Database.

In 2014–16, among Indigenous Australians, the rates of hospitalisations for mental and behavioural disorders was higher among those aged 50–64 than among those aged 65 and over for most broad groups of conditions (Figure 4.7). An exception was the rate of hospitalisations due to organic (including symptomatic) mental disorders, which was higher among those aged 65 and over than among the younger age groups; this reflects higher rates of hospitalisation due to dementia and delirium in older age ranges (see Section 3.5.2 for information on hospitalisations due to dementia).

Figure 4.7: Rate of mental health-related hospitalisations among Indigenous Australians aged 50 and over, by type of condition and age group, 2014–16



Notes

1. Data are based on principal diagnosis (see Table S4.8 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S4.8.

Source: AIHW analysis of the National Hospital Morbidity Database.

Hospitalisations due to self-harm

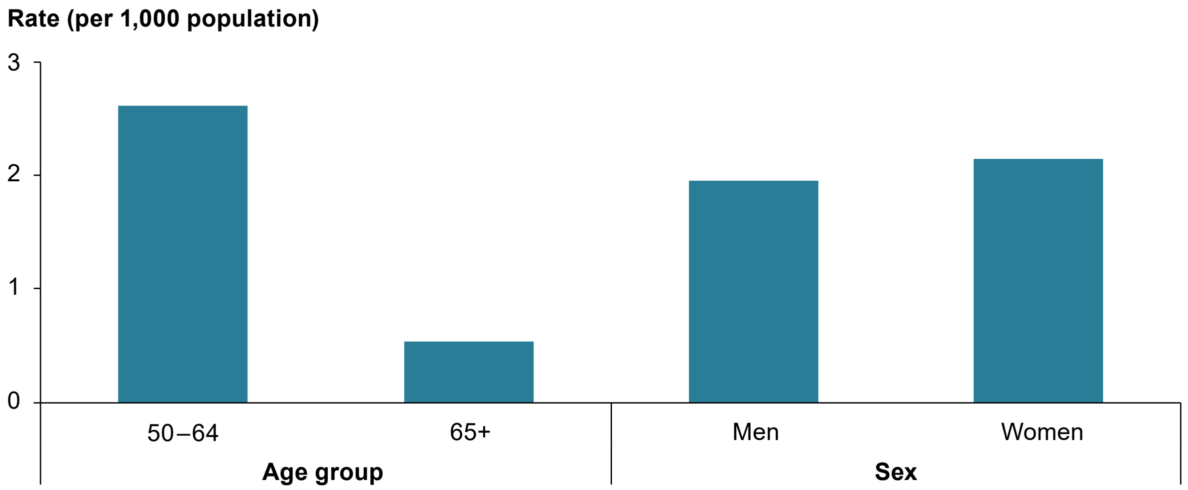
Data in this section relate to admitted patient hospitalisations with a principal diagnosis of injury and poisoning and a first reported external cause of self-harm. It should be noted that many acts of intentional self-harm do not result in admission to hospital.

In the 2-year period 2014–16, among Indigenous Australians aged 50 and over there were:

- 440 hospitalisations with a principal diagnosis related to self-harm—representing 3.8% of hospitalisations with this diagnosis among all Australians aged 50 and over (Table S1.1)
- 2 hospitalisations per 1,000 population due to self-harm (Table S4.13).

Among Indigenous Australians aged 50 and over in 2014–16, the rate of hospitalisation for self-harm was similar for men and women, but higher in the 50–64 age group (Figure 4.8).

Figure 4.8: Hospitalisations from self-harm among Indigenous Australians aged 50 and over by age group and sex, 2014–16



Notes

1. Data are based on principal diagnosis and first reported external cause (see Table S4.8 for ICD-10-AM codes).
2. Data for this figure and notes about the analysis are shown in Table S4.13.

Source: AIHW National Hospital Morbidity Database.

4.3.3 Specialised mental health treatment

Mental illness can be treated in community and hospital-based outpatient care settings. Collectively, these services are referred to as community mental care. Data from the National Community Mental Health Care Database (NCMHCD) are used to describe the care provided by these services (see Box 4.2, Table S4.14 and Appendix A).

Box 4.2: National Community Mental Health Care Database—key terms

Community mental health care refers to government-funded and -operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

Service contacts are defined as the provision of a clinically significant service by a specialised mental health service provider for patient/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services (where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question). Any one patient can have 1 or more service contacts over the relevant financial year. Service contacts can include face-to-face communication, telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.

In data from the NCMHCD, it is also possible to count individual patients. The patient count is limited to those people registered with state and territory community mental health care systems and who have a unique person identifier—that is, a person has 1 identifier across all individual service providers within a state or territory. However, the vast majority of contacts are for registered clients; in 2015–16, 96.5% of all contacts were for registered clients (AIHW 2018e).

The NCMHCD includes information on community mental health service contacts as well as patients (with the latter removing double-counting where there are multiple service contacts for the same person in the period) (see Box 4.2).

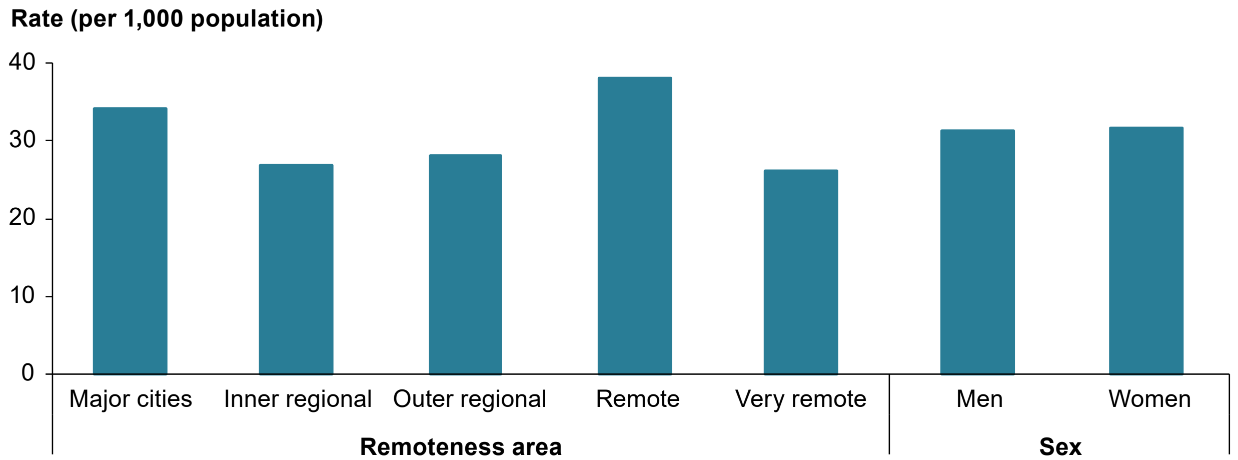
In 2015–16, there were nearly 78,900 community mental health service contacts provided to around 3,500 Indigenous Australian patients aged 50 and over—corresponding to about 23 contacts per patient. In 2015–16:

- 3.7% of all community mental health service patients aged 50 and over were Indigenous Australians (Table S1.1)
- 3.1% of the Indigenous Australian population aged 50 and over received community mental health services.

In 2015–16, among Indigenous Australian clients aged 50 and over, the most commonly reported mental-health related principal diagnosis was schizophrenia (12% of clients), followed by depressive episode (9%) (Table S4.15).

The use of community mental health services was broadly similar for women and men (32 and 31 clients per 1,000 population respectively) and varied by remoteness (Figure 4.9).

Figure 4.9: Indigenous community mental health service clients aged 50 and over, by remoteness and sex, 2015–16



Note: Data for this figure and notes about the analysis are shown in Table S4.16.

Source: NCMHCD.

In addition to these services, the Australian Government also funds organisations to provide mental health and substance misuse services primarily to Indigenous Australians (AIHW 2018c). These services are reported to the Online Services Report (OSR) data collection. In 2016–17, there were 80 organisations providing social and emotional wellbeing services, with around 16,300 clients reporting to this collection. However, information on how many of these clients are aged 50 and over is not available.

4.4 Mental health-related deaths

Information on suicide and mental health-related deaths is available from the National Mortality Database (see Appendix A). Mortality data are presented for the 5 jurisdictions with adequate Indigenous identification—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.

4.4.1 Deaths from suicide

Over the 5-year period, 2012–2016, across New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined:

- there were 59 deaths from suicide among Indigenous Australians aged 50 and over—representing 1.5% of suicides among the total Australian population aged 50 and over (Table S1.1)
- there were 13 Indigenous deaths from suicide per 100,000 population of Indigenous Australians aged 50 and over (Table S4.17).

In 2012–2016, among Indigenous Australians aged 50 over in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined, the rate of suicides were:

- higher for men than women (22 compared with 5 deaths per 100,000 population)
- higher for those aged 50–64 (15 per 100,000 population), than for those aged 65 and over (8 per 100,000).

4.4.2 Overall mental health-related deaths

Data in this section relate to deaths where there was an underlying cause of death related to mental health (see Table S4.18 for cause of death codes included in this analysis). Examples include:

- organic, including symptomatic, mental disorders—this category includes a range of mental disorders shown to be caused by a brain disease or injury, or another condition resulting in brain dysfunction (WHO 2016); examples include dementia and delirium
- conditions due to psychoactive substance use—for example, psychotic disorder due to drug use (see Chapter 7 for further information on alcohol and substance use)
- other mental health-related conditions—for example, schizophrenia and mood (affective) disorders.

Over the 5-year period 2012–2016, in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined:

- there were 361 mental health-related deaths among Indigenous Australians aged 50 and over—representing 0.8% of all mental health-related deaths among the total Australian population aged 50 and over (Table S1.1)
- there were around 80 mental health-related deaths per 100,000 population among Indigenous Australians aged 50 and over (Table S4.19).

Across the 5-year period, 2012–2016, in the combined jurisdictions, the rate of mental health-related deaths among Indigenous Australians aged 50 and over were:

- higher for women than men—88 compared with 71 per 100,000 population
- considerably higher among those aged 75 and over (727 per 100,000 population) than in younger age groups (rates ranging from 17 per 100,000 for those aged 50–64 to 118 per 100,000 for those aged 70–74) (Table S4.19).

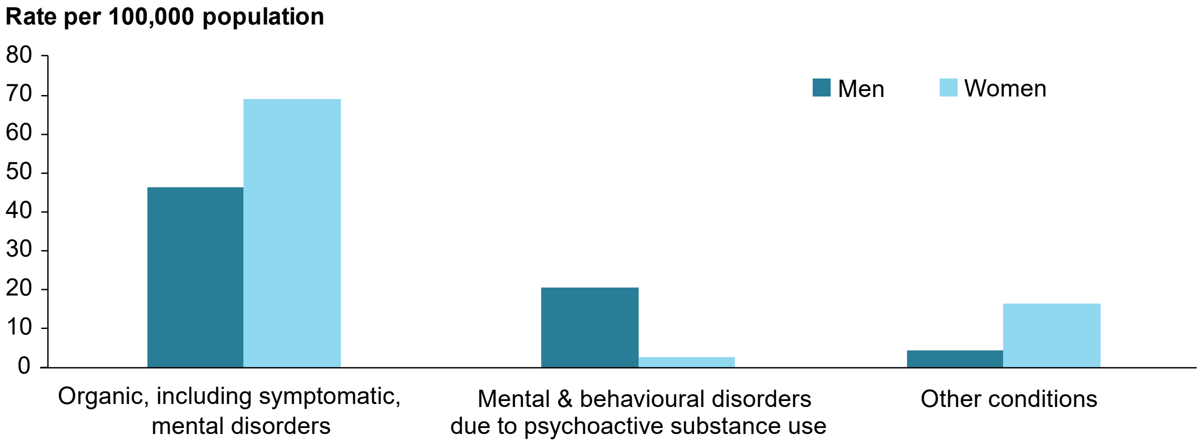
The higher rate of mental health-related deaths in the older age groups partly reflects the higher rates of deaths from dementia.

Among Indigenous Australians aged 50 and over in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined, across broad categories of mental health-related deaths over the 5-year period 2012–2016:

- 73% were due to organic (including symptomatic) mental disorders
- 14% were due to conditions arising from psychoactive substance use
- 13% were due to other mental health-related conditions (Table S4.18).

For both Indigenous Australian men and women aged 50 and over, mental health related deaths were most commonly caused by organic (including symptomatic) mental disorders. The rate of deaths from organic mental disorders was higher for women than for men, while the rate of deaths from disorders due to psychoactive substance use was higher for men than for women (Figure 4.10).

Figure 4.10: Rate of mental health-related deaths among Indigenous Australians aged 50 and over, by type of disorder and sex, 2012–2016



Notes

1. Data are based on underlying cause of death (see Table S4.18 for ICD-10 codes).
2. Data for this figure and notes about the analysis are shown in Table S4.18.
3. Data are reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined.

Source: AIHW analysis of National Mortality Database.

4.5 Negative impacts on social and emotional wellbeing

To respond meaningfully to the specific vulnerabilities of Aboriginal and Torres Strait Islander people requires an understanding of the continuing legacy of colonisation and intergenerational trauma within a cross cultural context, and adopting a multidimensional approach to health and wellbeing (Healing Foundation 2018). In particular, it is important to recognise that the extent to which older Indigenous Australians may be willing to report instances of abuse or to seek help from services may be influenced by the negative consequences of history and ongoing experiences of racism, discrimination and disadvantage (Hirschfield & Bowers 1997, Victorian Government 2015).

4.5.1 Historical context

The historical impact of colonisation in Australia resulted in a loss of Indigenous culture and languages, affecting Indigenous people's emotional and social wellbeing (Dudgeon & Walker 2015). The socioeconomic disadvantages that Indigenous Australians experience are interrelated not only with this destruction of traditional language and cultural structure, but also with loss of land, removal of children, intergenerational trauma and relatively high rates of incarceration (Zubrick et al. 2014). Discrimination has also had psychological effects, with long-term consequences that are often transgenerational (Waterworth et al. 2015).

Indigenous Australians have shown resilience, persistence and adaptation in the face of colonisation and adversity; nonetheless these experiences have had profoundly negative and long-lasting impacts on their wellbeing (Dudgeon & Walker 2015, Zubrick et al. 2014). Racism and discrimination cause psychological distress and increase the risk of mental health issues—including depression, and risky behaviours such as substance use (Ferdinand et al. 2012, Priest et al. 2011). The 2014–15 NATSISS asked respondents whether they had been treated unfairly due to being an Aboriginal or Torres Strait

Islander Australian. In 2014–15, among Indigenous Australians aged 50 and over:

- 29% (an estimated 27,500) had experienced unfair treatment in the last 12 months due to being Indigenous
- 13% (an estimated 13,000) had avoided situations in the last 12 months as a result of past unfair treatment due to being Indigenous (Table S4.20).

4.5.2 The Stolen Generations

One of the most profound negative consequences of historical Australian Government policies was the removal of Indigenous children from their families. This practice occurred as a systemic part of government policies in the 20th century and is now referred to as The Stolen Generations. A 2018 AIHW analysis of the ABS 2014–15 NATSISS estimated that 13,800 people aged 50 and over in 2014–15 were removed from their families, representing 14% of all Indigenous Australians aged 50 and over (AIHW 2018g).

The 2018 AIHW analysis showed that those removed from their families—used as a proxy measure for The Stolen Generations—were significantly more likely to experience a range of adverse health, cultural and socioeconomic outcomes than Indigenous Australians who were not removed (Table S4.21). After accounting for other factors that could influence results, Indigenous Australians aged 50 and over who reported being removed from their family experienced higher odds of an adverse outcome in 10 of the 20 selected outcomes. Compared with the reference group, the proxy Stolen Generation aged 50 and over were:

- 2.8 times as likely to have government payments as their main income source
- 2.7 times as likely not to be the owner of a home
- 2.3 times as likely to have ever been formally charged by police
- 2.0 times as likely to have ever been incarcerated
- 2.0 times as likely not to have good health (measured using a composite index)
- 1.9 times as likely to be a current smoker.

4.5.3 Life stressors

In the 2014–15 NATSISS, Indigenous Australians self-reported on the types of stressors they had experienced during the previous 12 months. These included such events as personal illness or injury, death of a family member, job-related issues, relationship problems, and being a victim of violence or crime. In 2014–15, almost two-thirds (65%) of Indigenous Australians aged 50 and over were estimated to have experienced at least 1 stressor in the previous 12 months. Of those people:

- 46% experienced the death of a family member or close friend
- 29% experienced a serious illness
- 15% experienced mental illness
- 12% were not able to get a job
- 9% experienced alcohol-related problems (AIHW analysis of ABS 2016c).

5

Housing circumstances

Houses in good condition and with adequate space have been linked to positive effects on Aboriginal and Torres Strait Islander family relationships, leading to fewer instances of domestic violence (SCRGSP 2016).

Cultural and social factors may influence appropriate household size; for example, Indigenous households often include kin who are elderly or in poor mental or physical health (McDonald 2011).

As older people experience increasing care needs, this may require renegotiation of roles and responsibilities within the family and across the generations. Family members may be interdependent on each other—for housing, emotional support and other assistance.

5.1 Housing situation

Housing tenure describes whether a dwelling is owned, rented, or occupied under some other arrangement. Data reported in this section on housing tenure are from the 2016 Census of Population and Housing. The data describe the tenure type of the dwelling in which Indigenous Australians aged 50 and over live, rather than the tenure type of each individual. Not all people in a household necessarily share in the costs and potential benefits of ownership/rental of a home (see Box 5.1 for housing tenure types defined in this section).

Box 5.1: About the housing tenure data in this section

For the analyses in this chapter using 2016 Census data, distinctions are made between the following tenure types.

Owned dwellings

This category includes:

- dwellings that are owned outright
- dwellings that are owned with a mortgage (includes homes being purchased under rent/buy scheme—that is, households that are both purchasing some equity in the dwelling and paying rent for the remainder).

Rented dwellings

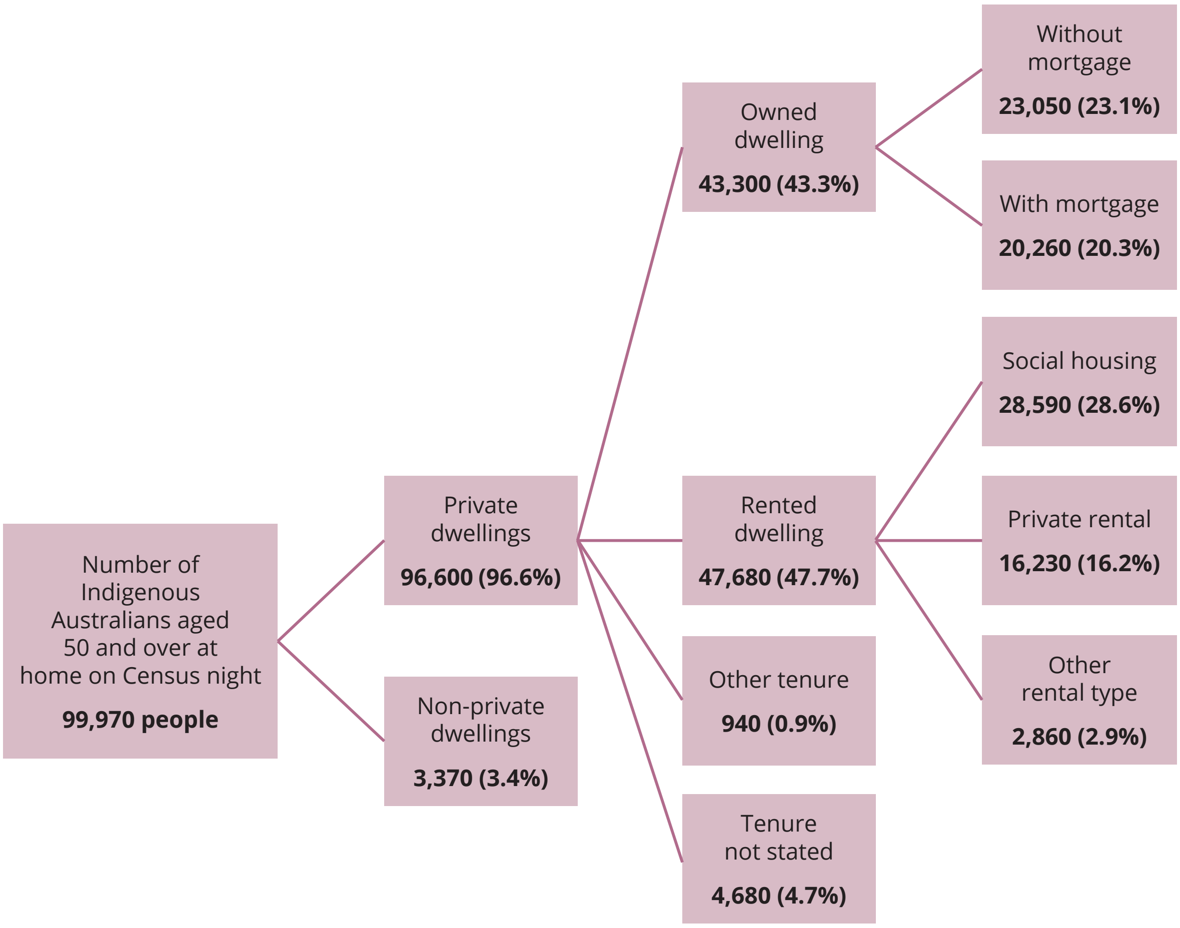
This category includes dwellings that are being rented. Further distinctions are made according to the type of landlord:

- **social housing**—dwellings being rented from a state or territory housing authority, or from a community housing provider (regardless of whether they are renting through a mainstream social housing program or Indigenous-specific program)
- **private rental**—dwellings being rented from a real estate agent, or from a person not in the same households (parent, other relative or other person)
- **other rentals**—dwellings being rented from other types of landlords (for example, through an employer or residential park) or where landlord type was not stated
- **other tenure type**—includes dwellings occupied under a life tenure scheme (that is, households or individuals who have a 'life tenure' contract to live in the dwelling but usually do not have any equity in the dwelling; a common arrangement in retirement villages).

In the 2016 Census, there were approximately 99,970 Indigenous Australians aged 50 and over who were at their usual address on Census night. Of these people:

- 97% (96,600) were living in private dwellings, with the majority of those living in a rented dwelling, followed by those living in an owned dwelling
- 3% (3,370 people) were living in non-private dwelling (Figure 5.1).

Figure 5.1: Indigenous Australians aged 50 and over, by dwelling type and housing tenure, 2016



Notes

1. Numbers shown are Census counts rounded to the nearest 10. For confidentiality reasons, the ABS randomly adjusts Census TableBuilder data; consequently, data in this figure may not sum to the total and may differ slightly from data published elsewhere.
2. Data for this figure and notes about the analysis are shown in Table S5.1.

Source: AIHW analysis of the 2016 Census of Population and Housing (ABS 2017a).

5.2 Housing quality

The NATSISS collects information on a range of structural issues in dwellings, relating to electricity or plumbing, major cracks in walls or floor, termites or rot, and foundation problems.

In 2014–15, based on self-report, 22% (an estimated 22,000) of Indigenous Australians aged 50 and over were living in a dwelling with major structural problems. The proportion of people living in a dwelling with structural problems was higher for women than for men (25% and 19%) and for those living in remote areas compared with non-remote areas (31% and 20%) (ABS 2016c). The NATSISS reports on a composite measure for people living in housing considered to be of an acceptable standard—a dwelling with no more than 2 major structural problems, and with working facilities for washing people, washing clothes or bedding, preparing food, and working sewerage facilities.

In 2014–15, among Indigenous Australians aged 50 and over, an estimated 81% lived in a house that met acceptable standards—more in non-remote than remote areas (83% and 74%) (Table S5.3).

5.3 Household overcrowding

The NATSISS reports on housing use based on the Canadian National Occupancy Standard for Housing Appropriateness—which determines bedroom requirements based on the people in a household, and on the age, sex and relationships of members. Those dwellings requiring at least 1 additional bedroom are considered overcrowded (ABS 2016e).

In 2014–15, 11% of Indigenous Australians aged 50 and over (an estimated 11,000 people) lived in an overcrowded dwelling—more in remote than non-remote areas (27% and 7%) (ABS 2016c).

5.4 Housing assistance

Housing assistance aims to relieve the pressures of housing costs and provide safe and secure housing for many low-income households, particularly the disadvantaged or vulnerable. Due to the multiple disadvantages that many Indigenous Australians face in the housing market, they are a priority group for many assistance services.

Housing assistance is generally provided through subsidised rental housing (social housing), financial payments (such as Commonwealth Rent Assistance, or CRA), other support for private renters, and through specialist homelessness services (SHS). This section provides information on assistance received through CRA and social housing (see Box 5.2).

The social housing data are administrative data from the AIHW National Housing Assistance Data Repository and the Australian Government Housing Data Set (via the Department of Social Services) (see Appendix A).

Box 5.2: What types of housing assistance are available?

Housing assistance is provided through the provision of social housing, financial assistance and through specialist homelessness services.

Commonwealth Rent Assistance (CRA) is a non-taxable income supplement funded by the Australian Government. It is payable to people who rent in the private housing market and receive an income support payment, or more than the base rate of Family Tax Benefit Part A, and pay rent above the minimum threshold. The minimum threshold and maximum rates vary according to the composition of an income unit's household, including the number of children. CRA may also be payable to people living in mainstream community housing or Indigenous community housing (ICH) and, in some jurisdictions, to people living in state owned and managed Indigenous housing.

Social housing is rental housing provided by not-for-profit, non-government or government to eligible households, with rents below market rates (based on a tenant's income). There are 4 main types: 2 are 'mainstream' programs available to all Australians (public housing and community housing), and two are aimed at Indigenous Australians (state owned and managed Indigenous housing, and Indigenous community housing).

All states and territories have public housing programs, and 5 jurisdictions—New South Wales, Queensland, South Australia, Tasmania and the Northern Territory—provide SOMIH programs. Data reported in this section do not include the Northern Territory as these were reported in the SOMIH collection for the first time after 30 June 2016.

5.4.1 Commonwealth Rent Assistance (CRA)

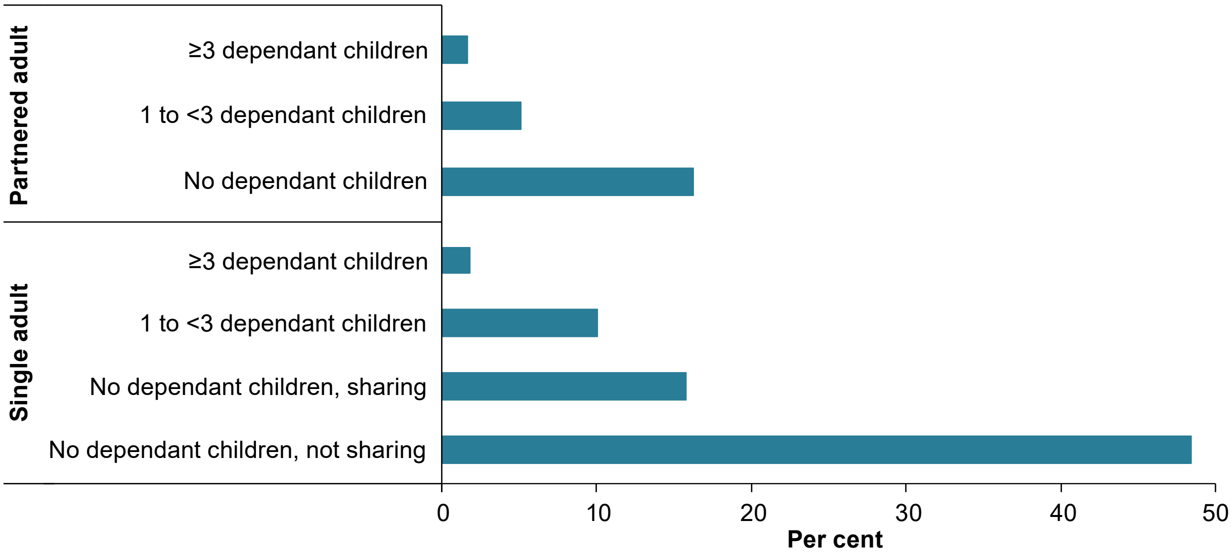
CRA is paid to 'income units'—an income unit can be a single person with or without dependant children, or a couple with or without dependant children. It is not identical to the concept of 'household' as used in the social housing administrative data, since unrelated adults living in one household, but not as a family, may each receive CRA payments.

Data in this section are reported for Indigenous Australians aged 50 and over who were part of an income unit receiving CRA as at 30 June 2017. Data are from the Australian Government Housing Data Set (see Appendix A).

As at 30 June 2017, around 17,600 Indigenous Australians aged 50 and over were living in an income unit that was receiving CRA—consisting of:

- 9,966 women (57%) and 7,648 men (43%)
- 5,599 living in *Major cities* (32%), 5,482 (31%) in *Inner regional* areas, 4,925 (28%) in *Outer regional* areas and 1,599 (9%) in *Remote* and *Very remote* areas combined
- 76% (13,409) were the sole adult in the income unit—including:
  - 11,314 who had no dependant children (64% of Indigenous Australian recipients aged 50 and over), and 2,095 with dependant children (12%)
- 24% (4,205) were a partnered income unit (Table S5.5).

Figure 5.2: Indigenous Australians aged 50 and over receiving CRA, by type of income unit, as at 30 June 2017



Notes

1. Data for this figure and notes about the analysis are shown in Table S5.5.
2. In this figure, 'sharing' refers to an accommodation arrangement where a single tenant with no dependent children has legal right to share a bathroom, kitchen or bedroom with someone else. A subset of those sharing their accommodation are also 'treated as sharers' under Sharer Provisions for Rent Assistance (see, http://guides.dss.gov.au/guide-social-security-law/3/8/1/100).
3. Excludes CRA recipients who were members of a couple but were separated due to illness or were temporarily separated (0.7% of tenants). These people are included in the denominator for the calculation of proportions.

Source: AIHW analysis of Department of Social Services, Australian Government Housing Data Set.

5.4.2 Social housing

Data on social housing presented in this section are from the AIHW National Housing Assistance Data Repository (see Appendix A). There are 4 main types of social housing programs in Australia (see Box 5.2):

- public rental housing
- stated owned and managed Indigenous housing (SOMIH)
- community housing
- Indigenous community housing (ICH).

As shown in Table 5.1, the availability of data by Indigenous status varies according to the type of program, as well as the counting unit—that is, whether the data counts people or households (the latter of which can consist of multiple people living together).

Table 5.1: Availability of Indigenous status information in main social housing programs, by program and counting unit, 30 June 2016 data

Counting unit	Public rental housing	SOMIH	Community housing	ICH
Tenants (people)	✓	✓	✗	✗
Households	✓	✓	✓	✗

✓ available

✗ not available

Note: This table relates to the availability of data by Indigenous status and does not indicate the quality or completeness of any such information.

Due to differences in the availability of data, the information that can be reported for each program in relation to older Indigenous Australians varies—see Box 5.3. The data presented in this chapter for public rental housing and SOMIH are not comparable to the data presented for community housing and ICH, and it is not possible to derive a total number of older Indigenous Australians aged 50 and over supported by at least one program.

Box 5.3: Reporting on the use of social housing programs by Indigenous Australians aged 50 and over

As the focus of this report is Indigenous Australians aged 50 and over, this section would ideally report on the number of Indigenous Australian tenants aged 50 and over, however, this is possible only for public housing and SOMIH.

For community housing, Indigenous status is collected for households, but not individual tenants (see Table 5.1). Consequently, it is possible to report the number of Indigenous Australian households (that is, households with at least 1 Indigenous Australian member) with a tenant aged 50 and over, but not possible to know whether that tenant is an Indigenous Australian.

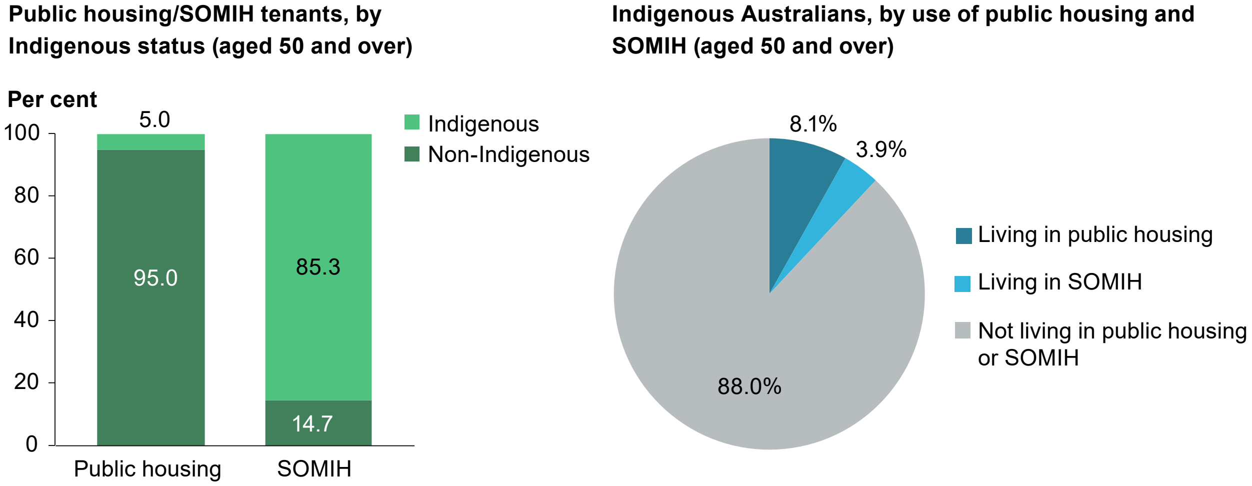
For ICH, Indigenous status information is not collected. As the program is targeted at Indigenous Australian households, it is assumed that the households supported have at least 1 Indigenous member; hence the number of households with a tenant aged 50 and over has been reported as a proxy for the number of Indigenous households with a tenant aged 50 and over. However, it is not possible to know whether the tenant aged 50 and over is Indigenous. There are also problems with data completeness and coverage of households and tenants, and national data are not available.

Public rental housing and state owned and managed Indigenous housing tenants

All states and territories have public housing programs, and 5 states and territories—New South Wales, Queensland, South Australia, Tasmania and the Northern Territory—provide SOMIH programs. Data reported in this section do not include the Northern Territory as information about these dwellings and households were only reported in the SOMIH collection from 1 July 2016.

As at 30 June 2016, there were around 13,500 Indigenous Australians aged 50 and over who lived in social housing managed through either the public housing or SOMIH programs; these comprise 68% (around 9,100 people) in public housing and 32% (around 4,300) in SOMIH. This relates to 5% of total public housing tenants aged 50 and over who were Indigenous, and 85% of total SOMIH tenants aged 50 and over who were Indigenous (Figure 5.3).

Figure 5.3: People aged 50 and over—public housing and SOMIH tenants by Indigenous status, and use of public housing and SOMIH use among Indigenous Australians, 30 June 2016



Notes

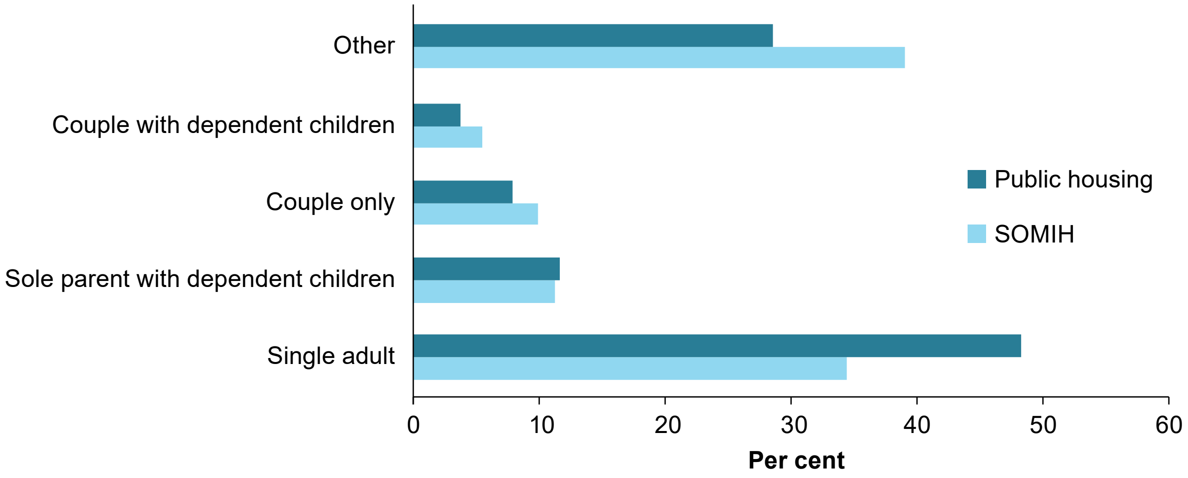
1. Data for this figure and notes about the analysis are shown in tables S1.1, S5.6.
2. In the figure on the right, the 'Not living in public housing or SOMIH' includes people receiving other forms of social housing assistance (for example, community housing), as well as those not receiving any social housing assistance.

Source: AIHW National Housing Assistance Data Repository.

Information on household composition for tenants in public housing and SOMIH shows that, as at 30 June 2016:

- 48% of Indigenous Australian tenants aged 50 and over in public housing were living in a single adult household (4,406 tenants)
- 34% of Indigenous Australian tenants aged 50 and over in SOMIH were living in single adult households (1,490 tenants)
- just over 1 in 10 households with an Indigenous Australian tenant aged 50 and over were sole parents with dependant children across both public housing and SOMIH (11% and 12% respectively) (Figure 5.4).

Figure 5.4: Indigenous Australian tenants aged 50 and over in public housing and in SOMIH, by household composition, 30 June 2016



Notes

1. Data for this figure and notes about the analysis are shown in Table S5.7.
2. 'Other' includes other single income unit household, group household, multiple family household, and unknown.

Source: AIHW National Housing Assistance Data Repository.

As at 30 June 2016, among Indigenous Australian tenants aged 50 and over:

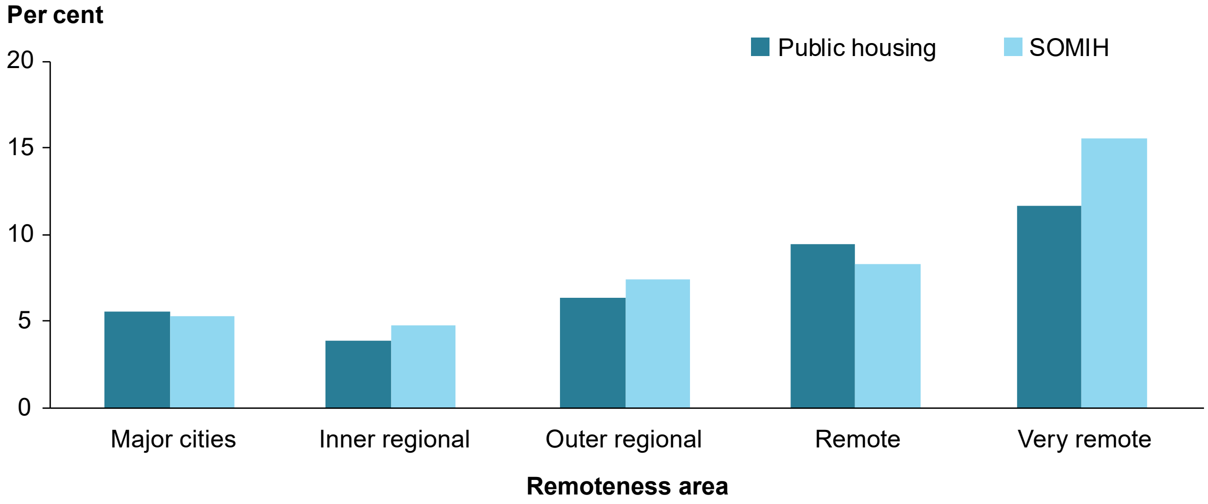
- 42% of those living in public housing had a disability, and 19% had no disability (with information on disability status not provided for the remaining 39% of tenants)
- 41% of those living in SOMIH had a disability, and 39% had no disability (with information on disability status not provided for the remaining 20% of tenants).

Information is also available on overcrowding of public housing and SOMIH dwellings, based on the Canadian National Occupancy Standard. As at 30 June 2016, among Indigenous Australian tenants aged 50 and over:

- 6% (nearly 600) of tenants in public housing were living in overcrowded conditions
- 7% (around 300) of tenants in SOMIH were living in overcrowded conditions (Table S5.9).

Figure 5.5 shows the proportion of Indigenous Australian tenants aged 50 and over who were living in overcrowded dwellings, by remoteness. As at 30 June 2016, tenants in *Very remote* areas were most likely to be living in overcrowded dwellings, across both public housing (12%) and SOMIH (16%), followed by those in *Remote* areas (9% and 8% respectively).

Figure 5.5: Proportion of total Indigenous Australian tenants aged 50 and over in public housing and SOMIH who were living in overcrowded dwellings, by remoteness areas, 30 June 2016



Note: Data for this figure and notes about the analysis are shown in Table S5.9.

Source: AIHW National Housing Assistance Data Repository.

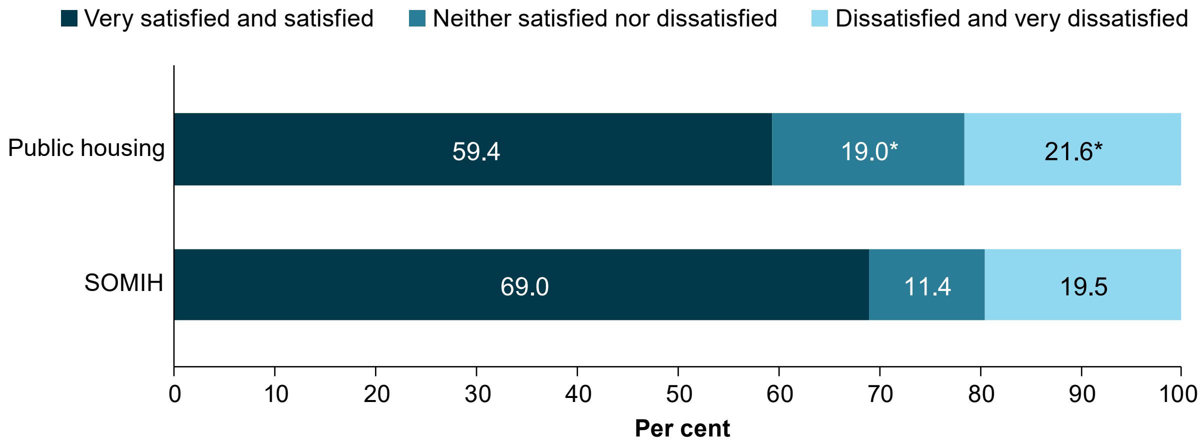
Information on the satisfaction of tenants living in social housing is available from the National Social Housing Survey (NSHS). The most recent NSHS survey with results available sampled tenants in public housing, SOMIH and community housing between April and June 2016. This section reports data for Indigenous Australian tenants aged 55 and over (it is not possible to report data for people aged 50 and over; see Appendix A).

There were 699 Indigenous social housing tenants aged 55 and over who participated in the 2016 survey—including 180 public housing tenants, 453 SOMIH tenants, and 66 community housing tenants. Data in this section are based on weighted responses from the public housing and SOMIH tenants. Community housing data are not provided due to the small number of Indigenous respondents aged 55 and over and consequent concerns about the reliability of the data.

Among Indigenous NSHS tenants aged 55 and over:

- 59% of public housing tenants were very satisfied or satisfied with the services provided by their housing organisation
- 69% of SOMIH tenants were very satisfied or satisfied with the services provided by their housing organisation (Figure 5.6).

Figure 5.6: Satisfaction with services provided by housing organisation, Indigenous Australian tenants aged 55 and over in SOMIH and public housing, 2016 (per cent)



* Estimate has a relative standard error between 25% and 50% and should be used with caution.

Notes

1. Responses to this question are the views of the person in the household who completed the survey form on behalf of their household.
2. Data for this figure and notes about the analysis are shown in Table S5.10.
3. Percentages may not sum to 100% due to rounding.

Source: AIHW analysis of the 2016 National Social Housing Survey.

Community housing

For the community housing program, national information on Indigenous status is available for households, but not for tenants (see Box 5.3).

All states and territories have information on community housing dwellings; information on the number of households in these dwellings as at 30 June 2016 was available for all jurisdictions except the Northern Territory.

As at 30 June 2016, there were 1,690 Indigenous households (households with at least 1 Indigenous Australian member) in community housing who had a tenant aged 50 and over—representing 32% of all Indigenous households in community housing (Table S5.11).

It is not possible to report the number of Indigenous Australian tenants aged 50 and over in these households.

Indigenous community housing

Indigenous community housing (ICH) is owned and/or managed by an Indigenous community housing organisation. These organisations may either own the dwellings they manage, or lease them from a state or territory housing authority.

Information on the Indigenous status of tenants or households assisted through this program is not collected (see Box 5.3). As the program is targeted at Indigenous households, in this report, it is assumed that the households supported by this program have at least 1 Indigenous Australian member, and households with a tenant aged 50 and over has been reported as a proxy for number of Indigenous households with a tenant aged 50 and over.

All states and territories except the Australian Capital Territory have an ICH program. Information about the households in those dwellings as at 30 June 2016 was available for 5 jurisdictions—Victoria, Queensland, Western Australia, South Australia and Tasmania. In these jurisdictions, as at 30 June 2016, there were around 3,200 households living in ICH with a tenant aged 50 and over (25% of the ICH households in these jurisdictions; Table S5.12). This is an underestimate of the number of ICH households with a tenant aged 50 and over, as household information is not available for New South Wales and the Northern Territory in the ICH collection. As at 30 June 2016, 39% of all ICH dwellings were in these 2 jurisdictions.

5.5 Homelessness and marginal housing

Homelessness is multifaceted, and there is no internationally agreed definition. The ABS developed a definition of homelessness for statistical purposes, which considers someone homeless if they do not have suitable accommodation alternatives and their current living arrangement:

- is in a dwelling that is inadequate;
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations (see (ABS 2018c) for detailed definitions).

The ABS definition of homelessness includes those living in ‘severely’ crowded dwellings, defined as one that needs 4 or more extra bedrooms to accommodate those who usually live there (based on the Canadian National Occupancy Standard). People in these dwellings are considered homeless as they do not have control of, or access to, space for social relations.

This definition was developed for application to the general population in Australia. When interpreting the data in this section, it is important to consider perspectives of homelessness among the Indigenous Australian population. The ABS has undertaken research about how its statistical definition of homelessness may be understood in the Indigenous Australian context—see Box 5.4. Indigenous Australians may consider disconnection from country, family and/or community to be homelessness (which is not captured by the ABS definition).

Box 5.4: Indigenous Australian perspectives on homelessness

During 2013 and 2014, the ABS consulted with Indigenous Australians, outreach workers and service provider organisations about Indigenous Australian concepts of 'home' and 'homelessness', and how these perceptions align with the statistical definition of homelessness. A wide variety of perspectives of homelessness were expressed among those Indigenous Australians involved in the consultations. While many perspectives aligned with the ABS statistical definition, there were some differences.

Homelessness was understood by many Indigenous Australians to include disconnection from country, family and/or community. For example, some people who are not captured in the statistical definition of homelessness may consider themselves homeless if their dwelling was not located in their community or 'on country'. It was also noted that, in some cases, people living on country in an improvised dwelling (such as a tent) felt at home through their connection to country. To avoid disconnection from country, some Indigenous Australians reported that, rather than moving to suitable housing in another area, they may live on country in crowded conditions, or sleep outside or in improvised dwellings if no suitable housing was available.

In Indigenous Australian communities where cultural and kinship ties were strong, homelessness was often understood to be disconnected from family; conversely, home could be somewhere other than their usual place of residence if they were with family (including their immediate and extended family).

As well, it was reported that Aboriginal people are often mobile and may be connected to multiple communities, having more than one 'usual address' where they feel at home.
In contrast, the findings suggested that Torres Strait Islander people tend to be less mobile, and understand their usual address to be the home where they live most of the time.

Sources: ABS 2013c, 2014e.

5.5.1 Prevalence of homelessness

Using the ABS statistical definition, on Census night in 2016:

- an estimated 3,060 Indigenous Australians aged 50 and over experiencing homelessness—14% of the total homeless population aged 50 and over (Table S1.1)
- considered as a population rate, among Indigenous Australians aged 50 and over, there were 28 homeless people per 1,000 population.

The proportion of the total homeless population aged 50 and over who were Indigenous Australians varied according to the type of homelessness. In 2016 among homeless Australians aged 50 and over, 31% of those in severely overcrowded dwellings were Indigenous Australians, as were 21% of those in improvised dwellings, tents, or sleeping out (that is those sleeping on the streets, in abandoned buildings, under bridges or in cars), 14% of those in support accommodation for the homeless, and between 3% and 5% for the other types of homelessness (AIHW analysis of ABS 2017f, customised data request).

Among the estimated 3,060 Indigenous Australians aged 50 and over experiencing homelessness:

- 56.6% were in severely overcrowded dwellings
- 17.4% were living in improvised dwellings, tents or sleeping out
- 11.8% were in supported accommodation for the homeless
- 8.1% were in boarding houses
- 5.9% were staying temporarily with other households
- 0.3% in other temporary lodgings.

5.5.2 Past experiences of homelessness

The 2014–15 NATSISS collected information on whether people had experienced homelessness during their lifetime. The questions included in were informed by the findings of ABS consultations on the perspectives of homelessness among Indigenous Australians (see Box 5.4).

Note that the NATSISS did not specifically ask about the experience of living in severely crowded dwellings, which (as discussed in the previous section) is considered to be homelessness under the ABS statistical definition.

Based on 2014–15 NATSISS data, among Indigenous Australians aged 50 and over, an estimated:

- 23% had experienced homelessness
- 18% living in a remote area had experienced homelessness compared with 25% living in a non-remote area (Table S5.14).

5.5.3 People in marginal housing

In addition to estimates of homelessness, the ABS also produced estimates of people who were not homeless but were living in some form of marginal housing. These people may be at risk of homelessness. Data from the 2016 Census show that, among Indigenous Australians aged 50 and over:

- nearly 1,200 were living in 'other crowded dwellings'—defined as dwellings requiring 3 extra bedrooms based on the Canadian National Occupancy Standard (rather than 4 or more, as per the definition of 'severely crowded' dwellings). This corresponds to a rate of 11 people per 1,000 population
- around 200 were 'marginally housed in caravan parks'—that is, they had a usual address in a caravan, cabin or houseboat in a caravan park and were unlikely to have accommodation alternatives. This corresponds to a rate of about 2 people per 1,000 population
- 105 were in 'other improvised dwellings'—that is, they were living in improvised dwellings, tents or sleeping out, but were not considered, on balance, to be homeless. This corresponds to a rate of about 1 person per 1,000 population.

5.5.4 Homelessness services

This section presents information on the use of government-funded specialist homelessness services (SHS) by Indigenous Australians aged 50 and over, using data from the Specialist Homelessness Services Collection (SHSC), which is managed and reported on by the AIHW (see Appendix A). Data presented in this report may differ slightly from those in the accompanying in-brief report as the administrative data were revised and these updated data are reflected in this more recent report.

A specialist homelessness agency reporting to the SHSC is an organisation that receives government funding to provide accommodation and other SHS to people who are homeless or at risk of homelessness.

Number and characteristics of SHS clients

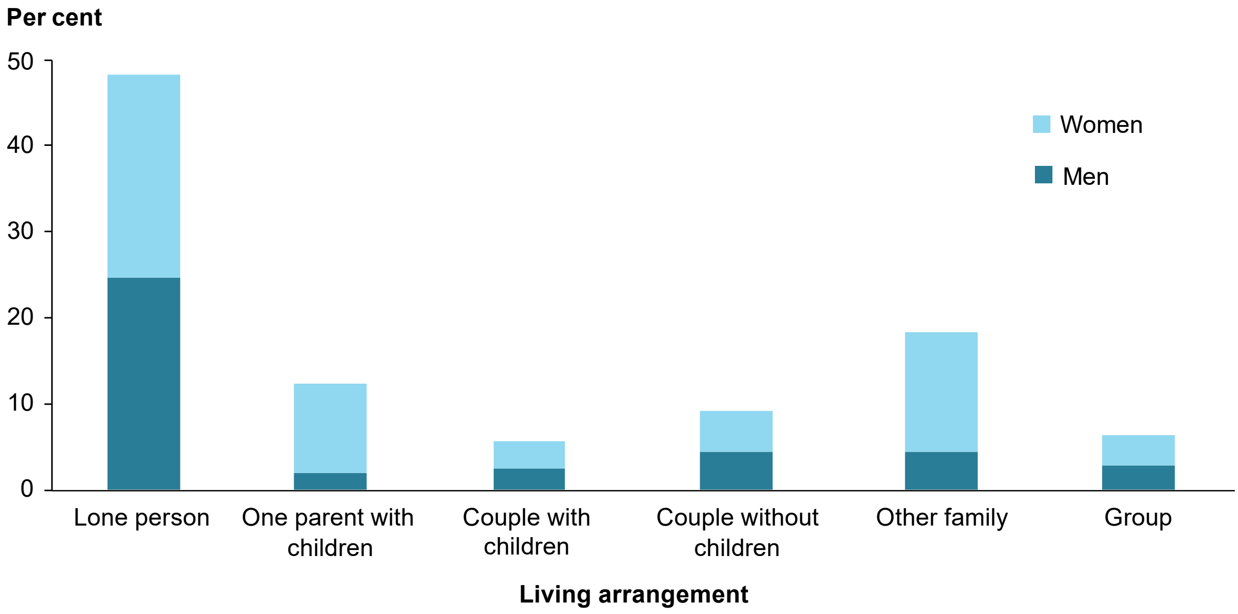
In 2016–17:

- SHS assisted about 5,200 Indigenous Australian clients aged 50 and over—representing 16.1% of all SHS clients aged 50 and over (Table S1.1)
- among Indigenous Australians aged 50 and over, 46 in every 1,000 were assisted by SHS
- among Indigenous Australians aged 50 and over, women sought assistance from SHS at a higher rate than men—52 compared with 38 clients per 1,000 population (Table S5.15)
- one-fifth of Indigenous Australian clients aged 50 and over receiving support from SHS had experienced domestic and family violence—an estimated 1,100 clients. Although the majority of services are provided to victims, the data do not distinguish where it is the perpetrators who are seeking services (for more detail see section following on SHS clients who experienced domestic violence; Table S5.20).

Living arrangements

Among SHS Indigenous Australian clients aged 50 and over in 2016–17, at the beginning of the support period the proportion of total clients living as a lone person was higher among men; in all other living arrangement categories the proportion of women was higher (Figure 5.7).

Figure 5.7: Indigenous Australian SHS clients aged 50 and over, by living arrangement at the beginning of support and sex, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S5.16.

Source: AIHW analysis of the Specialist Homelessness Services Collection.

Housing situation

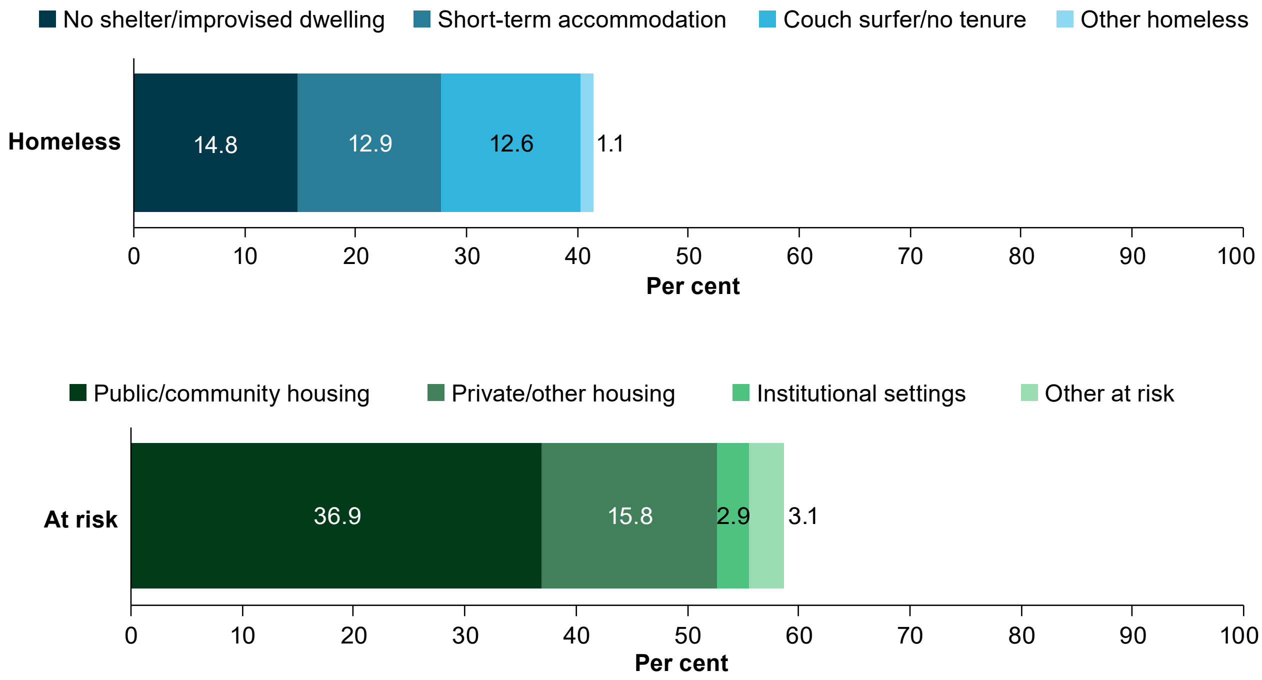
All clients of SHS are either homeless or 'at risk' of homelessness (for example, people may be housed but at risk of homelessness because of financial stress, family and domestic violence, or a relationship/family breakdown).

'Homeless' status is derived for a client based on the client's housing circumstances and is measured at the beginning and end of their support period. Among Indigenous Australian SHS clients aged 50 and over in 2016–17:

- almost 6 in 10 (59%) were housed at the time of seeking assistance, but at risk of becoming homeless. Most commonly, these people were living in public or community housing at the beginning of the support period (37% of all clients)
- 41% were homeless at the beginning of their support period, with 15% of clients sleeping rough (that is, they had no shelter or were living in an improvised dwelling), 13% in short-term accommodation, and 13% 'couch surfing' with no tenure (Figure 5.8).

Among Indigenous Australians aged 50 and over, the proportion of clients who were homeless at the beginning of support was higher for men than women—51% compared with 35% (Table S5.17).

Figure 5.8: Indigenous Australian SHS clients aged 50 and over, by housing situation at the beginning of support, 2016–17



Notes

1. Percentage calculations are derived using all Indigenous Australian clients aged 50 and over, excluding those with a ‘not stated’ housing situation at the beginning of support.
2. Data for this figure and notes about the analysis are shown in Table S5.17.

Source: AIHW analysis of the Specialist Homelessness Services Collection.

Main reason for seeking assistance

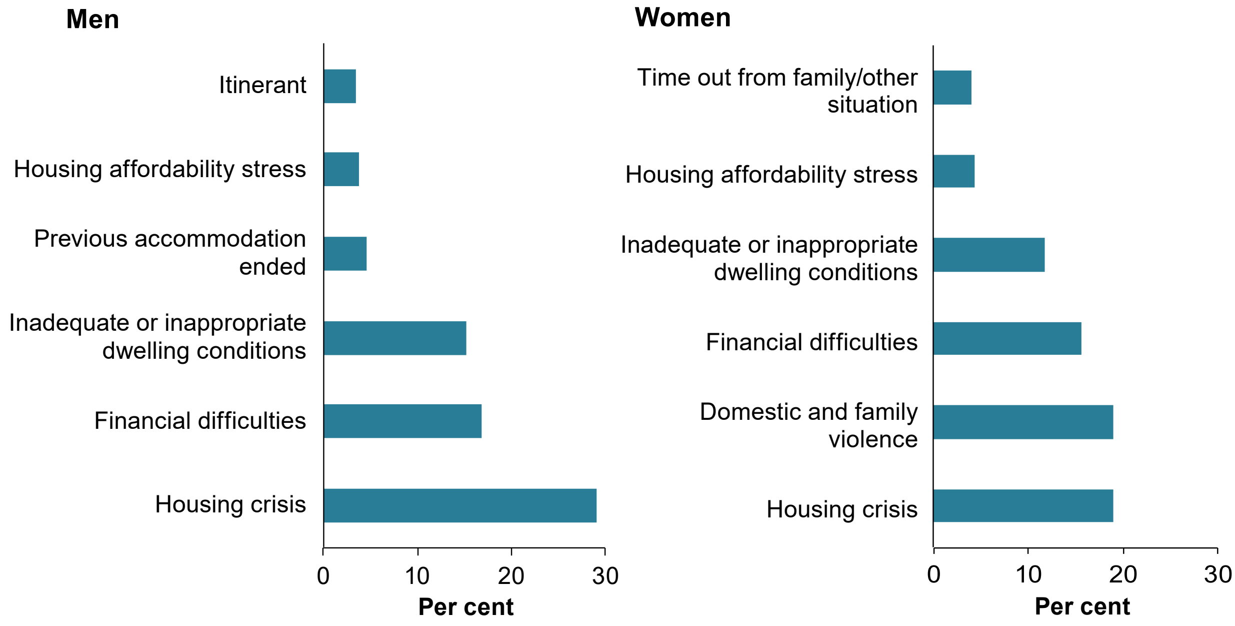
In 2016–17, among Indigenous Australian clients aged 50 and over, the most common main reasons for seeking SHS assistance were:

- housing crisis—23% of clients identified this as the main reason for seeking assistance
- financial difficulties—reported by 16% of clients
- inadequate or inappropriate dwelling conditions—reported by 13% of clients
- domestic and family violence—reported by 12% of clients (Table S5.18).

The most commonly reported main reasons for seeking assistance differed by sex for Indigenous Australians aged 50 and over (Figure 5.9):

- for men—housing crisis was the most common main reason for seeking assistance (29% of clients), followed by financial difficulties (17%) and inadequate or in appropriate dwelling conditions (15%)
- for women—housing crisis and family and domestic violence were the most common main reasons for seeking assistance (both 19%), followed by financial difficulties (16%).

Figure 5.9: Top 6 most common main reasons for seeking assistance among Indigenous Australian SHS clients aged 50 and over by sex, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S5.18.

Source: AIHW analysis of the Specialist Homelessness Services Collection.

Need for and provision of SHS

Housing and accommodation services provided by agencies include:

- short-term or emergency accommodation
- medium-term/transitional housing
- long-term housing
- assistance to sustain housing tenure—either to sustain tenancy or prevent tenancy failure or eviction, or assistance to prevent mortgage foreclosures.

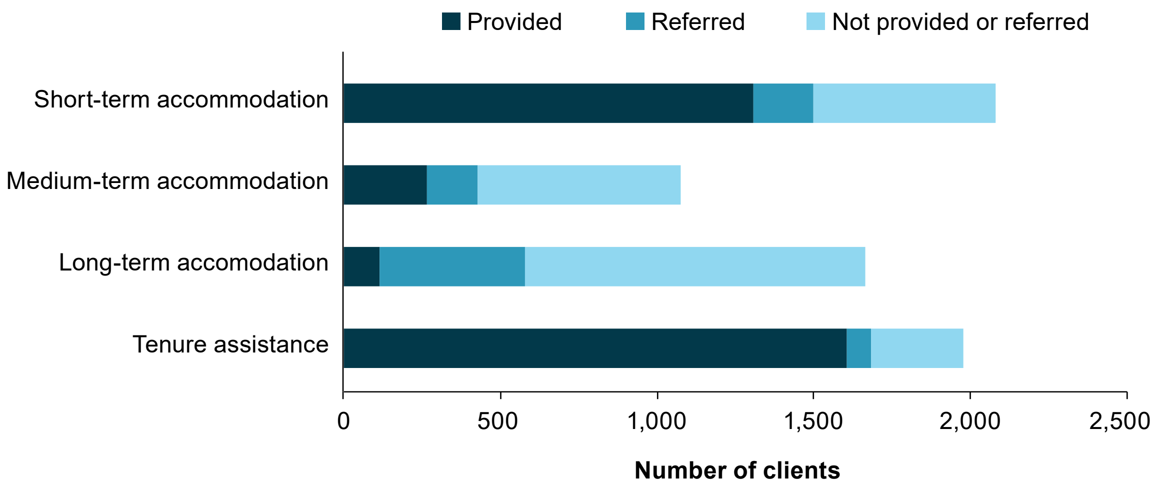
SHS clients can identify a need for 1 or more of these accommodation services.

In 2016–17, among Indigenous Australian SHS clients aged 50 and over:

- 40% (nearly 2,100 people) needed short-term accommodation services
- 21% (nearly 1,100 people) needed medium-term accommodation services
- 32% (nearly 1,700 people) needed long-term accommodation services
- 38% (nearly 2,000 people) needed assistance to sustain housing tenure (Figure 5.10).

Of Indigenous Australian clients aged 50 and over who needed assistance to sustain housing tenure or short-term accommodation, clients were either provided with that assistance or referred to another agency for service provision (Figure 5.10). Those clients who needed medium or long-term accommodation were more likely to have an unmet need for accommodation—that is, they were neither provided with the assistance nor referred. The proportion of Indigenous Australian clients aged 50 and over with unmet need for housing/accommodation services ranged from 15% for those requiring assistance to sustain housing tenure to 65% for those requiring long-term accommodation (Table S5.19).

Figure 5.10: Indigenous Australian SHS clients aged 50 and over who needed assistance with accommodation, by type of accommodation needed and service provision status, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S5.19.
Source: AIHW analysis of Specialist Homelessness Services Collection.

Aside from accommodation, SHS agencies also provide various other types of assistance—including general support and assistance (for example, advice and information, meals, living skills), as well as more targeted services (for example, medical services, financial advice, and legal services). Table S5.19 includes data on the use of some of these services.

SHS clients who experienced domestic violence

This section relates to SHS clients who either:

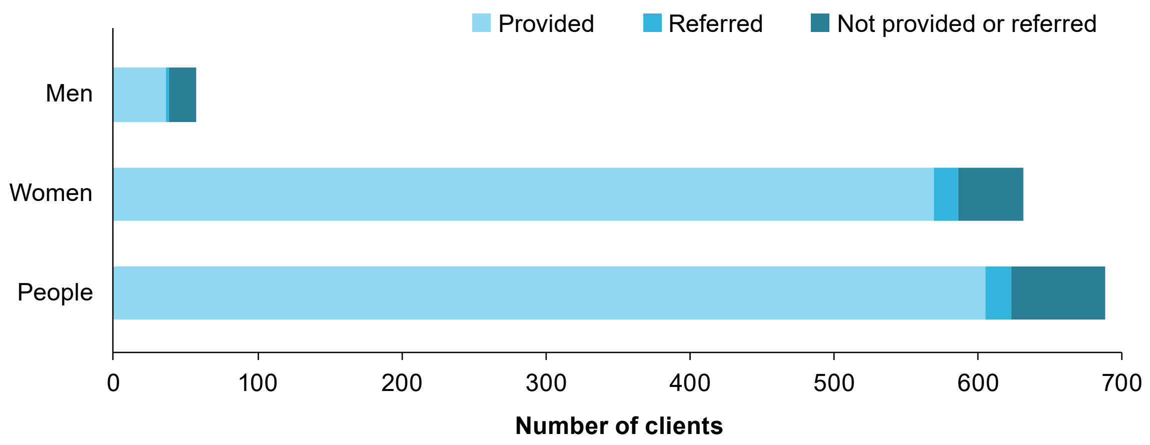
- reported domestic or family violence as a reason for seeking assistance; or
- were assessed as having a need for assistance relating to domestic or family violence.

While SHS agencies mainly assist people who are victims of domestic and family violence, they may also assist perpetrators of violence who seek homelessness services. Currently, the Specialist Homelessness Services Collection (SHSC) cannot separately identify these groups.

In 2016–17, 20% of Indigenous Australians aged 50 and over seeking SHS had experienced domestic and family violence—an estimated 1,100 clients. Among these, 90% were women, and 53% were aged 50–54 (Table S5.20).

Nearly two-thirds (64%) of Indigenous Australian SHS clients aged 50 and over who had experienced domestic and family violence identified needing specific assistance for this reason (estimated 700 people). Assistance may include therapeutic discussion or group sessions, counselling and specialised domestic violence services. Of the 700 clients who identified needing assistance for this reason, 88% were provided with assistance, 3% received a referral, and the remaining 9% were neither provided with assistance nor referred (Figure 5.11).

Figure 5.11: Indigenous Australian SHS clients aged 50 and over who needed assistance for domestic and family violence, by sex and service provision status, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S5.21.

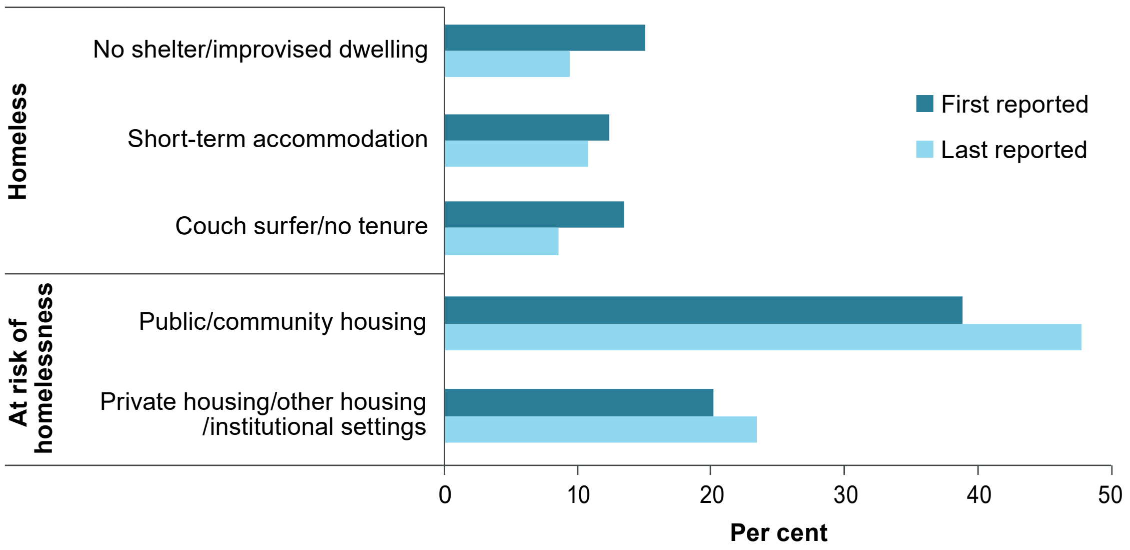
Source: AIHW SHSC.

Housing outcomes of SHS clients

In 2016–17, there were nearly 3,900 Indigenous Australian SHS clients aged 50 and over for whom all support periods were completed at the end of the financial year (completion occurs the day the client last received services). Among these clients, at the end of their support period in 2016–17:

- 29% were homeless—down from 41% at the start of their first support period in 2016–17
- 9% were sleeping rough—down from 15% at the start of their first support period in 2016–17
- 48% were in public or community housing—up from 39% at the start of their first support period in 2016–17 (Figure 5.12).

Figure 5.12: Indigenous Australian SHS clients aged 50 and over with closed support, by housing situation by first reported support period and last reported support period, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S5.22.

Source: AIHW analysis of the Specialist Homelessness Services Collection.

6

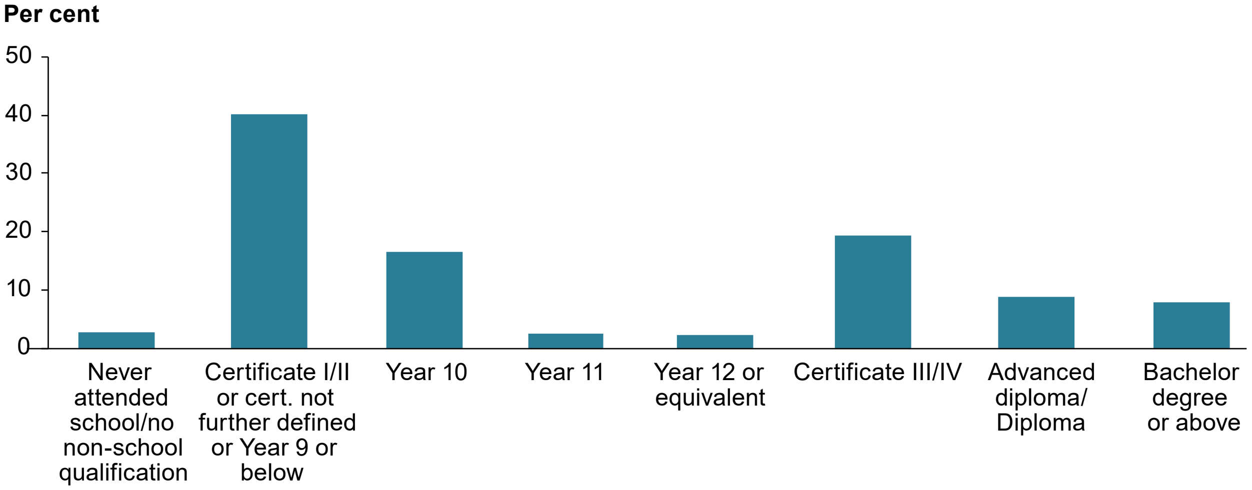
Education, employment and financial security

Socioeconomic determinants such as financial resources may influence an individual's risk or capacity to respond to particular vulnerabilities, either indirectly or directly. This chapter looks at selected measures of education, employment and financial security for Aboriginal and Torres Strait Islander people aged 50 and over.

6.1 Education

The NATSISS collected information on the highest level of educational attainment among Indigenous Australians. In 2014–15, among Indigenous Australians aged 50 and over, 36% (an estimated 34,500 people) had attained qualifications above Year 12, including: certificate level III/IV (19%), diplomas or advanced diplomas (9%) and bachelor degrees or above (8%) (Figure 6.1).

Figure 6.1: Highest level of educational attainment among Indigenous Australians aged 50 and over, 2014–15



Notes

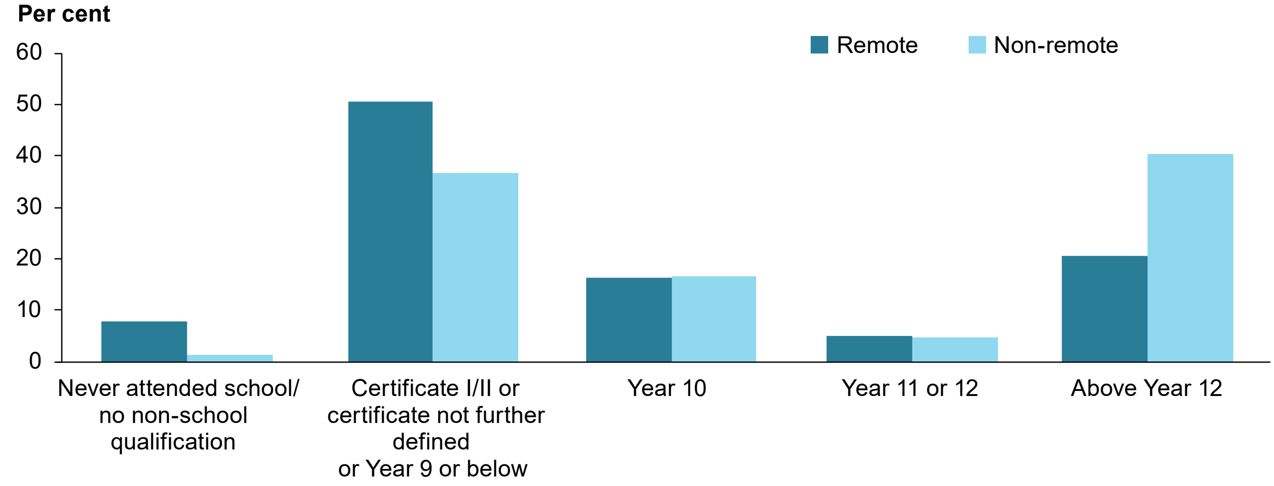
1. Data for this figure and notes about the analysis are in Table S6.1.
2. 'Bachelor degree or above' includes postgraduate, graduate diploma and graduate certificate and bachelor degree. 'Certificate I/II or Cert. not further defined or Year 9 or below' includes certificate I and II, certificate not further defined and Year 9 and below.

Source: AIHW analysis of ABS 2016c.

Among Indigenous Australians aged 50 and over in 2014–15:

- 40% of those living in non-remote areas had attained qualifications above Year 12, compared with 20% of those living in remote areas
- 50% of those living in remote areas reported certificate level I/II or Year 9 or below as their highest level of attainment, compared with 37% in non-remote areas (Figure 6.2).

Figure 6.2: Highest level of educational attainment among Indigenous Australians aged 50 and over, by remoteness, 2014–15



Notes

1. ‘Above Year 12’ includes postgraduate degree, graduate diploma and graduate certificate, bachelor degree, advanced diploma and diploma and certificate III and IV. ‘Year 11 or 12’ includes Year 12 or equivalent and Year 11. ‘Certificate I/II or certificate not further defined or Year 9 or below’ includes certificate I and II, certificate not further defined and Year 9 and below.
2. ‘Never attended school/no non-school qualification’ in non-remote areas has a high relative standard error (>25%) and should be interpreted with caution.
3. Data for this figure and notes about the analysis are in Table S6.2.

Source: AIHW analysis of ABS 2016c.

6.2 Employment

The NATSISS collected information on labour force status, employment status and the number of hours worked per week.

The labour force comprises people who are:

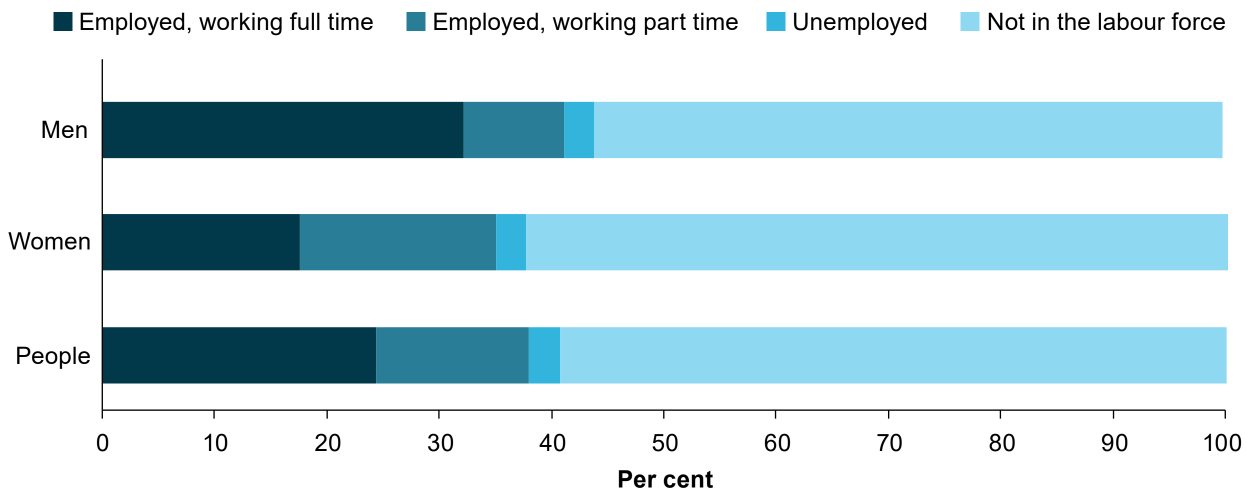
- employed—that is, people who have worked for at least 1 hour in the reference week, or
- unemployed—that is, people who are without work, but have actively looked for work in the last 4 weeks and are available to start work (see (ABS 2016e) for detailed definitions in the context of the NATSISS).

The remainder of the population is not in the labour force.

In 2014–15, among Indigenous Australians aged 50 and over:

- 59% (an estimated 58,500 people) were not in the labour force. Those aged 65 and over were less likely to be in the labour force than those aged 50–64 (8% compared with 52%)
- 41% (an estimated 40,300 people) were in the labour force—consisting of 38% who were employed and 3% who were unemployed (Figure 6.3).

Figure 6.3: Employment status by sex, Indigenous Australians aged 50 and over, 2014–15



Notes

1. For both men and women, the percentages for 'unemployed' have a relative standard error of 25% to 50% and should be used with caution.
2. Data for these figures and notes about the analysis are in Table S6.3.

Source: AIHW analysis of ABS 2016c.

Among Indigenous Australians aged 50 and over in the labour force, the proportion employed was similar for men and women (93% and 94% respectively), but lower in remote areas than in non-remote areas (89% and 95%) (Table S6.4).

Among Indigenous Australians aged 50 and over who were employed, almost two-thirds (64%) worked full-time—with men more likely than women to be employed full-time (78% compared with 50%) (Table S6.5).

6.3 Volunteer work

The 2016 Census collected information on whether Australians had participated in voluntary work in the previous 12 months—consisting of unpaid help given (in the form of time, service or skills) to a club, organisation or association. In 2016, among Indigenous Australians aged 50 and over, 17% (an estimated 16,500 people) had volunteered for an organisation or group in the previous 12 months. Those in non-remote areas were more likely than those in remote areas to have volunteered in the previous 12 months (17% compared with 14%) (AIHW analysis of ABS 2016c).

Research suggests that Census data may underestimate the level of volunteering among Indigenous Australians, as they relate only to formal volunteering through an organisation or group. Participation in volunteering by Indigenous Australians often includes a large amount of informal volunteering, such as childcare, care of older people, care of people with long-term illness and disability and domestic work for others (CIRCA 2016).

6.4 Income and income support

6.4.1 Income support and Family Tax Benefit payments

This section presents information on Indigenous Australians aged 50 and over who received various Australian Government payments, based on administrative data collected by the Department of Social Services (DSS). See Appendix A for information on Indigenous identification in DSS data.

Government assistance in the form of income support payments is a key factor in ensuring social and economic wellbeing for those Australians with limited financial resources. As all income support payments in Australia are means-tested, a reliance on these payments is one indicator that people may otherwise be experiencing poverty (McLachlan et al. 2013).

This section provides information on Indigenous Australians aged 50 and over who are receiving an income support payment—that is, one of the following: ABSTUDY (Living Allowance), Age Pension, Austudy, Carer Payment, Disability Support Pension, Newstart Allowance, Parenting Payment (Partnered/Single), Partner Allowance, Sickness Allowance, Special Benefit, Widow Allowance, Widow B Pension, or Wife Pension.

People can receive only 1 income support payment at any point in time. However, people receiving income support payments may also be receiving other allowances or supplements, such as the Carer Allowance or Family Tax Benefit (FTB). Information on receipt of the FTB by older Indigenous Australians is also provided in this section.

Note that the administrative data presented in this section are not directly comparable with the survey data on receipt of government pensions or allowances presented in the previous section. This is due to differences in the scope of the data (for example, which payments are included) and other aspects of the collections.

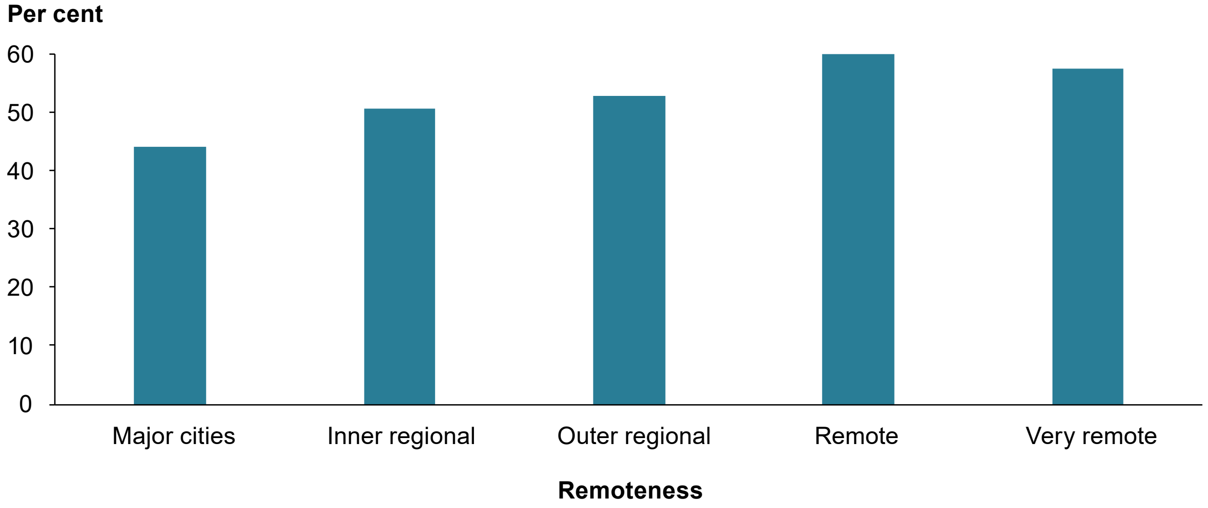
As at 30 June 2017:

- around 59,500 Indigenous Australians aged 50 and over were receiving income support — constituting 1.8% of the total Australian population aged 50 and over who were receiving income support (Table S1.1)
- among Indigenous Australians aged 50 and over, about 1 in 2 were receiving some form of income support.

Among Indigenous Australians aged 50 and over, women were more likely than men to be income support recipients—54% of women compared with 47% of men as at 30 June 2017. This was largely due to higher proportions of Age Pension and Carer Payment recipients among women (18% of women compared with 15% of men for age pension; 5% of women compared with 3% of men for Carer Payments (Table S6.6).

The proportion of Indigenous Australians aged 50 and over receiving income support ranged from 44% in *Major cities* to 60% in *Remote* areas (Figure 6.4).

Figure 6.4: Rate of income support among Indigenous Australians aged 50 and over, by remoteness, 30 June 2017



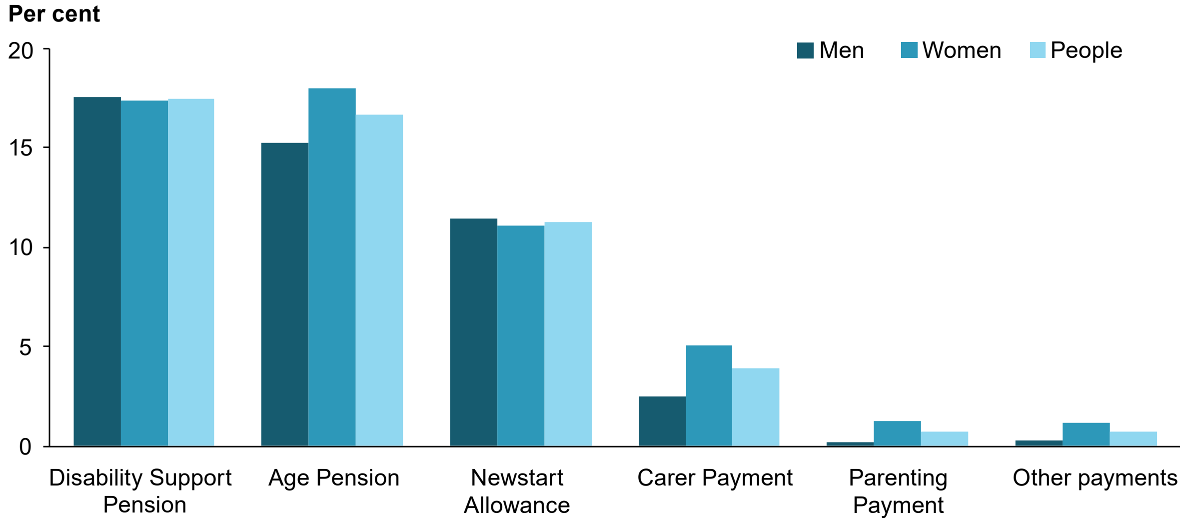
Note: Data for this figure and notes about the analysis are in Table S6.7.

Source: AIHW analysis of data provided by the Department of Social Services (based on Department of Human Services administrative data; DSS Blue Book dataset).

Among Indigenous Australians aged 50 and over, the four main types of income support payments received were:

- Disability Support Pension (17% of the Indigenous Australian population aged 50 and over)
- Age Pension (17%)
- Newstart Allowance (11%)
- Carer Payment (4%) (Figure 6.5).

Figure 6.5: Income support among Indigenous Australian population aged 50 and over, by type of income support payment and sex, 30 June 2017



Note: Data for this figure and notes about the analysis are in Table S6.6.

Source: AIHW analysis of data provided by the Department of Social Services (based on Department of Human Services administrative data, DSS Blue Book dataset).

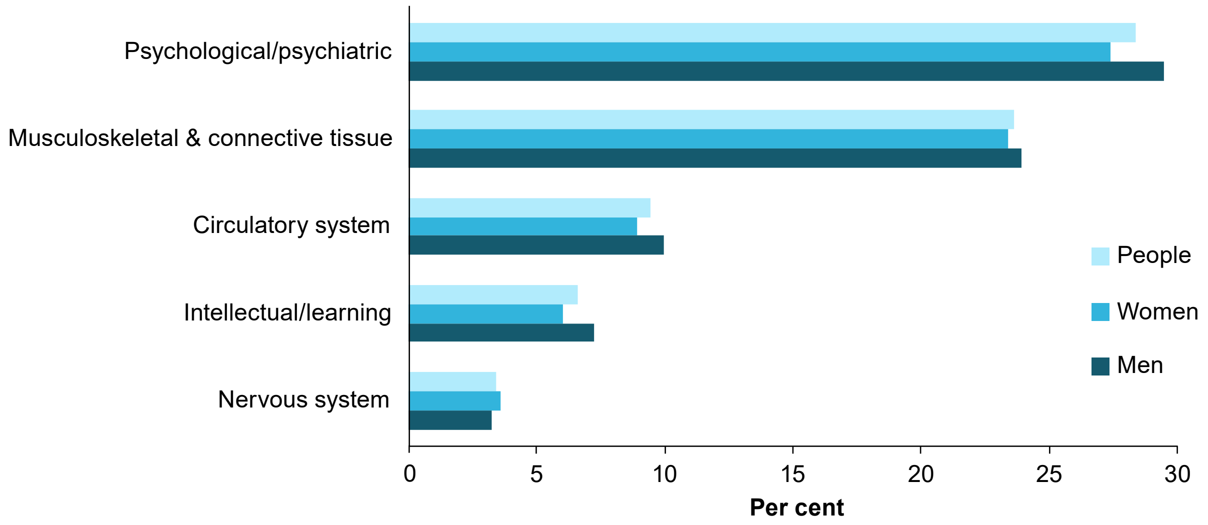
Disability Support Pension

The Disability Support Pension is an income support payment for Australians who have a permanent physical, intellectual or psychiatric condition that prevents them from working at least 15 hours per week in the next 2 years.

As at 30 June 2017, around 20,400 Indigenous Australians aged 50 and over received the Disability Support Pension. The top 5 primary medical conditions among Disability Support Pension recipients were:

- psychological and psychiatric conditions (28%)
- musculoskeletal and connective tissue conditions (24%)
- conditions of the circulatory system (9%)
- intellectual or learning disabilities (7%)
- conditions of the nervous system (3%) (Figure 6.6).

Figure 6.6: Top 5 primary medical conditions among Indigenous Australian Disability Support Pension recipients aged 50 and over, by sex, 30 June 2017



Note: Data for this figure and notes about the analysis are in Table S6.8.

Source: AIHW analysis of data provided by the Department of Social Services (Department of Human Services Administrative data (DSS extracts—ISSD, BDS, BB and CDS).

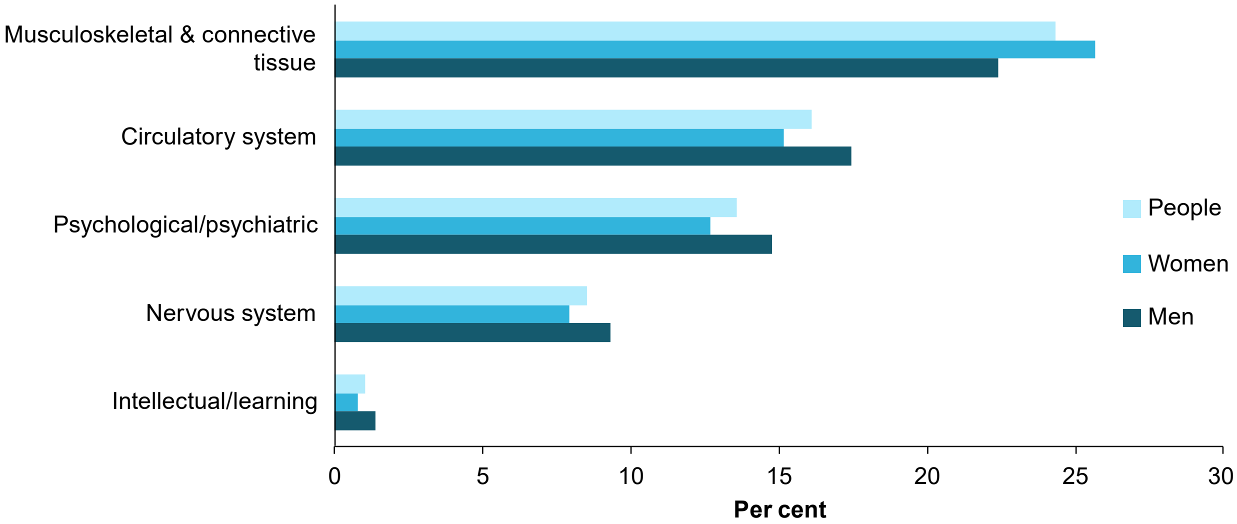
Carer Payment

A Carer Payment is an income support payment for Australians who give constant care to someone who has a severe disability, illness, or an adult who is frail and old.

Data presented in this section relate to the care receivers—that is, those Indigenous Australians aged 50 and over who are the recipients of care. The care receivers are the focus here as they may potentially be more vulnerable. The top ranked primary medical conditions among those receiving care were:

- musculoskeletal and connective tissue disorders (24%)
- circulatory system conditions (16%)
- psychological/psychiatric conditions (14%) (Figure 6.7).

Figure 6.7: Top 5 listed primary medical conditions among Indigenous Australians aged 50 and over being cared for by someone receiving a Carer Payment, by sex of care recipient, 30 June 2017



Note: Data for this figure and notes about the analysis are in Table S6.9.

Source: AIHW analysis of data provided by the Department of Social Services (Department of Human Services Administrative data (DSS extracts—ISSD, BDS, BB and CDS).

Family Tax Benefit recipients

Family payments are another important component of Australia's social security system and provide additional means-tested support to families and individuals with dependent children. Family Tax Benefit (FTB) is a two-part payment that helps eligible families with the cost of raising children (DSS 2018). It includes:

- FTB Part A—paid per dependent child, with the amount paid depending on a family's circumstances
- FTB Part B—paid per-family and gives extra help to single parents (or nonparent carers) and some couple families with one main income.

The FTB is assessed as a family unit. It is paid to the nominated partner in couple relationships. Data presented here are based on the self-identified Indigenous status of the FTB recipient only. It does not take into account the Indigenous status of the recipient's partner.

As at 30 June 2017, around 8,500 Indigenous Australians aged 50 and over were receiving some form of FTB—corresponding to 7% of Indigenous Australians aged 50 and over (Table S6.10).

Among Indigenous Australians aged 50 and over receiving the FTB as at 30 June 2017, half (57%) had only 1 child on a FTB payment, one-quarter (25%) had 2 children, with the remainder having 3 or more children on a FTB payment (Table 6.1).

Recipients of FTB may also be eligible for income support payments. As at 30 June 2017, about 4 in 5 Indigenous Australian FTB recipients aged 50 and over (81%) were also receiving an income support payment (Table 6.1).

Table 6.1: Indigenous Australian FTB recipients aged 50 and over by number of children and additional income support payment status, 30 June 2017

Number of FTB children	Whether receiving an additional income support payment		Total number of recipients
	Yes	No	
Number (%)			
1	3,937 (57)	935 (59)	4,872 (57)
2	1,751 (25)	409 (26)	2,160 (25)
3 or more	1,241 (18)	233 (15)	1,474 (17)
Total recipients	**6,929 (100)**	**1,577 (100)**	**8,506 (100)**

Note: Customers who are income test exempt for FTB purposes are recorded as 'Receives an income support payment'. Customers who do not receive an income test exemption for FTB purposes are recorded as 'Does not receive an income support payment'.

Source: AIHW analysis of data provided by DSS (based on Department of Human Services FTB Instalment Package, Version 24.0.0; Data Load Version 7.4. Reporting date—30 June 2017).

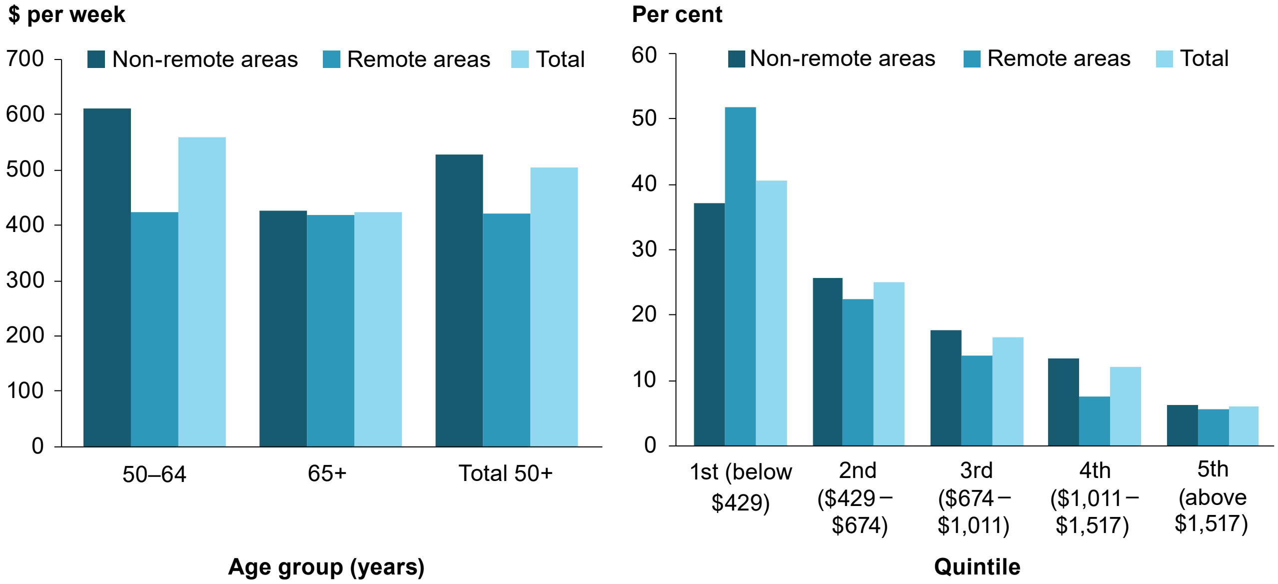
6.4.2 Household income

In the 2014–15 NATSISS, household income was calculated based on the gross personal income for each member of the household. In measuring and comparing income, it is important that the number of people living in a household (particularly children) is taken into account. To do this, incomes are adjusted to create a comparable measure called equivalised gross household income. Household incomes were then divided into 5 equal groups (called quintiles).

In 2014–15, among Indigenous Australians aged 50 and over:

- the median equivalised gross household income was $503 per week:
  - among those aged 65 and over, median household income was similar in remote and non-remote areas ($418 compared with $427, respectively)
  - among those aged 50–64, median household income was lower in remote than non-remote areas ($423 compared with $610) (Table S6.11)
- 41% (an estimated 29,600 people) lived in households where the weekly household income was in the bottom 20% of incomes (the lowest quintile, incomes of less than $429 a week):
  - the proportion in the lowest quintile was higher in remote then in non-remote areas (52% compared with 37%) (Figure 6.8).

Figure 6.8: Median equivalised household gross weekly income ($ per week) by age group and remoteness, and equivalised household weekly income (quintiles) by remoteness, among Indigenous Australians aged 50 and over, 2014–15



Notes

1. Data for these figures and notes about the analysis are in tables S6.11, S6.12.
2. The percentage for the fifth quintile in remote areas has a relative standard error of 25% to 50% and should be used with caution.

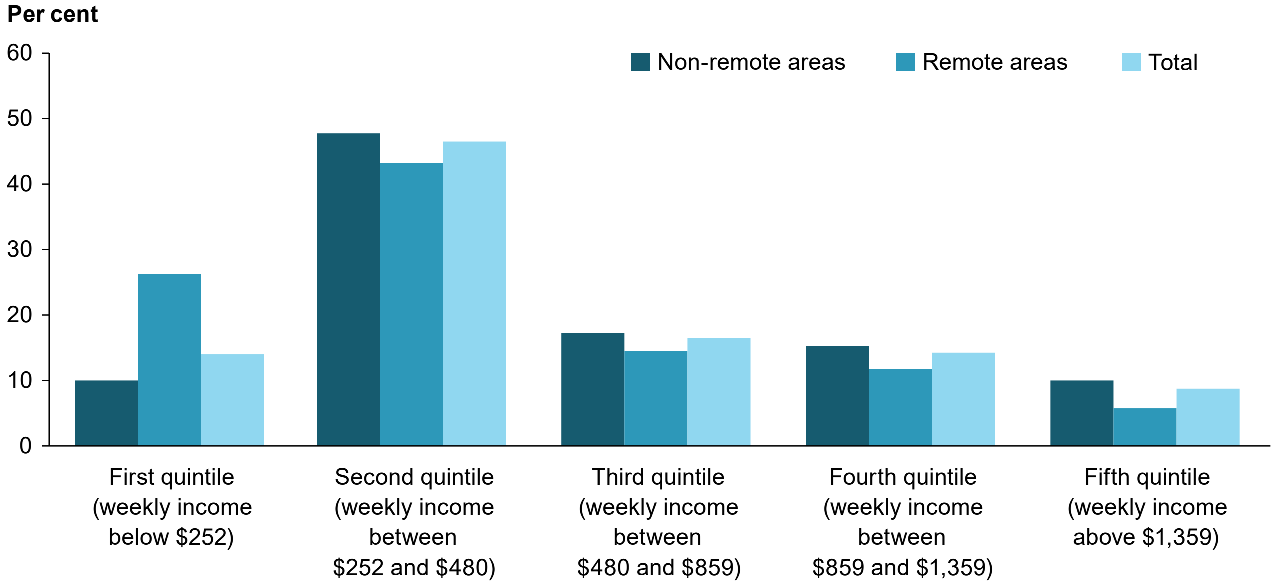
Source: AIHW analysis of ABS 2016c.

6.4.3 Personal income

Data from the NATSISS show that, among Indigenous Australians aged 50 and over, in 2014–15:

- the median gross personal income was $420 per week, with the median lower among those in remote than in non-remote areas ($370 compared with $425)
- 61% (an estimated 53,200 people) had personal incomes in the bottom 40% of personal weekly incomes (the lowest 2 quintiles, with incomes of less than $480 a week)
- 9% had personal incomes in the top 20% of incomes (highest quintile, incomes of more than $1,359 per week):
  - those in remote areas were less likely than those in non-remote areas to have personal incomes in the top 20% (6% compared with 10%) (Figure 6.9).

Figure 6.9: Proportion of Indigenous Australians aged 50 and over in personal weekly income quintile groups, by remoteness, 2014–15



Notes

1. Data for this figure and notes about the analysis are in Table S6.13.
2. The fourth and fifth quintiles for those not in the labour force have high relative standard error (>25%) and therefore should be interpreted with caution.

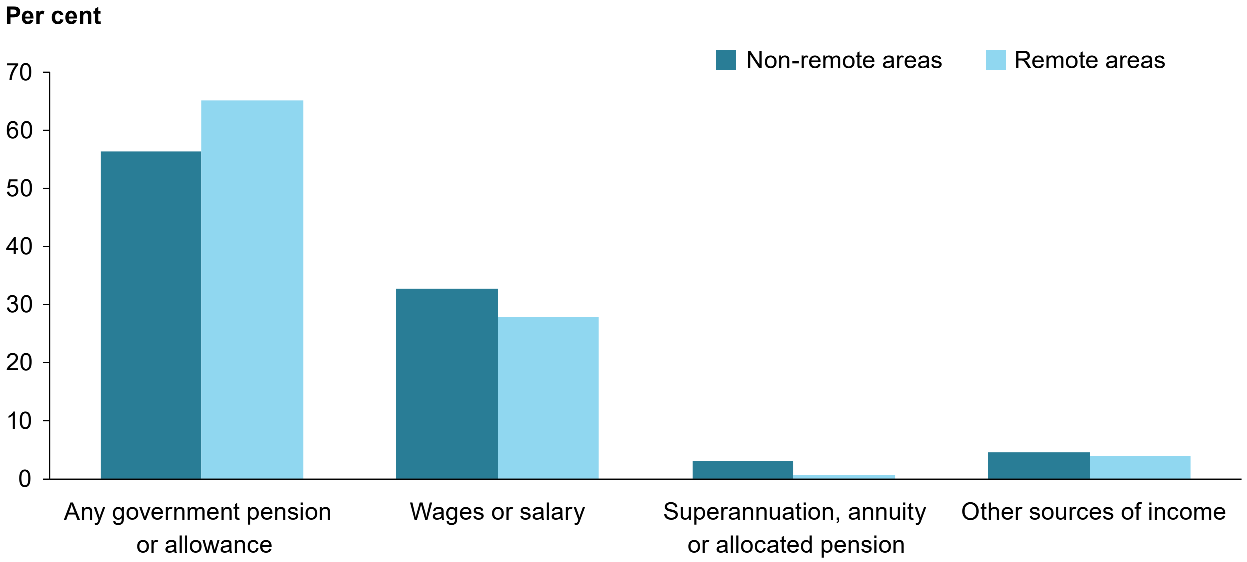
Source: AIHW analysis of ABS 2016c.

Main source of personal income

Among Indigenous Australians aged 50 and over, in 2014–15:

- 64% (estimated 62,900 people) received a government pension or allowance—higher among those living in remote than non-remote areas (70% compared with 62%)
- 59% reported a government pension or allowance as their main income source—higher among those living in remote than non-remote areas (65% compared with 56%)
- 32% reported wages or salary as their main source of income (Figure 6.10).

Figure 6.10: Main personal income source among Indigenous Australians aged 50 and over, by remoteness, 2014–15



Notes

1. The percentage for superannuation, annuity or allocated pension in remote areas has a relative standard error of greater than 50% and is considered too unreliable for general use.
2. Data for this figure and notes about the analysis are in Table S6.14.

Source: AIHW analysis of ABS 2016c.

6.5 Financial stress

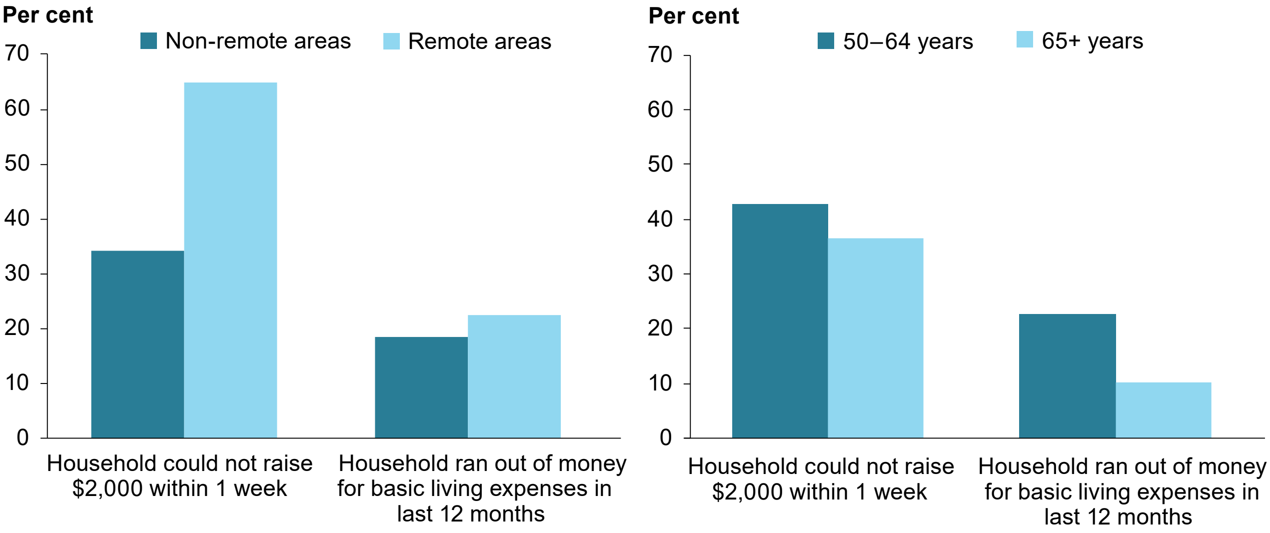
In the 2014–15 NATSISS, information was collected on selected measures related to whether households were experiencing financial stress and economic hardship, including:

- a household's ability to raise $2,000 in 1 week in an emergency
- whether any member of the household had run out of money for basic living expenses in the last 12 months.

In 2014–15, among Indigenous Australians aged 50 and over:

- 41% (an estimated 38,700 people) lived in households where they could not raise $2,000 within 1 week in an emergency:
  - those in remote areas were more likely than those in non-remote areas to be unable to raise the money (65% compared with 34%)
- 19% lived in households where members had run out of money for basic living expenses in the last 12 months
- those aged 50–64 were more likely than those aged 65 and over to live in households that ran out of money for basic living expenses in the last 12 months (23% compared with 10%) and that could not raise $2,000 within 1 week in an emergency (43% compared with 37%) (Figure 6.11).

Figure 6.11: Selected indicators of household financial stress among Indigenous Australians aged 50 and over, by remoteness and age group, 2014–15



Note: Data for these figures and notes about the analysis are in Table S6.15.

Source: AIHW analysis of ABS 2016c.

7

Alcohol and substance use

Older people with alcohol and other drug (AOD) problems can be at risk of exploitation from a range of flow-on effects, including substance-related cognitive loss that reduces their ability to respond, substance-related disabilities that result in reliance on others for assistance or care, and social isolation (WHO 2018).

Substance addiction may be one of the consequences of elder abuse (Joosten et al. 2017). While less is known about the characteristics of people who perpetrate elder abuse, the perpetrator's alcohol and drug use have also been identified as risk factors (Kaspiew et al. 2016).

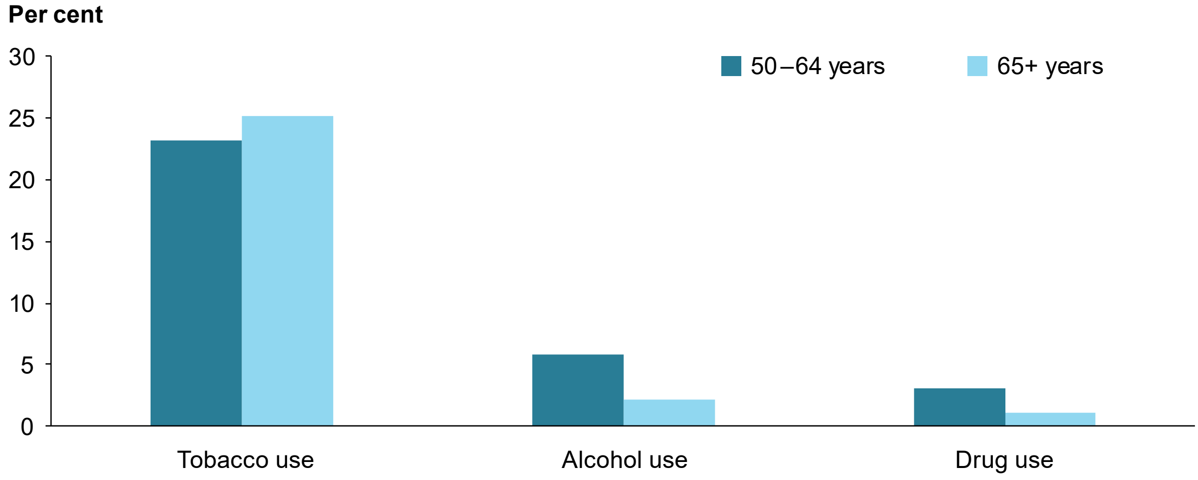
7.1 Burden of disease from tobacco, alcohol and other drug use

Burden of disease analysis is a way of measuring the combined fatal and non-fatal impacts of diseases and injuries on a population. It takes into account people's age at death and the severity of disease in addition to counting deaths and disease prevalence. Burden of disease is measured in disability-adjusted life years, or DALYs (see Box 3.4).

Data from the Australian Burden of Disease Study (ABDS) 2011 indicate that of the total disease burden experienced among Indigenous Australians aged 50 and over in 2011 (over 66,000 DALYs):

- 24% (over 15,800 DALYs) was attributable to tobacco
- 4% (almost 3,000 DALYs) was attributable to alcohol use
- 2% (almost 1,600 DALYs) was attributable to drug use (Figure 7.1).

Figure 7.1: Proportion of total disease burden attributable to tobacco, alcohol use, and drug use among Indigenous Australians aged 50 and over, by age group, 2011



Notes

1. The ABDS 2011 assessed the impact of 29 different modifiable risk factors; together, these risk factors explained 52% of total burden for Indigenous Australians aged 50 and over.
2. Data for this figure and notes about the analysis are shown in Table S7.1.

Source: AIHW analysis of the 2011 ABDS.

7.2 Prevalence of harmful use

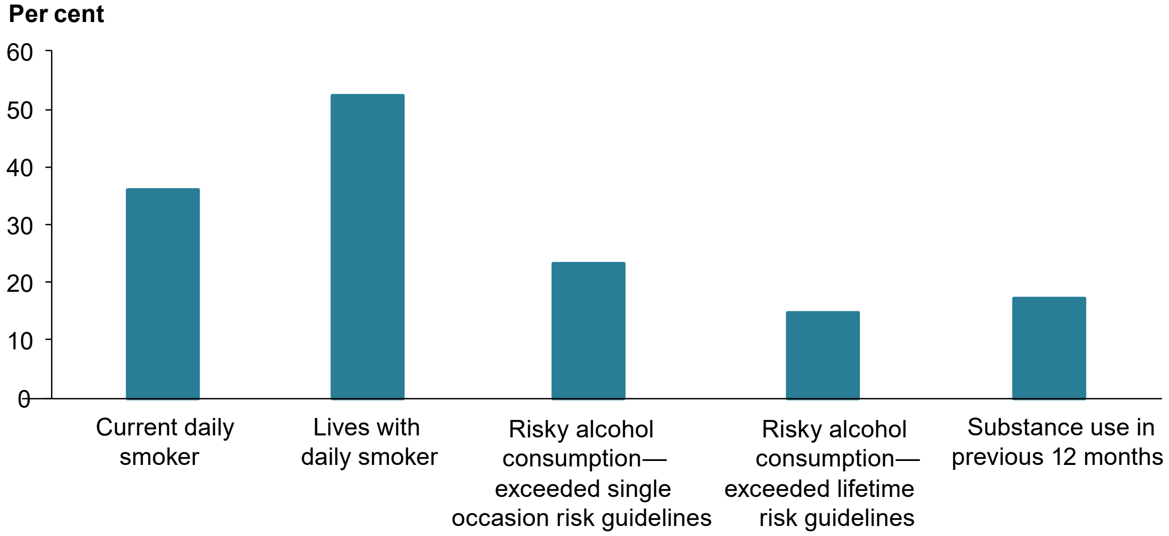
7.2.1 Tobacco use

In the 2014–15 NATSISS, among Indigenous Australians aged 50 and over:

- 37% (an estimated 36,700 people) reported that they were current smokers:
  - 36% smoked tobacco products daily (Figure 7.2)
  - 1% smoked tobacco less often than daily
- 63% (an estimated 61,900 people) reported that they were non-smokers:
  - 37% were ex-smokers
  - 26% had never smoked (Table S7.1 and AIHW analysis of 2014–15 NATSISS).

The NATSISS also collected information about smoking in the household. In 2014–15, about half of Indigenous Australians aged 50 and over (52%) were living in a household with at least 1 daily smoker, and 24% lived in a household in which someone smoked inside (Table S7.2 and AIHW analysis of ABS 2016c).

Figure 7.2: Tobacco, risky alcohol consumption and substance use among Indigenous Australians aged 50 and over, selected measures, 2014–15



Notes

1. Data on risky alcohol consumption are based on consumption over the previous 12 months.
2. Data for this figure and notes about the analysis are shown in Table S7.2.

Source: AIHW analysis of ABS 2016c.

7.2.2 Alcohol consumption

Risky alcohol consumption is associated with increased risk of chronic diseases, injury and death—older Australians are particularly vulnerable to the effects due to body composition, metabolic capacity and the presence of co-morbid conditions (NHMRC 2009).

Risky alcohol consumption is defined in this section according to the 2009 National Health and Medical Research Council (NHMRC) guidelines for lifetime and single occasion risk (see Box 7.1).

Exceeding lifetime risk guidelines is a major risk factor for conditions such as liver disease, pancreatitis, heart disease, stroke, diabetes, obesity and cancer (AHMAC 2017). Exceeding single occasion risk guidelines (or binge drinking) also contributes to injuries and deaths due to violence, self-harm, transport accidents and falls.

Box 7.1: Alcohol consumption risk levels

The 2014–15 NATSISS assessed risky alcohol consumption levels using both the 2001 and 2009 National Health and Medical Research Council (NHMRC) guidelines. In this report, risk levels are based on the 2009 guidelines. The following levels were deemed to have exceeded the guidelines for:

- single occasion risk—at levels of more than 4 standard drinks on a single occasion
- lifetime risk—at levels of more than 2 standard drinks per day on average.

One standard drink contains 10g of alcohol (equivalent to 12.5 mLs of pure alcohol), and the guidelines relate to both males and females.

In the 2014–15 NATSISS, lifetime risk was assessed based on a person's reported usual daily consumption of alcohol and the frequency of consumption in the 12 months prior to interview, while single occasion risk was assessed based on the quantity of alcohol consumed in a single day during the 2 weeks prior to interview.

Sources: ABS 2016d, NHMRC 2009.

Based on self-reported levels of alcohol consumption among Indigenous Australians aged 50 and over in the 2014–15 NATSISS, among those whose risk could be determined:

- 23% (an estimated 22,200 people) consumed more than 4 standard drinks on a single occasion in the previous year, exceeding the guidelines for single occasion risk
- 15% (an estimated 14,100 people) consumed more than 2 standard drinks per day on average over the previous year, exceeding the guidelines for lifetime risk
- among Indigenous Australians aged 50 and over, men reported higher levels than women for both single occasion risk (34% compared with 13%) and lifetime risk (24% compared with 6%) (AIHW analysis of ABS 2016c).

In the 2014–15 NATSISS, information on both single occasion risk and lifetime risk was available for about 97% of Indigenous Australians aged 50 and over (an estimated 95,500 people). Among these people:

- 12% exceeded both single occasion and lifetime risk guidelines
- 11% exceeded single occasion risk guidelines only
- 2% exceeded lifetime risk guidelines only
- 75% did not drink at risky levels (AIHW analysis of ABS 2016b).

7.2.3 Substance use

Information on substance use—that is, illicit substance and/or misuse of prescription drugs—was collected as part of the 2014–15 NATSISS. Due to the potentially sensitive nature of the questions, responses were voluntary; in 2014–15, information on substance use was available for 88% of Indigenous Australians aged 50 and over (an estimated 87,300 people). Among Indigenous Australians aged 50 and over who provided substance use information:

- 17% (an estimated 15,300) used illicit substances and/or misused prescription drugs in the last 12 months
- people living in non-remote areas were more likely to have used substances in the previous 12 months than those in remote areas (20% compared with 9%)
- the most commonly used substance was pain killers or analgesics for non-medical purposes (9% in the previous 12 months) followed by marijuana, hashish or cannabis resin (8%) (AIHW analysis of ABS 2016c).

In 2014–15, compared with those with no substance use, Indigenous Australians aged 50 and over reporting substance use in the last 12 months were more likely to:

- be a current smoker (57% compared with 32%)
- have experienced unfair treatment in the last 12 months because they are Indigenous (40% compared with 26%)
- have consumed alcohol at levels that exceeded the 2009 NHMRC guidelines for single occasion risk (41% compared with 20%) and lifetime risk (33% compared with 11%)
- have experienced homelessness (39% compared with 20%)
- have been formally charged by police at least once during their lifetime (55% compared with 31%) (AIHW analysis of ABS 2016c).

7.3 Alcohol and drug related hospital use

This section provides information on hospital service use among Indigenous Australians aged 50 and over, both for admitted patient care hospitalisations and emergency department presentations. There will be some overlap in people's receiving assistance in admitted patient care hospitalisations and emergency department presentations—for example, an individual admitted to hospital after presenting to an emergency department.

7.3.1 Emergency department presentations

Information on emergency department presentations related to alcohol and drug use is available from the National Non-admitted Patient Emergency Department Care Database.

The quality of the data reported for Indigenous status in emergency departments has not been formally assessed. In addition to this, the scope may not include services provided in areas where the proportion of Indigenous Australians (compared with other Australians) is higher than average. Therefore, data should be interpreted with caution (see Appendix A for detailed information on data quality).

Data in this section relate to emergency presentations with a major diagnostic block of Alcohol/drug abuse and alcohol/drug induced mental disorders. Major diagnostic block is a classification that groups emergency department presentations based on diagnosis information (AIHW 2017d).

In the 2-year period 2015–17:

- 18% (5,367) of all presentations for alcohol/drug abuse and alcohol/drug induced mental disorders among the total population aged 50 and over were for Indigenous Australians (Table S1.1)
- among Indigenous Australians aged 50 and over, there were 24 presentations due to alcohol/drug abuse and alcohol/drug induced mental disorders per 1,000 population—that is, on average, 2 presentations for every 100 Indigenous Australians aged 50 and over (Table S7.3).

In 2015–17, among Indigenous Australians aged 50 and over, the rate of presentations for alcohol/drug abuse and alcohol/drug induced mental disorder was higher for:

- men than women (32 compared with 17 per 1,000 population)
- those aged 50–64 than those aged 65 and over (31 compared with 6 per 1,000 population)
- those living in remote areas than non-remote areas (37 compared with 19 per 1,000 population) (Figure 7.3, Table S7.3).

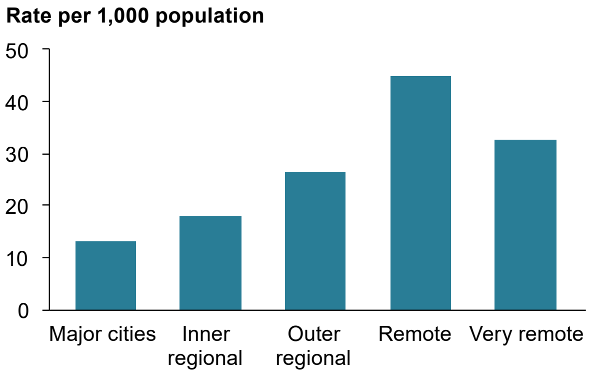
Triage category indicates the urgency of the patient's need for medical and nursing care at, or shortly after, the time of presentation. In 2015–17, of presentations for alcohol/drug abuse and alcohol/drug induced mental disorders among Indigenous Australians aged 50 and over:

- 10% were assigned to the 2 most urgent triage categories—Resuscitation (0.8%) and Emergency (8.9%) (should receive care immediately or within 10 minutes)
- 31% were classified as Urgent (should receive care within 30 minutes)
- 36% were classified as Semi-urgent (should receive care within 60 minutes)
- 23% were classified as Non-urgent (should receive care within 120 minutes).

Presentations for people living in *Inner regional* and *Outer regional,* and *Remote* and *Very remote* areas were more likely to be assigned as Non-urgent or Semi-urgent than presentations for those in *Major cities* (Figure 7.3).

Figure 7.3: Emergency department presentations due to alcohol and drug use among Indigenous Australians aged 50 and over, by various characteristics, 2015–17

By remoteness



By sex

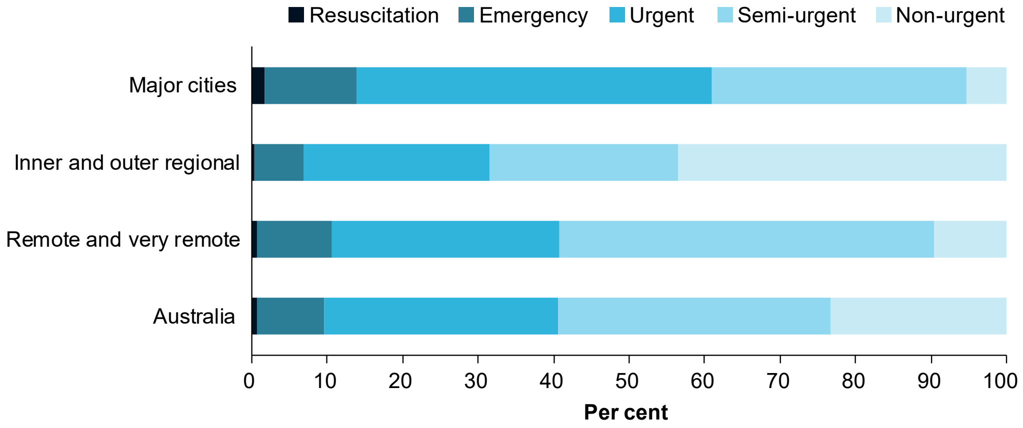
Males: 3,395 presentations
Females: 1,972 presentations

By age

50–64 years: 5,014 presentations
65+ years: 353 presentations

5,367 ED presentations
due to alcohol and drug use
among Indigenous Australians
aged 50 and over
in 2015–17

By urgency triage category and remoteness



Notes

1. Data are based on major diagnostic block. Includes emergency department presentations with a major diagnostic block Alcohol/drug abuse and alcohol/drug induced mental disorders.
2. Data for this figure and notes about the analysis are shown in tables S7.3 and S7.4.

Source: AIHW NNAPEDCD.

7.3.2 Admitted hospitalisations

Information on hospitalisations related to alcohol and drug use are available from the National Hospital Morbidity Database (see Appendix A for detailed information on data quality). Data in this section relate to admitted patient hospitalisations that are directly attributable to alcohol or drug use; they do not cover those hospitalisations where alcohol or drug use may be a contributing factor but the link is not direct or immediate (for example, various cancers).

Tobacco related hospitalisations are also not included in this report, as admissions directly attributable to tobacco do not reflect the impact of its use, with most conditions related to tobacco having an indirect link.

In the 2-year period 2014–16, among Indigenous Australians aged 50 and over, based on principal diagnosis, there were:

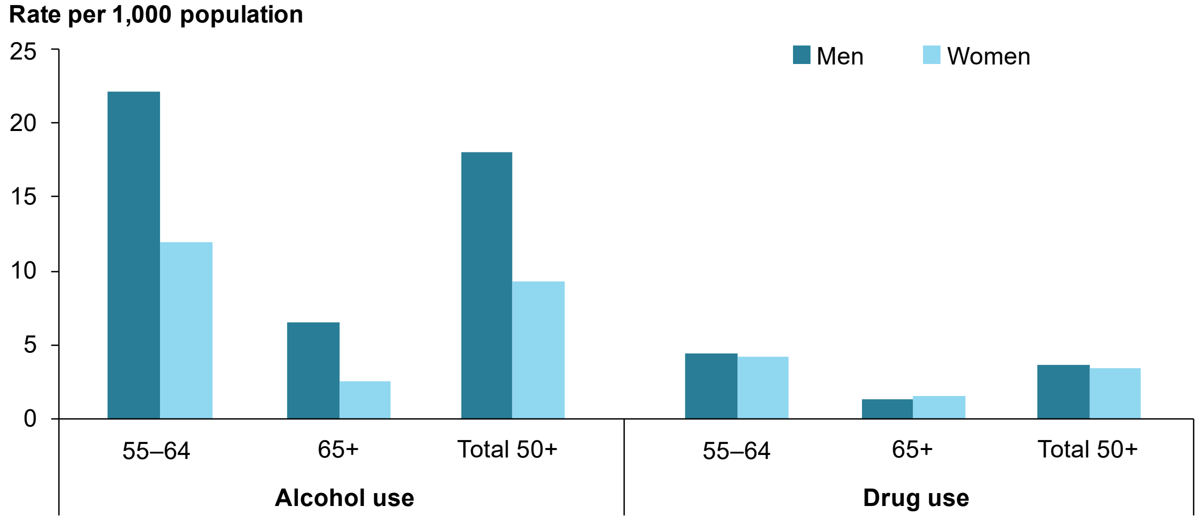
- nearly 2,900 hospitalisations related to alcohol use; 60% of these were due to acute intoxication (Table S7.5)
- around 760 hospitalisations related to drug use (Table S7.6).

In 2014–16, 5.3% of hospitalisations related to alcohol use among people aged 50 and over were for Indigenous Australians, and 3.7% of hospitalisations related to drug use (Table S1.1).

Among the Indigenous Australian population aged 50 and over, in 2014–16, there were:

- 13.5 hospitalisations related to alcohol use per 1,000 population; the rate for men was twice that for women (18.0 compared with 9.3 per 1,000 population)
- 3.5 hospitalisations related to drug use per 1,000 population; rates for men and women were similar (3.6 compared with 3.4 per 1,000 population, respectively) (Figure 7.4).

Figure 7.4: Hospitalisation rate due to alcohol and drug use for Indigenous Australians aged 50 and over, by age group and sex, 2014–16



Notes

1. Data are based on principal diagnosis (see tables S7.6 and S7.7 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S7.6 and S7.7.

Source: AIHW analysis of National Hospital Morbidity Database.

7.4 Specialised drug and alcohol treatment

Alcohol and other drug (AOD) treatment services assist people to deal with their drug use. Treatment objectives may include reducing or ceasing drug use as well as improving social and personal functioning. These treatments can come in many forms, from counselling to pharmacotherapy (chemical substitution treatment for opioid dependence). The family and friends of people using drugs may also be assisted and supported.

In Australia, publicly-funded AOD treatment services are available in all jurisdictions—state and territory governments fund most, though the Australian Government funds some. Services are also privately funded, however these data are not available for reporting.

7.4.1 Publicly-funded alcohol and other drug treatment services

Information on publicly-funded AOD treatment services in Australia is collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) (see Box 7.2 for further information and key terms). This section presents information on the use of these services by Indigenous Australians aged 50 and over.

In addition to these services, the Australian Government also funds organisations to provide substance-use services primarily to Indigenous Australians (AIHW 2018c). Some services may be in scope for the AODTS NMDS; however, most do not contribute to the data collection as they currently provide data to the Online Services Report (OSR) data collection. In 2016–17, there were 80 organisations providing substance-use services that reported to the Online Services Report data collection, with around 39,400 clients receiving at least 1 type of service. As detail on how many of these clients are aged 50 and over is not available, no further information on these services is provided in this section.

Box 7.2: Alcohol and other drug treatment services—key terms

Information on publicly-funded AOD treatment services in Australia, and the people and drugs treated, are collected through the AODTS NMDS. Key terms used in this chapter, in the context of data drawn from the AODTS NMDS, are defined below.

For further information about the AODTS NMDS, see *Alcohol and other drug treatment services in Australia 2016–17* (AIHW 2018i).

Clients: Client information is collected at the episode level in the AODTS NMDS. The collection does not contain a unique identifier for clients, however from 2012–13, a statistical linkage key (SLK) was introduced which enables the number of clients receiving treatment to be estimated. For the 2016–17 collection, SLK data were not available for all clients; and in this section only data relating to clients with a valid SLK are reported.

Closed treatment episode: A closed period of contact between a client and a treatment provider, or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months, or when treatment is ceased (see **Reasons for cessation**).

Principal drug of concern: The main substance that the client stated led them to seek treatment from the AOD treatment agency.

Reasons for cessation: The reasons for a client's ceasing to receive a treatment episode from an AOD treatment service include:

- expected cessation: episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement
- unexpected cessation: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- administrative cessation: episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

Treatment type: The principal activity that is determined at assessment by the treatment provider to be necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. Rehabilitation, withdrawal management (detoxification), and pharmacotherapy are not available for clients seeking support for someone else's drug use.

Client and episode characteristics

In 2016–17, around 1,300 Indigenous Australian clients aged 50 and over received nearly 2,000 closed treatment episodes from publicly funded AOD treatment agencies across Australia, for either their own or someone else's drug use.

In 2016–17, among Indigenous Australians aged 50 and over:

- 1,210 received treatment from publicly-funded AOD treatment agencies across Australia for their own drug use—a rate of 1,054 per 100,000 population, or about 1 in 95 Indigenous Australians aged 50 and over
- 87 received assistance in relation to someone else's drug use—a rate of 76 per 100,000 population (Table 7.1).

Table 7.1: Indigenous Australian clients(a), treatment episodes and rates of assistance for alcohol and other drug treatment services, people aged 50 and over, by client type, 2016–17

Client type	Own drug use	Other's drug use
Number of episodes	1,836	121
Number of clients	1,210	87
Episodes per client	1.5	1.4
Rate of episodes (per 100,000)	1,600	105.4
Rate of clients (per 100,000)	1,054	75.8

(a) Based on client records with a valid Statistical Linkage Key (SLK); data on number of clients have not been adjusted for missing or invalid SLKs.

Notes

1. Data relate to publicly-funded alcohol and other drug treatment services.

2. Table excludes clients with not stated age.

Source: AODTS NMDS.

In 2016–17, Indigenous Australian clients aged 50 and over constituted 8.5% of all clients aged 50 and over who received treatment for their own drug use, and 4.3% in relation to someone else's drug use (Table S1.1).

Over the 3-year period 2014–15 to 2016–17, among more than 2,900 Indigenous Australian clients aged 50 and over:

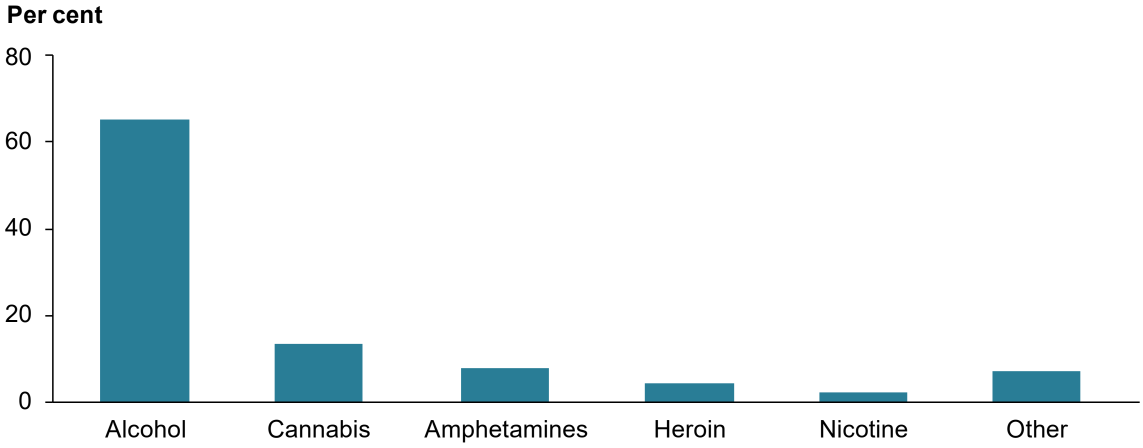
- 80% received treatment in a single year only
- 16% received treatment in at least 2 years
- 4% received treatment over the 3 years (Table S7.8).

Principal drugs of concern

In 2016–17, for closed treatment episodes for own drug use among Indigenous Australian clients aged 50 and over:

- alcohol was the most common principal drug of concern—that is, the primary drug leading someone to seek treatment—accounting for about two-thirds (65%) of all closed treatment episodes in this cohort
- the next most common principal drugs of concern were cannabis (13.5% of closed treatment episodes) and amphetamines (7.6%) (Figure 7.5).

Figure 7.5: Closed alcohol and other drug treatment episodes provided to Indigenous Australian clients aged 50 and over for own drug use, by principal drug of concern, 2016–17



Notes

1. The top 5 most common principal drugs of concern for Indigenous Australians aged 50 and over are shown; all other principal drugs of concern are included in the 'other' category.
2. Data for this figure and notes about the analysis are shown in Table S7.9.

Source: AODTS NMDS.

Treatment received for own drug use

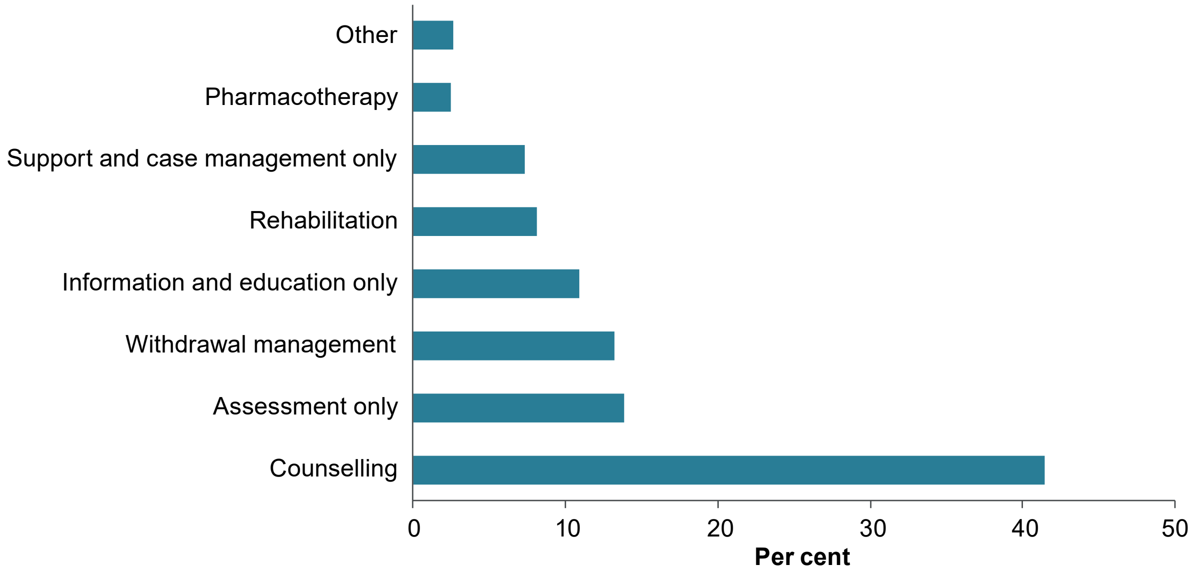
AOD treatment services assist people to deal with their drug use through a range of treatments. Treatment services include detoxification and rehabilitation, counselling, and pharmacotherapy, and are delivered in residential and non-residential settings.

In relation to the treatment setting, in 2016–17, among Indigenous Australian clients aged 50 and over receiving assistance for their own drug use:

- 63% of closed treatment episodes were provided in non-residential treatment facilities
- 18% of closed treatment episodes were provided in a residential treatment facility
- 16% of closed treatment episodes were provided in an outreach setting (that is, any public or private location where services are provided away from the main service location, or a mobile service) (Table S7.10).

Counselling was the most common main treatment type among Indigenous Australians aged 50 and over receiving treatment for their own drug use in 2016–17 (41%), followed by assessment only (14%) and withdrawal management (13%) (Figure 7.6).

Figure 7.6: Closed alcohol and other drug treatment episodes provided for own drug use, Indigenous Australian clients aged 50 and over, by main treatment type, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S7.11.

Source: AODTS NMDS.

In 2016–17, for treatment for own drug use among Indigenous Australians aged 50 and over:

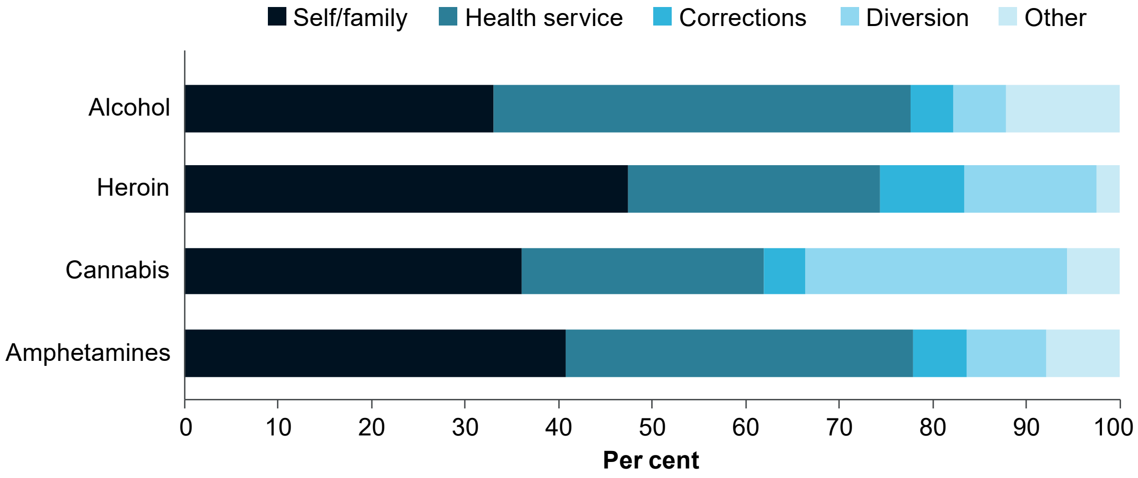
- more than 1 in 4 closed episodes (26%) ended within 1 day
- 30% ended between 2 and 29 days
- 23% ended between 30 and 90 days
- 21% lasted 91 days (3 months) or more (Table S7.12).

Referral source

In 2016–17, the most common source of referral for treatment episodes for own drug use among Indigenous Australians aged 50 and over was a health service (42%), followed by self/family (35%) (Table S7.13).

The referral source varied somewhat by principal drug of concern. In 2016–17, diversion was a more common referral source where cannabis was the principal drug of concern. It applied for 28% of closed episodes for Indigenous Australians aged 50 and over, compared with 14.1% for heroin, 8.6% for amphetamines and 5.7% for alcohol (Figure 7.7).

Figure 7.7: Closed alcohol and other drug treatment episodes provided for own drug use, Indigenous Australian clients aged 50 and over, by source of referral, 2016–17



Note: Data for this figure and notes about the analysis are shown in Table S7.13.

Source: AODTS NMDS.

Treatment completion

Reasons for clients no longer receiving treatment from an alcohol and other drug treatment service include expected cessations (for example, treatment was completed), unexpected cessations (for example, non-compliance), and administrative cessation (for example, client transferred to another service provider) (see also Box 7.2).

In 2016–17, of treatment episodes for Indigenous Australians aged 50 and over who were receiving assistance for their own drug use:

- 66% were expected or completed cessations
- 20% were unexpected episode cessations
- 5.7% were administrative cessations
- 8.2% ended for other reasons (Table S7.14).

7.4.2 Pharmacotherapy for opioid dependence

Opioid pharmacotherapy treatment is one of the main treatment types used for dependence on opioid drugs (such as heroin and morphine). It involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid that is taken orally. In Australia, 3 medications are registered for long-term maintenance treatment for opioid-dependence:

- methadone
- buprenorphine
- buprenorphine-naloxone.

Data on people accessing pharmacotherapy to treat opioid dependence is available from the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection (AIHW 2018j). For the 2017 NOPSAD collection, data relating to older Indigenous Australians were available for New South Wales, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory (see also Appendix A).

On a snapshot day in June 2017, in these 5 jurisdictions combined:

- 444 Indigenous Australians aged 50 and over were on a course of pharmacotherapy treatment for their opioid dependence, representing 6.8% of all clients aged 50 and over (Table S1.1).
- among Indigenous Australian clients aged 50 and over, methadone was the most commonly prescribed pharmacotherapy type (with 71% receiving methadone treatment) (Table 7.2).

Table 7.2: Indigenous Australian clients aged 50 and over receiving pharmacotherapy treatment on a snapshot day, by pharmacotherapy type, New South Wales, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory, 2017

Pharmacotherapy type	Number	%
Methadone	314	70.7
Buprenorphine	105	23.6
Buprenorphine-naloxone	25	5.6
Total	**444**	**100.0**

Notes

1. Unit record data were used to produce this table. Data for Victoria and Queensland were not available.
2. Victoria and Western Australia do not report Indigenous status.
3. These data should be treated with caution due to a high proportion of clients for whom Indigenous status was either not reported (16% of all clients aged 50 and over in 2017) or not stated (10% of all clients aged 50 and over in 2017).
4. Percentages may not sum to 100% due to rounding.

Source: 2017 NOPSAD collection.

8

Safety

There are no national prevalence estimates of safety-related vulnerabilities among Aboriginal and Torres Strait Islander people aged 50 and over. Indigenous Australians, however, are over-represented at all stages of the justice system, both as victims and offenders.

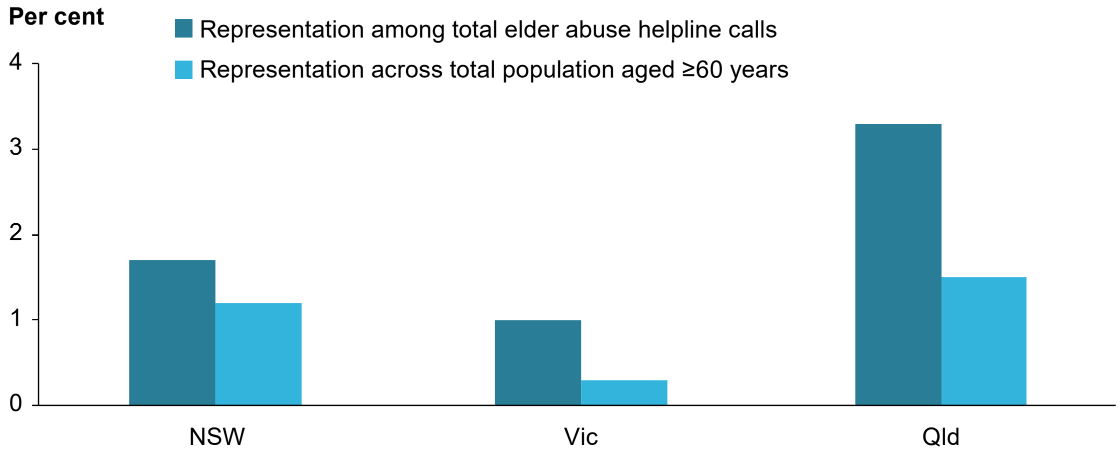
A variety of measures of physical and threatened violence are reported in this section as proxy measures for elder abuse, including reporting to elder abuse helplines, experiences of physical and threatened violence and feelings of personal and community safety.

8.1 Elder abuse helplines

Each state and territory in Australia has a telephone helpline for elder abuse, which provides information, advice and referrals relating to elder abuse. Data by Indigenous status of the older person seeking assistance are available for reporting from New South Wales, Victoria and Queensland.

Information from elder abuse helplines suggests that Indigenous Australians may be over-represented among older people seeking help with abuse (Figure 8.1). These data, however, do not provide evidence about the prevalence of elder abuse—they only relate to people contacting helplines, and the extent of contact with helplines is affected by knowledge of helplines, willingness to disclose and Indigenous identification. These data should be interpreted with caution as the helplines do not collect data according to nationally standardised definitions. Also, data were not provided for calls where it was not possible to collect detailed information about victims.

Figure 8.1: Indigenous Australians seeking help from state-based elder abuse helplines, 2017–18



Note: Elder abuse helplines collect and classify data in different ways, so caution should be exercised when comparing across states.

Source: AIHW analysis of data from the NSW Elder Abuse helpline and Resources Unit 2018; Seniors Rights Victoria 2018; Elder Abuse Prevention Unit 2016; ABS 2016 Census-based Estimated Resident Population.

8.2 Contact with legal services

This section looks broadly at contact with legal services to provide context on access to justice. People may have used legal services for many reasons, other than for criminal matters (for example land claims, writing a will). The 2014–15 NATSISS collected information on contact with legal services; however due to the sensitive nature of the topic, the reasons a person sought legal advice were not collected.

In 2014–15, an estimated 11% of Indigenous Australians aged 50 and over used legal services in the previous 12 months, with a similar proportion for men (11%) and women (10%). Of Indigenous Australians aged 50 and over who had used a legal service in the previous 12 months:

- 39% used an Aboriginal legal service
- 38% used a private legal service
- 27% used Legal Aid (Table S8.2; note that multiple responses were allowed) (ABS 2017c).

8.3 Personal and community safety

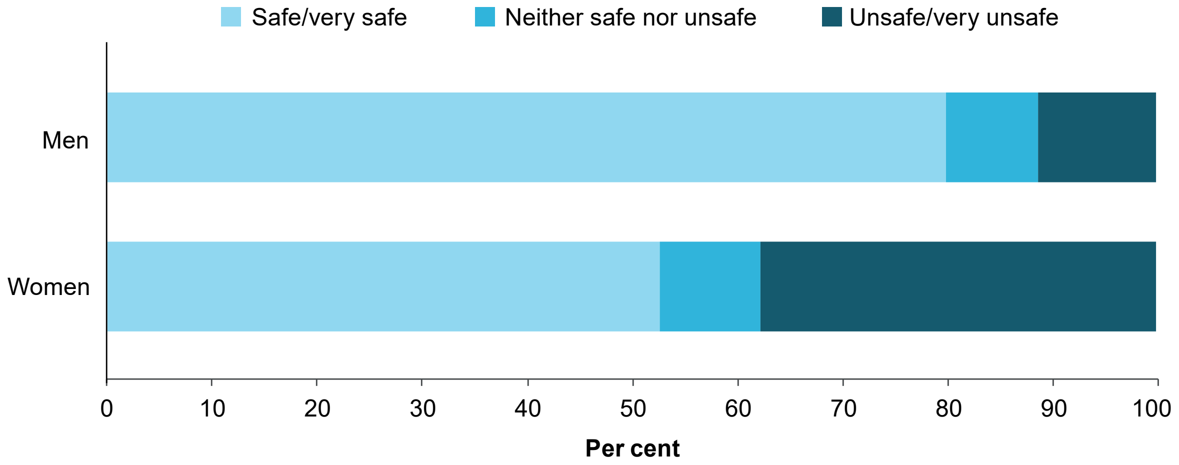
The 2014–15 NATSISS collected information on feelings of safety at home alone after dark, as well as feelings of safety walking alone in the local area after dark. Nearly all (98%) Indigenous Australians aged 50 and over reported that they spent time at home alone after dark. Of those people who spent time home alone after dark:

- an estimated 89% felt safe or very safe at home alone after dark, while 7% felt unsafe or very unsafe and the remainder felt neither safe nor unsafe
- women were nearly 4 times as likely as men to report feeling unsafe or very unsafe (11% compared with 3%) (Table S8.3).

In 2014–15, among Indigenous Australians aged 50 and over, 67% had walked alone in the local area after dark, with men more likely than women (83% compared with 54%) (Table S8.4). Of these people:

- 68% felt safe or very safe walking alone in their local area after dark, 9.3% felt neither safe nor unsafe, and 22.4% felt unsafe or very unsafe
- women were more likely than men to report feeling unsafe or very unsafe—38% compared with 11% (Figure 8.2).

Figure 8.2: Feelings of safety walking alone in local area after dark among Indigenous Australians aged 50 and over, by sex, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S8.4.

Source: AIHW analysis of ABS 2016c.

8.3.1 Neighbourhood or community problems

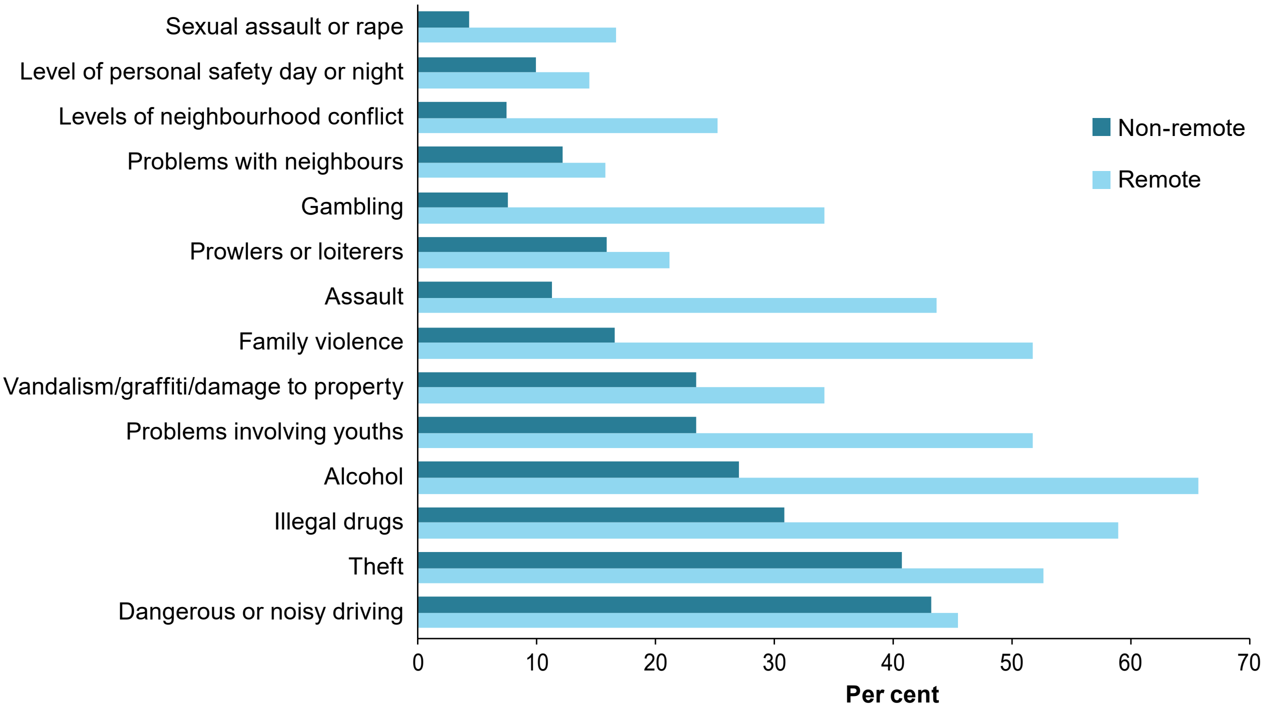
In the 2014–15 NATSISS, information was collected across 14 types of neighbourhood or community problems. Individuals were asked whether they thought there were problems in their community or neighbourhood. In 2014–15, among Indigenous Australians aged 50 and over:

- 70% perceived at least 1 neighbourhood or community problem in their local area (with broadly similar proportions for men and women—68% and 73% respectively)
- those living in remote areas were more likely than those in non-remote areas to perceive at least one neighbourhood or community problem in their local area—86% compared with 66% (tables S8.5, S8.6)
- the 5 most commonly reported neighbourhood or community problems perceived by respondents were dangerous and noisy driving (reported by 44% of Indigenous Australians aged 50 and over), theft (43%), illegal drugs (37%), alcohol (36%) and problems involving youths (30%) (Table S8.6)
- in remote areas, the most commonly reported perceived neighbourhood or community problem was alcohol (66%), followed by illegal drugs (59%). In non-remote areas, dangerous or noisy driving and theft were most commonly reported (43% and 41% respectively) (Table S8.6).

The reported prevalence of many problems was higher in remote than non-remote areas (Figure 8.3). For example, Indigenous Australians aged 50 and over in remote areas were more likely to perceive the following problems than those in non-remote areas:

- alcohol—reported by 66% of those in remote areas, compared with 27% in non-remote areas
- family violence—52% compared with 17%
- assault—44% compared with 11% (Figure 8.3).

Figure 8.3: Proportion of Indigenous Australians aged 50 and over who perceived there were selected neighbourhood or community problems, by remoteness, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S8.6.

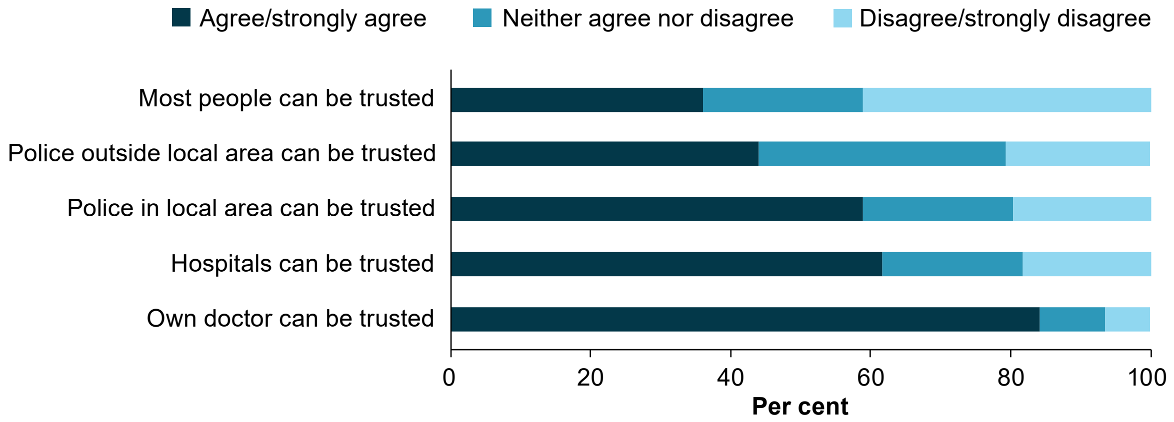
Source: AIHW analysis of ABS 2016c.

8.3.2 Level of trust in people

In the 2014–15 NATSISS, Indigenous Australians self-reported on their level of trust in people in their community. Among Indigenous Australians aged 50 and over, who self-reported on their level of trust across specific people or services:

- around one-third (an estimated 36%) agreed or strongly agreed that they could trust most people
- an estimated 59% agreed or strongly agreed that they could trust police in the local area
- an estimated 62% agreed or strongly agreed that they could trust hospitals—a higher rate for those who lived in remote areas (73%) than for those in non-remote areas (58%)
- an estimated 84% agreed or strongly agreed that they could trust their own doctor (Figure 8.4).

Figure 8.4: Proportion of Indigenous Australians aged 50 and over, by how strongly they agreed that they could trust specific people or services, 2014–15



Note: Data for this figure and notes about the analysis are shown in Table S8.7.

Source: AIHW analysis of ABS 2016c.

8.4 Victims of crime

Information is presented here on experiences of physical and threatened violence, based on self-reported NATSISS data, as well as information on victims of selected crimes based on administrative data sources—such as police and hospital records.

Each subsection includes some information on victims of crimes related to family violence. Family violence refers to violence between family members as well as between current or former intimate partners (AIHW 2018b). For this report, domestic violence is considered to be a subset of family violence. It refers to violent behaviour between current or former intimate partners—typically, where one partner tries to exert power and control over the other, usually through fear. It can include physical, sexual, emotional and psychological abuse.

8.4.1 Self-reported victims of physical and threatened violence

In the 2014–15 NATSISS, Indigenous Australians reported on their experiences of physical or threatened violence. Among Indigenous Australians aged 50 and over, an estimated:

- 6.5% experienced physical violence in the previous 12 months. Based on the most recent incident:
  - 86% knew the offender
  - 55% had been physically harmed or injured
  - 59% had reported the most recent experience of physical violence to police
  - for 83%, alcohol or other substances contributed to the most recent incident
- 9.5% had experienced threatened physical violence in the previous 12 months—about one-quarter (26%) of these people reported the most recent threat to the police (tables S8.9, S8.10)
- 13.5% experienced either actual physical violence or threatened physical violence in the previous 12 months, with 6.8% experiencing threatened physical violence only, 3.9% experiencing physical violence but no threatened physical violence, and 2.8% experiencing both (tables S8.8, S8.9).

NATSISS data for 2014–15 indicate that Indigenous Australians aged 50 and over who reported experiencing physical violence in the previous 12 months were:

- 3 times as likely as those who had not experienced physical violence to have felt unsafe or very unsafe at home alone after dark—18% compared with 6%
- 2 times as likely as those who had not experienced physical violence to have high or very high levels of psychological distress (based on the Kessler Psychological Distress Scale questions)—59% compared with 30%
- more likely than those who had not experienced physical violence to live alone (39% compared with 25%) (Table S8.11).

Similarly, among Indigenous Australians aged 50 and over in 2014–15 who reported experiencing threatened physical violence, an estimated:

- 16% felt unsafe or very unsafe at home alone after dark, compared with 6% among those who had not experienced threatened physical violence
- 51% had high or very high levels of psychological distress, compared with 29% of those who had not experienced threatened physical violence
- 45% lived alone, compared with 24% of those who had not experienced threatened physical violence (Table S8.11).

Indigenous Australians who reported experiencing physical violence were also asked in the 2014–15 NATSISS about their relationship to the perpetrator. In 2014–15, among Indigenous Australians aged 50 and over who had experienced physical violence in the previous 12 months, the perpetrator was known to the victim in nearly 90% of incidents, while the perpetrator was reported to be a family member in 44% of all incidents (Table 8.1). The data also indicated that the child was the perpetrator for 14% of incidents, although this proportion should be interpreted with caution due to the small sample size and related uncertainty in the reliability of the estimate.

Table 8.1: Indigenous Australians aged 50 and over who had experienced physical violence in the previous 12 months, by relationship of perpetrator in most recent experience of violence, 2014–15

Relationship of perpetrator to the victim	Number	%
Child	*900	*14.1
Other family member[a]	1,900	29.7
Total family member	*2,800*	*43.8*
Other known person[b]	2,800	43.8
Did not know perpetrator	*700	*10.9
Total[c]	**6,400**	**100.0**

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

(a) Includes current and previous partners (de facto/husband/wife), parents, siblings, and other family members.

(b) Includes boyfriend, girlfriend or date, ex-boyfriend or ex-girlfriend, friend, work colleague/fellow school student, neighbour, known by sight only, other known person.

(c) Excludes people for whom information on the relationship with the perpetrator was not available.

Note: For confidentiality reasons, the ABS randomly adjusts NATSISS TableBuilder data; consequently, data in this table may differ slightly from data published elsewhere.

Source: AIHW analysis of ABS 2016c.

8.4.2 Police-recorded victims of selected crimes

Crime statistics on victims of certain offences recorded by police are available through the annual ABS Recorded Crime—Victims data collection (see Box 8.1 and Appendix A for further information).

This section presents data on Indigenous Australians aged 50 and over recorded as victims of assault, sexual assault and robbery during 2016. National data by Indigenous status were not available; data on assaults (including assaults related to family violence) were available for 3 jurisdictions—New South Wales, South Australia and the Northern Territory—while data on sexual assault and robbery were available for those 3 jurisdictions and Queensland. Data by Indigenous status for the other states and territories were assessed by the ABS as not being of sufficient quality for reporting (ABS 2017b).

Box 8.1: ABS Recorded Crime—Victims data collection: concepts and key terms

ABS *Recorded Crime—Victims* data do not provide a total count of unique victims, nor the total number of individual offences that came to the attention of police. Due to the nature of policing, many factors influence the level of recorded crime, which may not reflect changes in the actual number of criminal incidents (for example, legislation changes may affect the level of recorded crime and type of offences recorded).

Assault: Direct infliction of force, injury, or violence on a person(s), or the direct threat of force, injury or violence where there is apprehension that the threat could be enacted.

Family violence (*referred to as family and domestic violence in ABS collection)*: An offence involving at least 2 people who were in a specified family or domestic relationship at the time of the offence, or where the offence was determined by police, as part of their investigation, to be related to family and/or domestic violence.

Robbery: Unlawful taking of property, with the intent to permanently deprive the owner of the property, from the immediate possession, control, custody or care of a person or organisation, accompanied by use, and/or threatened use, of immediate force or violence.

Sexual assault: Physical contact, or intent of contact, of a sexual nature directed towards another person where that person does not give consent, gives consent as a result of intimidation or deception, or consent is proscribed (that is, the person is legally deemed incapable of giving consent).

Police-recorded assault

Based on 2016 police-recorded assaults data, among Indigenous Australians aged 50 and over in New South Wales, South Australia and the Northern Territory combined, there were:

- 868 victims of assault recorded—representing 7.2% of assault victims across the total population aged 50 and over in these 3 jurisdictions (Table S1.1)
- 16 victims of assault per 1,000 Indigenous Australian population aged 50 and over in these 3 jurisdictions—that is, on average, nearly 2 victims per 100 population (Table S8.12).

In 2016, among Indigenous Australians aged 50 and over, in New South Wales, South Australia and the Northern Territory combined, the rate of recorded assault for women was 1.6 times the rate for men (19 compared with 12 per 1,000 population) (Table S8.12).

Police-recorded relationship between offender and victim of assaults

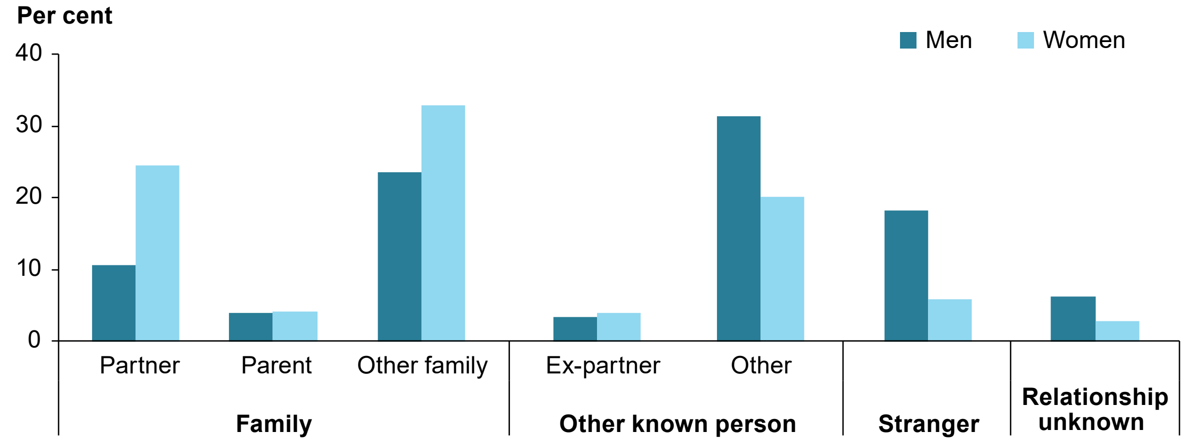
Police-recorded assaults data are available on the relationship between the offender and victim in New South Wales, South Australia and the Northern Territory combined. Looking broadly at the relationship between the offender and victim, in 2016, of Indigenous Australian victims of assault aged 50 and over, 86% (749) knew their offender, consisting of:

- 57% (498) who were family members
- 29% (251) who were non-family members (Table S8.12).

Figure 8.5 shows the relationship of the offender to victims of assault for Indigenous Australian men and women aged 50 and over in New South Wales, South Australia and the Northern Territory:

- women were more likely than men to know their offender (92% compared with 77%)
- partners contributed 25% of all assaults on women (compared with 11% for men)
- 'other family' contributed 33% of all assaults on women (compared with 24% for men)
- men were more likely to be victims of assault by a stranger than women (18% compared with 6%).

Figure 8.5: Proportion of Indigenous Australian victims of assault aged 50 and over, by relationship of offender to victim, in New South Wales, South Australia and the Northern Territory combined, by sex, 2016



Note: Data for this figure and notes about the analysis are shown in Table S8.12.

Source: AIHW analysis of ABS Recorded Crime—Victims data collection, 2016.

The police-recorded data also include a specific classification for assaults that are 'family and domestic violence-related (FDV)'. This classification relates to an offence involving at least 2 people who were in a specified family or domestic relationship at the time of the offence; or where the offence was determined by police to be FDV as part of their investigation (ABS 2017b).

According to this classification, in 2016, among Indigenous Australians aged 50 and over in New South Wales, South Australia and the Northern Territory combined, there were:

- 563 victims of FDV assaults recorded by police—representing 11% of all FDV assault victims among the total Australian population aged 50 and over in these 3 jurisdictions (Table S1.1)

- 10 victims of FDV assaults recorded by police per 1,000 Indigenous Australians in these jurisdictions (Table S8.13).

Among Indigenous Australians aged 50 and over in New South Wales, South Australia and the Northern Territory combined, the rate of FDV-related assaults recorded was:

- higher for those aged 50–64 than for those aged 65 and over (13 compared with 3 per 1,000 population) (Table S8.13)
- higher for women than men (14 compared with 6 per 1,000 population) (Table S8.14).

Of Indigenous Australians aged 50 and over who were victims of FDV assaults in 2016, 67% were assaulted in a residential setting, 22% were assaulted in a community location, and 34% had a weapon used in the incident (Table S8.14).

Police-recorded sexual assault and robbery

Based on 2016 police-recorded data, among Indigenous Australians aged 50 and over in New South Wales, Queensland, South Australia and the Northern Territory combined, there were:

- 56 victims of sexual assault—representing 7.5% of total sexual assault victims across the Australian population aged 50 and over in these jurisdictions (Table S1.1)
- 13 victims of robbery—representing 2.3% of robbery victims across the Australian population aged 50 and over in these jurisdictions (Table S1.1).

8.5 Hospitalisations for assault

National data on hospitalisations due to non-fatal assault are available from the National Hospital Morbidity Database (see Appendix A for detailed information on data quality). Hospitalisations provide some information on instances of assault that result in hospitalisations. However, these sources are likely to underestimate the true extent of assaults because not all victims seek medical attention and not all hospitalisations resulting from assault will be recorded as such; so, caution is advised in interpreting these data.

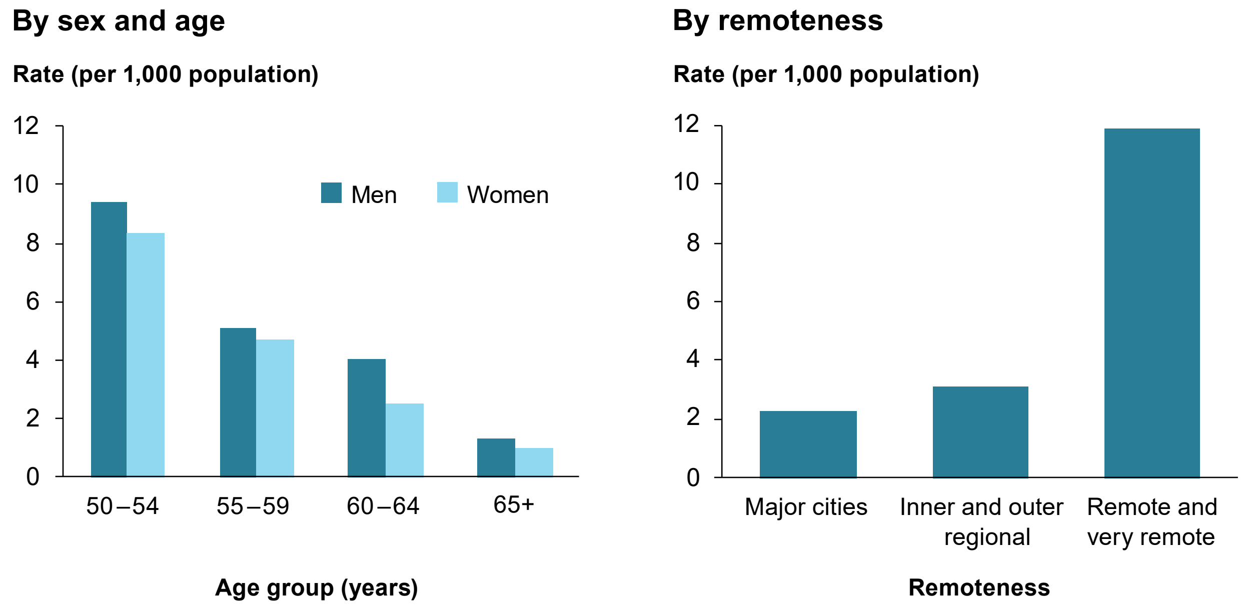
8.5.1 All assault hospitalisations

This section presents information on non-fatal hospitalisations that were due to assault. In the 2-year period 2014–16:

- there were 1,025 hospitalisations among Indigenous Australians aged 50 and over that were due to non-fatal assault—representing 17% of hospitalisations for non-fatal assault among the total Australian population aged 50 and over (Table S1.1)
- among Indigenous Australians aged 50 and over, there were 4.8 hospitalisations due to assault per 1,000 population (Table S8.16)
- among Indigenous Australians aged 50 and over, the rate of hospitalisations for non-fatal assaults reduced with age from 8.8 per 1,000 population among those aged 50–54 to 1.1 per 1,000 among those aged 65 and over, but increased with remoteness (Figure 8.6).

Note that for the accompanying *In brief* report an error occurred for these hospitalisations data, which has since been corrected.

Figure 8.6: Rate of non-fatal hospitalisations for assault among Indigenous Australians aged 50 and over, by sex and age, and by remoteness, 2014–16



Notes

1. Data are based on principal diagnosis and first reported external cause (see Table S8.16 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in tables S8.16, S8.17.

Source: AIHW analysis of the National Hospital Morbidity Database.

8.5.2 Family violence-related hospitalisations for assault

Information on family violence-related hospitalisations for assault are also available from the National Hospital Morbidity Database (see Appendix A).

In 2014–16, among Indigenous Australians aged 50 and over, the perpetrator was specified for 58% (592 hospitalisations) of non-fatal hospitalisations identified as bring due to assault (Table S8.18). Hospitalisations may lack specific information about a perpetrator for a number of reasons, including that information is not reported by or on behalf of victims, or is not recorded in the patient's hospital record.

In 2014–16, there were 454 non-fatal hospitalisations of Indigenous Australians aged 50 and over recorded as being due to a family violence-related assaults, representing:

- 77% of non-fatal hospitalisations for assault among Indigenous Australians where the perpetrator was specified (Table S8.19)
- one-quarter (26%) of all non-fatal hospitalisations for family violence-related assault among the total Australian population aged 50 and over (Table S1.1).

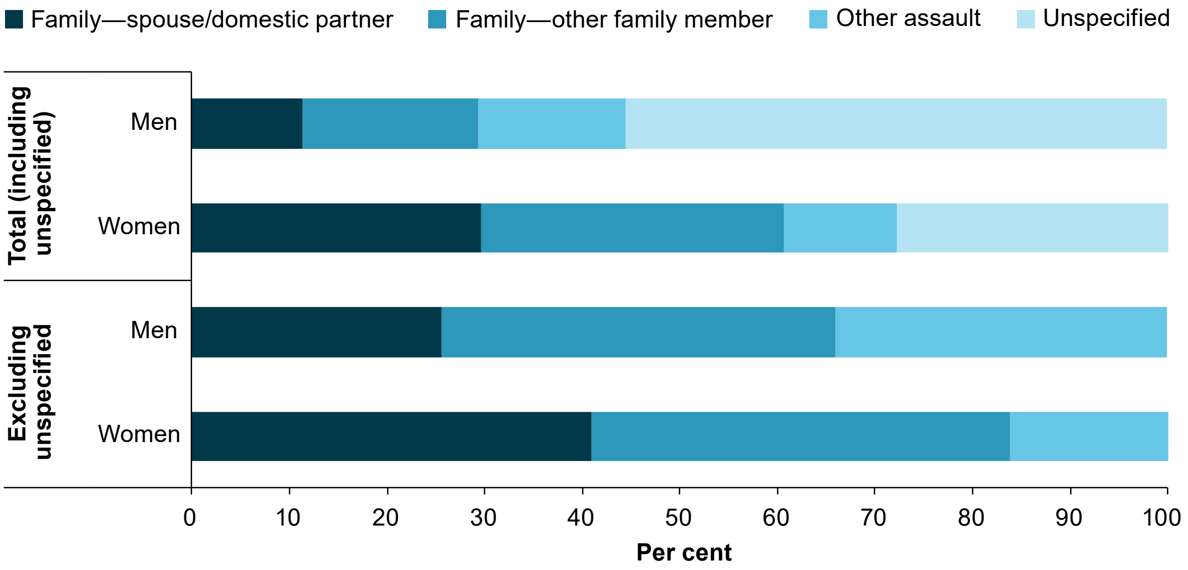
In 2014–16, among Indigenous Australians aged 50 and over:

- there were 2.1 non-fatal hospitalisations for assaults related to family violence per 1,000 population; the rate for women was 1.7 times the rate among men (2.6 compared with 1.5 per 1,000 population)

- the rate of non-fatal hospitalisation for assaults related to family violence was over 6 times higher in remote and very remote areas than in major cities (5.7 compared with 0.9 per 1,000 population) (tables S8.17, S8.18).

In 2014–16, the proportion of non-fatal hospitalisations for assaults related to family violence was higher for women than for men—84% compared with 66% (excluding hospitalisations where the perpetrator was unspecified) (Figure 8.7).

Figure 8.7: Non-fatal hospitalisations for assault among Indigenous Australians aged 50 and over, by relationship of victim to perpetrator and sex, 2014–16



Notes

1. Data are based on principal diagnosis and first reported external cause (see Table S8.16 for ICD-10-AM codes included in the analysis).
2. Data for this figure and notes about the analysis are shown in Table S8.19.

Source: AIHW analysis of the National Hospital Morbidity Database.

8.6 Criminal charges and incarceration

A recent study in the United States explored the interrelated impacts of mass incarceration on wellbeing. It was noted that incarceration rates reflect race inequality, and that race differences can further negatively affect their wellbeing of various minorities (Blankenship et al. 2018).

8.6.1 Charged by police

In the 2014–15 NATSISS, Indigenous Australians provided information on whether they had been formally charged by police. In 2014–15, among Indigenous Australians aged 50 and over:

- an estimated 36% had been formally charged by police in their lifetime
- the proportion who had been formally charged was higher for men than women—55% compared with 19% (Table S8.20).

8.6.2 Imprisonment

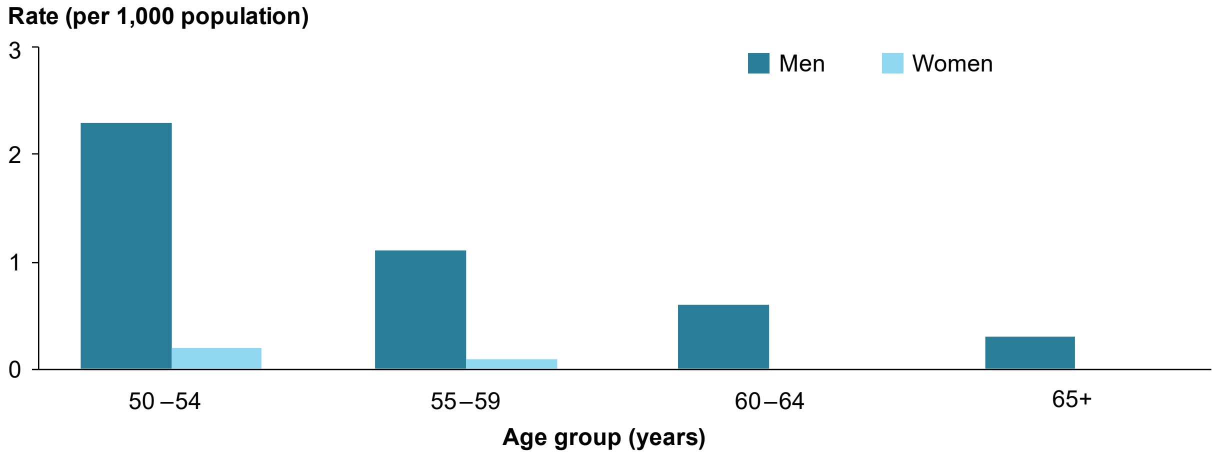
The ABS National Prisoner Census provides information on prisoners held in custody in Australian adult prisons across Australia on 30 June each year (ABS 2017c for more information about this data source). As at 30 June 2017, there were:

- 687 Indigenous Australians aged 50 and over in prison, representing 13% of all prisoners aged 50 and over (Table S1.1)
- 6 Indigenous Australians aged 50 and over per 1,000 population were in prison (Table S8.21).

As at 30 June 2017, among Indigenous Australians aged 50 and over:

- 91% of prisoners were men
- the imprisonment rate for men was 14 times the rate for women—11 compared with 0.8 per 1,000 population
- the imprisonment rate decreased with age among both men and women (Figure 8.8; Table S8.21).

Figure 8.8: Rate of imprisonment among Indigenous Australians aged 50 and over, by sex and age group, 30 June 2017



Note: Data for this figure and notes about the analysis are shown in Table S8.21.

Source: AIHW analysis of ABS 2017c.

Data related to imprisonment are also available from the 2014–15 NATSISS. In 2014–15, among Indigenous Australians aged 50 and over:

- an estimated 11% had been imprisoned during their lifetime
- the proportion of men who had been imprisoned was about 4 as high as the proportion of women—18% compared with 4% (Table S8.22).

8.7 Homicides

The Australian Institute of Criminology collects national data on homicides in Australia under the National Homicide Monitoring Program (NHMP). Information on homicides is based on administrative data and is available in relation to victims, offenders, and incidents. As homicides are a relatively rare event, data for this section are reported for a combined 25-year period (from 1 July 1989 to 30 June 2014) to improve robustness of the data. Data need to be interpreted with caution as situational trends over time will not be captured, and time series comparisons are out of scope for this report (see also Appendix A).

Over the period 1989–90 to 2013–14, among Indigenous Australians aged 50 and over, there were:

- 83 homicide victims (resulting from 81 homicide incidents)—representing 5% of homicide victims across the total Australian population aged 50 and over (Table S1.1)
- about 6 homicide victims per 100,000 population (Table 8.2).

Among Indigenous Australians aged 50 and over, men were 3 times as likely as women to be victims of homicide—9.0 compared with 2.9 per 100,000 population (Table 8.2).

Table 8.2: Indigenous Australian homicide victims aged 50 and over, by sex, 1989–90 to 2013–14

Sex	Number	Rate (per 100,000 population)(a)(b)
Men	61	9.0
Women	22	2.9
People	83	5.8

(a) For the rate calculations, the denominator was calculated by summing estimates of the population at the mid-point of each financial year (that is, at 31 December, from 1989 to 2013). As population estimates were available for 30 June only (rather than 31 Dec), the mid-year estimates were first derived by averaging the 30 June estimates bordering the financial year (for example, average of 30 June 2012 and 30 June 2013 for 2013–14 data). See also footnote (b).

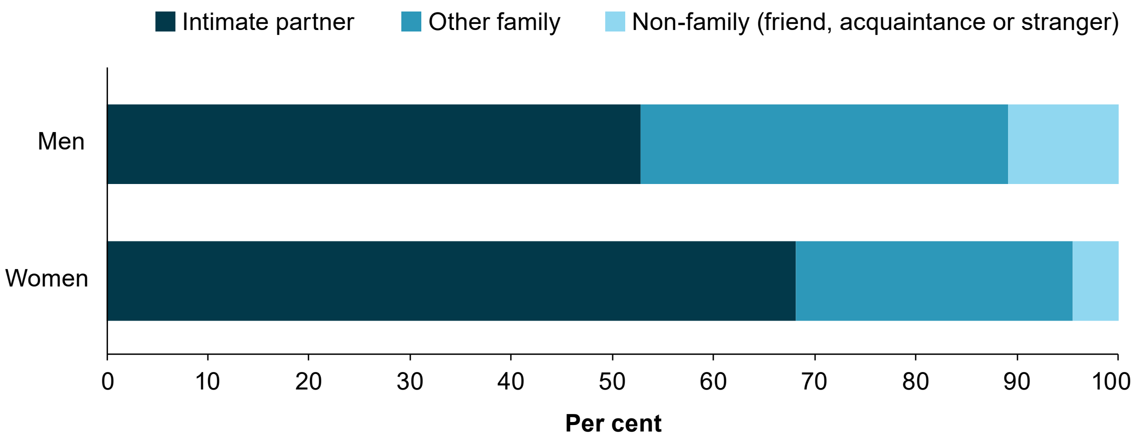
(b) The denominator population was derived using 2006 Census-based population estimates for June 1990 to June 1995, and 2011 Census-based estimates and projections (series B) for June 1996 to June 2014. See also footnote (a).

Sources: AIHW analysis of: data from the Australian Institute of Criminology National Homicide Monitoring Program 1989–90 to 2013–14 [computer file]; (ABS 2014b); (ABS 2009).

Over the period 1989–90 to 2013–14, among Indigenous Australian homicide victims aged 50 and over:

- 91% (70 victims) were killed by a family member—57% (44 victims) by an intimate partner, and 34% (26 victims) by another family member
- women were more likely than men to be killed by an intimate partner—68% of all female victims compared with 53% of all male victims (Figure 8.9).

Figure 8.9: Indigenous Australian homicide victims aged 50 and over, by relationship between victim and offender and sex, 1989–90 to 2013–14



Notes

1. Proportions were calculating after excluding victims for whom the relevant information was not available.
2. Data for this figure and notes about the analysis are shown in Table S8.23.

Source: AIHW analysis of Australian Institute of Criminology NHMP (computer file).

Among homicide incidents between 1989–90 and 2013–14 with an Indigenous Australian victim aged 50 and over:

- where a motive was recorded, 75% (53 incidents) were motivated by an argument—most commonly an alcohol-related argument (35%), followed by a domestic argument (30%) (Table S8.24)
- 73% (59 incidents) occurred in the presence of alcohol use—that is, alcohol was consumed by:
  - the offender only (5% of incidents)
  - the victim only (7%)
  - both the victim and offender (60%).

Appendix A

Key data sources

This appendix summarises the key data sources used in the report. Data sources are listed alphabetically for ease of reference.

Aboriginal and Torres Strait Islander Health Survey

The ABS 2012–13 AATSIHS was designed to obtain national benchmark information on a range of health-related issues and to enable monitoring over time on the health of Indigenous Australians (ABS 2013e). It combined the previous ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) with 2 new components:

- a National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey, which collected detailed nutritional and physical activity data
- a National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS), which collected blood and urine samples from adults to test for nutritional status and chronic disease markers.

In this report, all 3 components are collectively referred to as the 2012–13 AATSIHS.

Overall, the AATSIHS included a nationally representative sample of around 13,000 Indigenous Australians living in 8,300 private dwellings in remote and non-remote areas of Australia, including discrete Indigenous communities.

Chapter 3 of this report includes data from the AATSIHS on the prevalence of certain health conditions. While the prevalence of a few conditions (such as diabetes) and some risk factors (such as obesity) were ascertained by taking biomedical or other measures, most data from the AATSIHS were self-reported by survey participants (or their proxies). Whether or not a person reports having a condition often depends on whether the condition has been diagnosed—some conditions that have yet to be detected (for example, those in the early stages) may not be captured in self-reported data. In addition, the reporting of conditions and risk factors can be affected by imperfect recall, willingness to disclose and individual interpretations of survey questions.

Further information about the AATSIHS can be found in various ABS publications, including those that provide results from the survey (ABS 2013d, 2014a, 2014c) and the AATSIHS users' guide (ABS 2013b).

Alcohol and Other Drug Treatment Services National Minimum Data Set

The AODTS NMDS contains information on closed treatment episodes provided by publicly funded alcohol and other drug treatment services. The AIHW is responsible for collating data from jurisdictions into a national data set and analysing and reporting on the data.

Data in the AODTS NMDS are collected annually and relate to 'closed treatment episodes', defined as a treatment episode where one of the following apply:

- the treatment is completed or has ceased
- there has been no contact between the client and treatment provider for 3 months
- there is a change in the main treatment type, principal drug of concern or delivery setting.

For each treatment episode, information is collected on: characteristics of the client (such as Indigenous status, sex); whether the client is receiving treatment for their own drug use or someone else's drug use; drugs of concern; types of treatment; start/end dates of the episode; and the reason the episode was closed.

The AODTS NMDS does not contain a unique identifier for clients. However, from 2012–13 collection, a statistical linkage key (SLK) was introduced to enable clients to be counted. For the 2016–17 collection, approximately 99% of national data contained a valid SLK.

Information on the Indigenous status of clients is collected. In 2016–17, information on Indigenous status was not reported for 4.0% of clients aged 50 and over.

A data quality statement about the 2016–17 AODTS NMDS is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/693818.

Australian and New Zealand Dialysis and Transplant Registry

The Australian and New Zealand Dialysis and Transplant Registry (ANZDATA) collects information to monitor dialysis and transplant treatments from all renal units in Australia and New Zealand on all patients receiving kidney replacement therapy where the intention to treat is long-term. Cases of acute kidney injury are excluded. The registry is coordinated within the Queen Elizabeth Hospital in Adelaide and compiles data on incidence and prevalence of treated ESKD, complications, comorbidities and patient deaths. All relevant hospitals and related dialysis units participate. While patients have the option to opt out of having part or all of their data recorded, this rarely happens. The interpretation and reporting of these data are the responsibility of the AIHW and in no way should be seen as an official policy or interpretation of the ANZDATA.

Further information about the ANZDATA can be found in the 40th Annual ANZDATA Report 2017 (ANZDATA 2017).

Australian Burden of Disease Study 2011

In the Australian Burden of Disease Study (ABDS) 2011, the AIHW produced Australian-specific burden of disease estimates for the total population and the Aboriginal and Torres Strait Islander population. Estimates were produced for the year 2011, as well as for 2003, to allow for comparisons over time.

In the ABDS 2011, data to develop the burden of disease estimates were obtained from many different sources. Deaths data to estimate fatal burden were sourced from the AIHW's National Mortality Database.

Morbidity data to estimate non-fatal burden were drawn from a wide variety of existing sources of epidemiological measures (such as incidence, prevalence and mortality): disease registers, administrative data, surveys and epidemiological studies.

Risk factor exposure data were sourced from a variety of data sources including national surveys, registry data and monitoring programs. Relative risks were obtained mostly from the Global Burden of Disease Study 2010 or 2013, or from direct evidence from Australian data sources where available.

Other inputs were obtained from the 2010 or 2013 Global Burden of Disease Study. These included the standard life table for fatal burden, health states and disability weights for the non-fatal burden. Population estimates underpinning all estimates were sourced from the ABS.

For full details on the various methods, data sources and standard inputs see Australian Burden of Disease Study 2011: methods and supplementary material (AIHW 2016b), available on the AIHW website at: https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/burden-of-disease/reports.

Department of Social Services

The Department of Social Services provided data for this report regarding Commonwealth Rent Assistance, income support and Family Tax Benefits. In the Department of Social Services' data, it is optional for people to identify themselves as 'Indigenous'. This impacts on the completeness of the data and should be considered in any application or use of this information. Individuals who are identified as Indigenous includes people who self-identified themselves as being:

- Aboriginal;
- Torres Strait Islander;
- Aboriginal and Torres Strait Islander;
- Aboriginal and Torres Strait Islander and South Sea Islander;
- Torres Strait Islander and South Sea Islander;
- Aboriginal and South Sea Islander; or
- Indigenous Australian.

Individuals who are not identified as Indigenous includes people who:

- identified themselves as 'not being Indigenous'; or
- did not identify as being one of the sub-groups in the 'Indigenous group' above; and
- were not required to identify as being Indigenous or not being Indigenous; or
- have an 'unknown' value recorded in place of identifying as being Indigenous or not being Indigenous.

Some payments and concessions identify individuals as being South Sea Islander. Where 'identified South Sea Islander' is not included in a table, individuals who identify as being South Sea Islander are included as 'not being Indigenous'. This may affect results.

Disability Services National Minimum Data Set

The Disability Services National Minimum Data Set (DS NMDS) is an annual collection and national collation of a standard set of data items on disability support services provided under the National Disability Agreement (NDA). Funded agencies collect data from service users, and provide them to jurisdictions, which in turn provide them to the AIHW for national collation and reporting.

Data are collated and published annually by the AIHW. In any one year, people can receive services from more than 1 service outlet. In order to account for this, a statistical linkage key is used to estimate the unique number of service users during the period.

The scope of services included in the DS NMDS can vary in terms of not only the programs provided under the NDA across jurisdictions but also what programs are included in the data collection. For example, in most jurisdictions, specific mental health services are provided under health—rather than disability—portfolios. However, in Victoria and Queensland, specialist psychiatric disability services are included under the NDA.

The National Disability Insurance Scheme (NDIS) was launched in trial sites from 1 July 2013, with progressive roll-out to the full scheme from 1 July 2016. It is expected that many NDA service users will transition to the NDIS and hence exit the DS NMDS collection over time. This affects data from 2013–14 onwards. Some service type outlets may also be less responsive because of the complexities associated with the changeover to the NDIS.

Further information about disability support services provided under the NDA is available in (AIHW 2018f).

A data quality statement about the Disability Services National Minimum Data Set is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/686821.

National Aboriginal and Torres Strait Islander Social Survey

The 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) was the fourth social survey of Indigenous Australians, conducted by the ABS between September 2014 and June 2015. The survey was conducted in remote and non-remote areas in all states and territories of Australia, including discrete Indigenous communities. The 2014–15 NATSISS included a nationally representative sample of 11,178 Indigenous Australians living in 6,611 private dwellings in remote and non-remote areas of Australia, including discrete Indigenous communities. Information was collected on a range of demographic, social, environmental and economic characteristics.

Further information can be found in the ABS publication of results from the survey (ABS 2016d) as well as in the 2014–15 NATSISS user guide (ABS 2016e).

National Aged Care Data Clearinghouse

The National Aged Care Data Clearinghouse (the Data Clearinghouse) is an independent and central repository of national aged care data. The Data Clearinghouse is located at the AIHW for the purpose of providing aged care data to a range of stakeholders including policy makers, researchers, service providers and general consumers.

The Data Clearinghouse includes a broad range of aged care data, including (but not limited to) information relating to the following:

- residential aged care
- Home Care Packages Program (Home Care)
- Transition Care Program (TCP)
- Aged Care Assessment Program (ACAP)
- Aged Care Funding Instrument (ACFI)
- Commonwealth Home Support Programme (CHSP).

Data are provided annually (including full replacement of historical data) to the AIHW by the Department of Health. The data are sourced from Human Services payment systems, centralised client record systems and minimum datasets.

Data include information on aged care services (facilities/providers) as well as on the recipients of care. Information on whether clients identify as being of Aboriginal and Torres Strait Islander status is available, although this is collected voluntarily and the level of completeness varies by program. Among people aged 50 and over, and in relation to the time periods considered in this report, the proportion of people for whom Indigenous status was 'not stated' was low for those in residential aged care, Transition Care and ACAP (at 0.2% or less) (see Table S1.1). However, Indigenous status was missing for 9% of clients in the Commonwealth Home Support Programme, and 21% of clients receiving Home Care.

Further information about aged care in Australia and the National Aged Care Data Clearinghouse is available at: https://www.gen-agedcaredata.gov.au/.

A data quality statement about the National Aged Care Data Clearinghouse is available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/586498.

National Community Mental Health Database

The National Community Mental Health Care Database (NCMHCD) contains information on service contacts provided by public sector specialised community mental health services in Australia. Data are provided annually by states and territories to the AIHW.

The NCMHCD includes information relating to each individual service contact provided by an in-scope mental health service. Examples of information collected include demographic characteristics of patients, such as age and sex; clinical information, such as principal diagnosis and mental health legal status; and service provision information, such as contact duration and session type.

Indigenous status data should be interpreted with caution, as the data quality and completeness of Indigenous identification vary across states and territories. The way in which Indigenous Australian clients are identified varies between both jurisdictions and services within a jurisdiction. For the one person, a different Indigenous status can be recorded in different service contacts or between service providers. As well, Indigenous status is not recorded for some service contacts. In the 2015–16 collection, Indigenous status was missing for 3.3% of service contacts for people aged 50 and over.

A data quality statement about the National Community Mental Health Care Database is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/678386.

National Homicide Monitoring Program

The Australian Institute of Criminology (AIC) collects national data on homicides in Australia under the National Homicide Monitoring Program (NHMP). There are 2 key sources of data for the NHMP:

- offence records derived from each Australian state and territory police service. Where necessary, these are supplemented with information provided directly by investigating police officers and/or associated staff
- state coronial records, such as toxicology and post-mortem reports.

Where appropriate, the data are further supplemented by newspaper clippings. Newspaper media nationwide are monitored daily by staff at the AIC.

NHMP data are available in relation to incidents, victims and offenders:

- Information about the incident describes the case and its circumstances (for instance, location, date and time of the incident; status of investigation; whether the incident occurred during the course of another crime).
- Information about the victim includes sociodemographic information relating to the victim(s), details of the cause of death and the type of weapon used to kill the victims, and alcohol and illicit drug use.
- Information about the offender includes information about the person who has been charged, including sociodemographic characteristics of the offender, his/her previous criminal history, alcohol/illicit drug use, mental health status and relationship to the victim. The term offender refers to suspected offenders only and not to convicted people, unless otherwise stated.

Further information about the NHMP is available from Bryant & Bricknell 2017 and AIC 2018.

National Hospital Morbidity Database

The AIHW National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals in each state and territory. Information on the characteristics, diagnoses, external causes and care of admitted patients in public and private hospitals is provided annually to the AIHW by state and territory health departments.

The NHMD data in this report pertain to the 2-year period from 1 July 2014 to 30 June 2016 (described as '2014–16' throughout). Over the 2-year period, almost all public hospitals provided data for the NHMD except an early parenting centre in the Australian Capital Territory. The great majority of private hospitals also provided data except for private freestanding day hospital facilities in the Australian Capital Territory.

The counting unit for the NHMD is the 'separation'. Separation is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care. For this report, for readability, the term 'hospitalisation' is used to refer to a separation. Any one individual may have multiple hospitalisations; therefore, the number of hospitalisations does not equate to the number of people who were hospitalised in the period. Unless otherwise noted in footnotes, records for Hospital boarders, Posthumous organ procurement and Newborns without qualified days have been excluded from the analyses.

Each hospitalisation is assigned a principal diagnosis, while additional diagnoses are reported if the condition affected patient management. In this report, information on principal diagnosis was used to identify hospitalisations for specific types of ill-health; unless otherwise indicated, additional diagnoses have not been considered. Hospitalisations with a principal or additional diagnosis of injury and poisoning are also assigned an external cause. (An external cause is defined as the environmental event, circumstance or condition that was the cause of injury, poisoning or adverse event.) Some information is presented in this report using external cause data; for example, to report on hospitalisations due to assault. More than 1 external cause code may be reported for a hospitalisation. For the analyses in this report, only the first-recorded code has been used.

The diagnosis and external cause information in this report were classified using the ICD-10-AM (9th edition for 2015–16 data and 8th edition for 2014–15 data).

While there is some under-identification of Indigenous Australians in the NHMD, data for all states and territories are considered to be of sufficient quality for statistical reporting from the 2010–11 financial year onwards. In an analysis of the quality of Indigenous identification in hospitals data for 2011–12, it was estimated that 88% of Indigenous Australian patients were correctly identified in public hospitals (AIHW 2013). This varied between states and territories and across remoteness areas. It is unknown to what extent Indigenous Australians might be under-identified in private hospital admissions data.

Further details about the NHMD are available in the latest AIHW report, *Admitted patient care 2016-17: Australian hospital statistics* (AIHW 2018m). A complete data quality statement for the NHMD is available in Appendix A of that report.

National Housing Assistance Data Repository

The National Housing Assistance Data Repository (AIHW) collates state and territory data on households across the 4 main social housing programs—public rental housing, mainstream community housing, state owned and managed Indigenous housing (SOMIH), and Indigenous community housing (ICH). A brief overview of the collections for these 4 social housing programs is provided below. Further information about social housing assistance data is available in Housing assistance in Australia 2018 (AIHW 2018h).

Australian Government Housing Data Set

The Australian Government Housing Data Set (AGHDS) is a collection of administrative data about recipients of Commonwealth Rent Assistance (CRA). CRA is a non-taxable income supplement funded by the Australian Government.

CRA is paid to 'income units'—an income unit can be a single person with or without dependent children, or a couple with or without dependent children. One person in each income unit is classified as the primary reference person.

Information is collected on whether the reference person and/or their partner (in the case of couples) is of Aboriginal and/or Torres Strait Islander origin. Some members of an income unit may also self-identify as South Sea Islander.

Information on the extent of missing data about Indigenous status in CRA data cannot be determined since, in those data, information about Indigenous status only distinguishes between 2 groups: Indigenous Australian recipients and others. That is, data about non-Indigenous Australian recipients and those with missing Indigenous status information are not separately identified.

Community Housing Data Collection

Data in the Community Housing Data Collection are provided annually to the AIHW by the states and territories and are sourced from community housing organisations (CHOs) through a survey and from the state and territory administrative systems. The annual data collection captures information about CHOs, the dwellings and tenancy rental units they manage, households on the waiting list, and the tenants and households assisted.

Information on the Indigenous status of the individual tenants is not available from this collection; however it is available in relation to households—with Indigenous households identified as those with at least 1 member who identifies as being of Aboriginal and/or Torres Strait Islander origin. Providing information on Indigenous status is voluntary. For 30 June 2016 data, information on Indigenous status was not reported for 11% of community housing households (analysis of AIHW 2017a).

For the data period considered in this report (30 June 2016), information on Indigenous households with a tenant aged 50 and over was available for all jurisdictions except the Northern Territory. The Northern Territory submitted aggregate data to the collection, which includes dwelling- and organisation-level data, but not information on individual households or people.

A data quality statement about the Community Housing Data Collection is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/659303.

Indigenous Community Housing Data Collection

Data in the Indigenous Community Housing Data Collection are provided annually to the AIHW by the states and territories and are sourced from Indigenous Community Housing Organisations (ICHOs) and state and territory administrative systems and audits.

An ICHO is any organisation that is responsible for managing medium- to long-term housing for Indigenous Australians. This includes community organisations such as resource agencies and land councils, which have a range of functions, provided that they manage housing for Indigenous Australians.

All states and territories except the Australian Capital Territory have ICH dwellings. For the data period considered in this report (30 June 2016), information about the households in those dwellings was available for 5 states and territories—Victoria, Queensland, Western Australia, South Australia and Tasmania. New South Wales and the Northern Territory did not provide household information to the ICH collection for June 2016.

As the program is targeted at Indigenous households, it can be assumed that the vast majority of households supported by this program have at least 1 member who identifies as being of Aboriginal and/or Torres Strait Islander origin. However, no information about the Indigenous status of households or people living in ICH is collected.

A data quality statement about the Indigenous Community Housing Data Collection is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/660255.

National Social Housing Survey

The 2016 National Social Housing Survey (NSHS) included in this report, collected information from a randomly selected sample of households from 3 social housing programs—public housing, community housing and SOMIH—between May and August 2016. Indigenous community housing was out of scope for the 2016 survey (AIHW 2017b).

For tenants in public housing, community housing and SOMIH (in South Australia and Tasmania only), the 2016 NSHS was conducted via a mail-out paper questionnaire, with an option provided for online completion. SOMIH tenants in New South Wales and Queensland were surveyed via face-to-face interview. The overall response rate for the 2016 NSHS was 34% for the mail-out surveys and 59% for the face-to-face interviews.

In the survey, respondents were asked to indicate whether they (that is, the survey respondent) and/or any other members of the household are of Aboriginal or Torres Strait Islander origin. Respondents were also asked to select their applicable age group from a series of provided age ranges. In this report, data have been used for people who indicated that they were aged 55–64, 65–74 or 75 and over.

Although Indigenous status is collected for both the survey respondent and other household members, Indigenous status and age can only be combined for the survey respondent. In the 2016 survey, there were 699 Indigenous social housing tenants aged 55 and over who participated in the 2016 survey—including 180 public housing tenants, 453 SOMIH tenants, and 66 community housing tenants. Due to the small sample size of older Indigenous Australian tenants in community housing, this report presents data for public housing and SOMIH tenants only.

Rather than using raw survey outputs, estimates based on the NSHS are derived by applying 'weights' to the raw data, to help ensure (to the extent possible) that the estimates presented represent the total population (see AIHW 2017b for further details). All NSHS data in this report are based on weighted survey estimates.

A data quality statement about the NSHS is available at:
http://meteor.aihw.gov.au/content/index.phtml/itemId/661245.

Public Rental Housing Data Collection

All states and territories maintain administrative data sets on the public housing programs they provide. These data sets are provided annually to the AIHW and are incorporated in the Public Rental Housing Data Collection. This data collection includes information about dwellings, households assisted and households on waiting lists.

Information on the Indigenous status of tenants is collected voluntarily. However, there is a relatively high level of missing data on Indigenous status. At 30 June 2016, information on Indigenous status was missing for 25% of all tenants, and 27% of tenants aged 50 and over.

A data quality statement for the Public Rental Housing Data Collection is available at:
http://meteor.aihw.gov.au/content/index.phtml/itemId/656267.

State Owned and Managed Indigenous Housing Data Collection

Four states and territories—New South Wales, Queensland, South Australia and Tasmania—provide a range of state owned and managed Indigenous housing (SOMIH) programs and maintain administrative data sets about these programs. Extracts from these data sets are provided annually to the AIHW. This collection contains information about SOMIH dwellings, households and individual tenants.

As SOMIH is targeted at Indigenous households, the vast majority of households assisted by the program have at least 1 member who identifies as being of Aboriginal and/or Torres Strait Islander origin. Information on the Indigenous status of tenants is collected voluntarily, but is incomplete due to missing data. As at 30 June 2016, information on Indigenous status was missing for 10% of all SOMIH tenants, and 6% of tenants aged 50 and over.

Around 5,000 social housing dwellings in the Northern Territory were transferred from the ICH collection to remote public housing between 2008 and 2010 and are excluded from administrative data collections between 2008–09 and 2015–16, inclusive. In 2016–17, these dwellings were reported in the SOMIH collection for the first time; however, as data in this report relate to 30 June 2016, these are not included in this report.

A data quality statement for the State Owned and Managed Indigenous Housing Data Collection is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/656269.

National Mortality Database

The AIHW National Mortality Database holds records for deaths in Australia from 1964. Cause of Death Unit Record File data are provided to the AIHW by the Registries of Births, Deaths and Marriages and the National Coronial Information System (managed by the Victorian Department of Justice) and include cause of death coded by the Australian Bureau of Statistics (ABS). The data are maintained by the AIHW in the National Mortality Database.

In this report, mortality data are reported for 5 jurisdictions combined—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. The quality of Indigenous identification in mortality data for these 5 jurisdictions is considered to be adequate from 1998. Other jurisdictions have a small number of Indigenous Australian deaths, and identification of Indigenous Australian deaths in their death registration systems is relatively poor, making the data less reliable. Due to small numbers, data in this report are reported for 5 calendar years combined, from 2012 to 2016.

The Indigenous status of a deceased person is identified through the death registration process. Virtually all deaths in Australia are registered; however there is some degree of under-identification of Indigenous Australians in mortality data (ABS 2013a, 2017e). This is because a proportion of deceased Indigenous Australians are not reported as being Indigenous Australian by the family, health worker or funeral director during the death registration process. For a small number of deaths, information on the Indigenous status of the deceased is not stated. As well, where information on Indigenous status is recorded, there are concerns about the accuracy of that information (ABS 2017e).

In 2012–2016, in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined, Indigenous status was not reported for 0.7% of all deaths of people aged 50 and over.

In this report, deaths registered in 2014 and earlier are based on the final version of cause of death data; deaths registered in 2015 and 2016 are based on revised and preliminary versions, respectively, and are subject to further revision by the ABS.

For more information on the AIHW National Mortality Database see:
https://www.aihw.gov.au/about-our-data/our-data-collections/national-mortality-database/deaths-data.

The data quality statements underpinning the data in the AIHW National Mortality Database can be found in the following ABS publications:

- ABS quality declaration summary for *Deaths, Australia* (ABS 2017d)
- ABS quality declaration summary for *Causes of death, Australia* (ABS 2017e).

National Non-admitted Patient Emergency Department Care Database

The National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) is an annual compilation of episode-level data for emergency department presentations in public hospitals. The data are supplied to the AIHW by state and territory health authorities. The data cover waiting times and other characteristics of presentations to public hospital emergency departments.

The data in this report pertain to the 2-year period from 1 July 2015 and 30 June 2017 (described as '2015–17' throughout).

In the NNAPEDC, information captured about the reason for the emergency department presentation includes:

- principal diagnosis—that is, the diagnosis established at the conclusion of the patient's attendance in an emergency department to be mainly responsible for occasioning the attendance
- major diagnostic block—a classification that groups emergency department presentations based on diagnosis information.

Principal diagnosis data for 2015–17 were reported using various classifications; for the purpose of this report, the AIHW mapped the provided information to ICD-10-AM 3-character codes, where necessary. Indigenous status was not reported for 1.1% of emergency department presentations in 2015–17 among those aged 50 and over. However, the quality of Indigenous identification in NNAPEDCD data has not been formally assessed. In addition, the scope of the NNAPEDCD may not include some emergency services provided in areas where the proportion of the population who identify as being Indigenous Australian is higher than average. Therefore, caution should be used when interpreting data related to Indigenous Australians.

Further details about the NNAPEDCD are available in *Emergency department care 2016–17: Australian hospital statistics* (AIHW 2017d). A complete data quality statement for the NNAPEDCD is also available in Appendix A of that report.

National Opioid Pharmacotherapy Statistical Annual Data Collection

The National Opioid Pharmacotherapy Statistical Annual Data (NOPSAD) collection comprises data collected by state and territory health departments about opioid pharmacotherapy clients, prescribers and dosing points. Each jurisdiction uses different methods to collect data about the pharmacotherapy used to treat those with opioid dependence.

The NOPSAD collection includes information on 3 opioid pharmacotherapy drugs used for treating opioid dependence: methadone, buprenorphine and buprenorphine-naloxone. Each jurisdiction collects agreed data about clients who are receiving opioid pharmacotherapy on a snapshot day, usually a day in June each year. The snapshot day varies across jurisdictions.

Since 2012, most jurisdictions have provided the AIHW with unit record data in addition to aggregate data. Unit record data are provided by all jurisdictions except Victoria and Queensland.

Information on the Indigenous status of clients is collected but is not available for all states and territories. For the 2017 collection:

- 5 jurisdictions— New South Wales, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory—provided information on the Indigenous status of clients, including by pharmacotherapy type and age
- Western Australia did not report Indigenous status of the client
- Victoria reported the Indigenous status of client as an aggregated total—but breakdowns of Indigenous status by individual pharmacotherapy drug type and age were not available
- Queensland reported aggregated totals for the Indigenous status of a client, and for Indigenous status by pharmacotherapy type; however, data for Indigenous status by age were not available.

There are also issues with completeness of data by Indigenous status. In data for June 2017 from New South Wales, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory combined, information on Indigenous status was not reported for one-quarter (25%) of all clients aged 50 and over.

A data quality statement about the 2017 NOPSAD collection is available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/686955.

Recorded Crime—Victims

The ABS ‘Recorded Crime—Victims’ collection consists of administrative data about victims of selected criminal offences, which are supplied to the ABS by state and territory police agencies (ABS 2017b).

The selected offence categories included in the collection are: homicide and related offences, sexual assault, kidnapping/abduction, robbery, blackmail/extortion, unlawful entry with intent, motor vehicle theft, and other theft. The offences may have been reported to the police by a victim, witness or other person, or they may have been detected by police.

The data in this report relate to the period 1 January to 31 December 2016, and include all incidents of crime reported to or detected by police in this calendar year. This includes historical incidents that occurred prior to this period, but only came to the attention of police in 2016.

In the context of this collection, a victim can be a person, premises, organisation, or motor vehicle depending on the type of offence, and can be counted more than once. For example, an individual will be counted more than once if they experience the same offence on separate and unrelated occasions, or if they experience 2 or more different types of offences in the same incident.

The Indigenous status of individuals is based on self-identification by the individual who comes into contact with police, although some jurisdictions may allow the next of kin/guardian to provide this information where the individual is not able to answer for themselves. For the 2016 collection, the ABS assessed the quality of data by Indigenous status for a selected range of personal offences for New South Wales, Queensland, South Australia and the Northern Territory. Based on an assessment by the ABS, data by Indigenous status for the other jurisdictions were not of sufficient quality for reporting.

Further information about the Recorded Crime—Victims collection, including information about data quality, can be found in the ABS publication that provides results from this collection (ABS 2017b).

Specialist Homelessness Services

The Specialist Homelessness Services Collection (SHSC) collects information about clients of specialist homelessness agencies—that is, people who receive assistance from agencies funded by state and territory governments to respond to or prevent homelessness (AIHW 2018d). Some information is also collected about unassisted people—that is, people who seek services from a specialist homelessness services (SHS) agency but do not receive any services at that time.

SHS agencies provide services to people who are currently homeless, as well as to those who are at risk of homelessness, with services for the latter aimed at preventing them from becoming homeless. The SHSC does not capture all people who are homeless or at risk of homelessness; rather, it captures only those who seek assistance from an SHS agency.

Data about clients are submitted based on 'support periods'—that is, a period of support provided by an SHS agency to a client. Information about clients is linked using a statistical linkage key (SLK). In the 2016–17 collection, SLK data was invalid or missing for about 3% (14,300) of all support periods. This was adjusted for by applying weights at the client level. These weights increased the counts of clients, taking into account the number of service period records with invalid or missing SLK data along with the observed distribution of the number of visits per client. SHSC data were also adjusted for agency non-response.

A client is considered to be an Indigenous Australian if, at any time during the reference period (2016–17 data for this report), they identified as being of Aboriginal and/or Torres Strait Islander origin. In the SHSC, information on Indigenous status is only provided with explicit client consent to report this information. Aboriginal and Torres Strait Islander status was not reported for 10% of clients in 2016–17.

All data in this report relate to clients (rather than to support periods). The adjustments for non-response (agency non-response and data error in the SLK) result in estimated numbers of clients that are not whole numbers. When rounded to the nearest whole number, numbers of clients in subgroups shown in tables/figures may not add to the totals shown.

A data quality statement about the SHSC is available at:
http://meteor.aihw.gov.au/content/index.phtml/itemId/683255.

Appendix B

Indigenous languages

This appendix summarises information on Indigenous languages. Languages are ordered by number of Indigenous Australians aged 50 and over who speak them at home.

Indigenous Australians aged 50 and over speaking an Australian Indigenous language at home, by language, 2016

Language	No.	Language	No.	Language	No.	Language	No.
Yumplatok (Torres Strait Creole)	859	Wiradjuri	85	Nyangumarta	33	Wardaman	13
Kriol	795	Wik Mungkan	82	Ngarinyman	32	Djabugay	13
Pitjantjatjara	489	Western Arrarnta	79	Mayali	29	Anmatyerr, nfd	13
Djambarrpuyngu	480	Nunggubuyu	78	Iwaidja	28	Kaurna	12
Warlpiri	380	Eastern Arrernte	78	Banyjima	27	Lardil	12
Tiwi	370	Torres Strait Island Languages, nfd	76	Kaytetye	26	Dhangu, nfd	11
Kalaw Kawaw Ya/ Kalaw Lagaw Ya	271	Yindjibarndi	69	Dhuwala, nfd	25	Liyagalawumirr	11
Alyawarr	234	Bardi	65	Gupapuyngu	25	Yidiny	11
Murrinh Patha	219	Kuuk Thayorre	64	Djapu	24	Kimberley Area Languages, nec	11
Kunwinjku	214	Gurindji	62	Mudburra	24	Ngarluma	11
Luritja	188	Warumungu	62	Mangala	22	Ngan'gikurunggurr	10
Ngaanyatjarra	182	Jaru	54	Wambaya	20	Jingulu	10
Anindilyakwa	173	Ngarrindjeri	54	Nyikina	20	Ganalbingu	10
Cape York Peninsula Languages, nec	153	Kija	52	Ndjebbana (Gunavidji)	19	Wangkajunga	10
Arrernte, nec	140	Maung	51	Kune	19	Paakantyi	10
Guugu Yimidhirr	131	Wangkatha	51	Djinang, nfd	18	Yugambeh	10
Burarra	129	Dhuwal, nfd	49	Gudanji	17	Larrakiya	9
Aboriginal English, so described	119	Adnymathanha	44	Galpu	17	Wangurri	9
Walmajarri	116	Manyjilyjarra	42	Girramay	17	Ngarinyin	9
Anmatyerr, nec	116	Garrwa	40	Gamilaraay	17	Yorta Yorta	9
Arrernte, nfd	115	Gooniyandi	39	Yanyuwa	16	Kukatha	8
Martu Wangka	108	Gumatj	38	Dhalwangu	16	Marrithiyel	7
Yolngu Matha, nfd	100	Dhuwaya	37	Bunuba	16	Daatiwuy	7
Nyungar	99	Miriwoong	37	Gumbaynggir	16	Dhuwal, nec	7
Meriam Mir	92	Bandjalang	34	Na-kara	15	Madarrpa	7
Yankunytjatjara	91	Wajarri	34	Yawuru	15	Yulparija	7
Kuku Yalanji	85	Pintupi	33	Kukatja	14	Bidjara	7

Language	No.	Language	No.	Language	No.	Language	No.
Dhanggatti	7	Wubulkarra	5	Liyagawumirr	4	Tjupany	3
Rembarrnga	6	Kartujarra	5	Dhay'yi, nfd	3	Githabul	3
Malak Malak	6	Arabana	5	Marrangu	3	Kariyarra	3
Ngaliwurru	6	Karajarri	5	Djinang, nec	3	Kayardild	3
Wagiman	6	Palyku/Nyiyaparli	5	Wagilak	3	Nyamal	3
Ritharrngu	6	Dharawal	5	Nhangu, nec	3	Yinhawangka	3
Rirratjingu	6	Maringarr	4	Warramiri	3	Wergaia	3
Narungga	6	Gundjeihmi	4	Koko-Bera	3	Other languages nec/nfd (a)	1,783
Waanyi	5	Gun-nartpa	4	Bilinarra	3		
Kuninjku	5	Gurr-goni	4	Ngardi	3	**Total**	**10,720**

No. = number (Census count); nec = not elsewhere classified; nfd = not further defined.

(a) Includes: Other Indigenous Australian Languages, nfd; Other Indigenous Australian Languages nec; and Australian Indigenous Languages nfd.

Note: This table is based on AIHW analysis of ABS Census TableBuilder data. For confidentiality reasons, the ABS randomly adjusts Census TableBuilder data; hence, data in this table may not sum to the total, and may differ slightly from data published elsewhere. No reliance should be placed on small cells.

Source: AIHW analysis of ABS 2017a.

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Abbreviations

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABDS	Australian Burden of Disease Study
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACCHO	Aboriginal Community Controlled Health Organisations
ACFI	Aged Care Funding Instrument
AIHW	Australian Institute of Health and Welfare
ANZDATA	Australia and New Zealand Dialysis and Transplant Registry
AOD	alcohol and other drug
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ATSIHPF	Aboriginal and Torres Strait Islander Health Performance Framework
CHSP	Commonwealth Home Support Programme
CKD	Chronic kidney disease
COPD	chronic obstructive pulmonary disease
CRA	Commonwealth Rent Assistance (non-taxable Australian Government income supplement)
DALYs	Disability Adjusted Life Years (a combination of years of life lost (YLL) due to premature death and years of life lived with disability (YLD)
DS NMDS	Disability Services National Minimum Data Set
DSS	Department of Social Services
ERP	estimated resident population
ESKD	End-stage kidney disease
FDV	family and domestic violence-related
FTB	Family Tax Benefit
Home Care	Home Care Packages Program
ICD-10	International Classification of Diseases and Related Health Problems, 10th Revision
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICH	Indigenous Community Housing
IREGs	Indigenous Regions

NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIHMS	National Aboriginal and Torres Strait Islander Health Measures Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCMHCD	National Community Mental Health Care Database
NDA	National Disability Agreement
NDIS	National Disability Insurance Scheme
NHMD	National Hospital Morbidity Database
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSHS	National Social Housing Survey
OSR	Online Services Report
SDAC	Survey of Disability, Aging and Carers
SHS	specialist homelessness services
SHSC	Specialist Homelessness Services Collection
SLK	statistical linkage key
SOMIH	state owned and managed Indigenous housing
YLD	years lived with disability
YLL	years of life lost

Symbols

<	less than
≥	greater than or equal to
—	nil or rounded to zero
. .	not applicable
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data

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Related publications

A more concise version of this report was published separately online as *Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over—in brief*. See https://www.aihw.gov.au/reports/indigenous-australians/vulnerabilities-aboriginal-torres-strait-50-over/contents/table-of-contents.

Supplementary tables of data are published online in conjunction with this detailed report.

This report presents information on the complex and varied needs of Aboriginal and Torres Strait Islander people aged 50 and over. It brings together data from a range of sources to identify potential factors that may be associated with vulnerability to abuse. The report covers demographic characteristics, along with information on outcomes and service use related to aged care, health and functioning, social and emotional wellbeing, housing and homelessness, financial circumstances, alcohol and substance use, traumatic life events and safety.

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