

**INQUIRY INTO PROVISIONS OF THE PUBLIC HEALTH
AMENDMENT (REGISTERED NURSES IN NURSING
HOMES) BILL 2020**

Name: Professor Tony Broe

Date Received: 26 April 2021

Prof Tony Broe AM; BA; MB,BS; FRACP; FACRM

Brief CV:

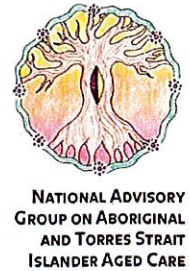
I have had a long career in Medicine: Since the 1970s – I have participated in development and coordination of Australian Health and Aged Care services – principally within NSW Health and with Commonwealth DoHA - with University positions at Sydney University and now UNSW.

I was awarded a 2 year NSW Public Service Board Fellowship and a WHO Fellowship in 1970 and completed my Geriatric Medicine and Neurology training overseas (Glasgow and Mayo Clinic) – returning to set up Aged Care and Dementia Care services in Western Sydney in 1970-80s; ACAT and Geriatric Rehabilitation Services across Metropolitan Sydney and Rural NSW in 1980-90s; and Aboriginal Health Services in Ageing and Chronic Disease from South East Health & UNSW – 2000-2021.

Relevant to the Terms of Reference of this Select committee on Registered Nurses in Nursing Homes, I have worked continuously in Hospital Aged Care, Hospital in the Home, Residential Aged Care, Respite Care, Advanced Care Directives and Aged Services Development - over my career - as well as my Public Health, Community Health and Academic Teaching and Research roles. I ran the **Sydney Older Persons Study** (1994 to 2000) from Sydney University.

Also perhaps relevant to Aboriginal Health and Aged Care in particular - I came to Medicine from Social Science (Anthropology, Geography, History). I ran the **Koori Growing Old Well Study** (2008-2020) on Social and Emotional Well-being as well as biological ageing and dementia – from my role at **Neuroscience Research Australia** (where I am a Senior Principal Research Scientist) in partnership with five NSW metropolitan and rural Aboriginal communities - while publishing a lot of papers and book chapters on Ageing and Aged Care and setting up multiple services.

Brief: Aboriginal and Torres Strait Islander residential aged care - Inquiry into the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020



Key points:

1. Older Aboriginal and Torres Strait Islander people have a right to receive aged care services from Community Controlled organisations and these organisations are best placed to provide culturally safe and appropriate care.
2. Community Controlled providers are disadvantaged by current approval and regulation requirements in aged care.
3. The priority for Aboriginal and Torres Strait Islander residential aged care is a culturally safe and appropriate consumer journey from assessment through to high quality service delivery.
4. The current proposed amendments would further disadvantage Community Controlled residential providers by increasing regulatory burden and exacerbating workforce challenges.

Summary

Aboriginal and Torres Strait Islander people have the right to receive trauma informed, culturally safe residential care. Culturally safe and appropriate services are best provided by Aboriginal Community Controlled Organisations (ACCOS) and Aboriginal and Torres Strait Islander staffⁱ. Inflexible regulation requirements and a lack of capacity building support from Government to meet these is a barrier to becoming an aged care provider for ACCOs. Additionally, the current Aboriginal and Torres Strait Islander aged care workforce, including registered nurses, is not large enough to meet the growing needs of the aging populationⁱⁱ. The lack of culturally safe options for Aboriginal and Torres Strait Islander people is a significant barrier to accessing residential aged careⁱ.

Access to residential aged care

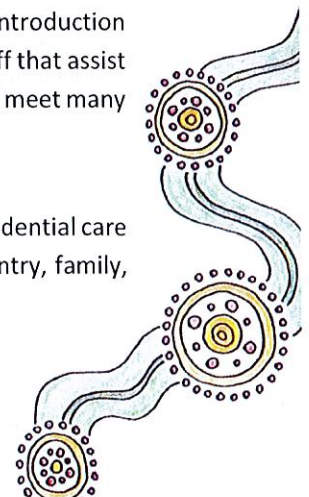
Fewer Aboriginal and Torres Strait Islander people over 50 years of age receive residential care (permanent and respite) than their non-Indigenous counterparts (10.4% and 23.3% respectively).ⁱ There are four reasons why Aboriginal, and Torres Strait Islander Australians do not currently receive, or receive inadequate/inappropriate, residential careⁱ:

- Limited culturally safe and appropriate options
- Access pathways
- Incorrect assessment
- System design

The Royal Commission into Aged Care Quality and Safety (Royal Commission)ⁱⁱ recommended introduction of system navigators/‘care finders’, who should be Aboriginal and/or Torres Strait Islander staff that assist Elders to access culturally appropriate aged care services. Implementation of this measure will meet many of the access challenges encountered by Aboriginal and Torres Strait Islander people.

Cultural safety

For Aboriginal and Torres Strait Islander people, receiving trauma informed, culturally safe residential care (and the government funding for that support) enables them to maintain connection to Country, family,



and Community, which is profoundly important to their spiritual, emotional, and mental healthⁱ. This is particularly significant because residential care evokes the institutionalization which members of the Stolen Generations suffered as minors.ⁱ Ensuring high quality and safe residential care for older Aboriginal and Torres Strait Islander people requires that care be culturally safe as well as clinically appropriate and enabling ACCO providers.

Growing ACCO providers

Rather than penalising or further disadvantaging ACCO providers accreditation approaches need to provide flexibility to enable ACCOs to meet regulatory requirements. The Royal Commission recognises the importance of ACCO providers and the need for Government support and tailored approaches to grow the sector. Recommendation 50.1 is for the Australian Government to assist ACCO providers to expand new or existing aged care services.ⁱⁱ The sub-recommendations under 50.2 outline that assistance should include 'flexible approval and regulation' and 'special consideration' including additional time to meet requirements, tailored ways to demonstrate capability requirements, exemptions (in limited cases), and financial assistance for capacity-building.ⁱⁱ

Workforce

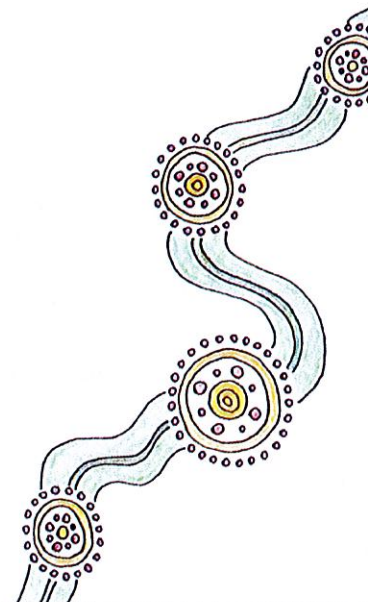
NAGATSIAC supports the need for a high standard of clinical care for older people, and this requires the clinical skills and cultural safety that are provided by an Aboriginal and Torres Strait Islander workforce. The evidence provided to the Royal Commission clearly demonstrated the existing workforce challenges for the sector and ACCO providers. Based on the most recent available 2016 data, there are only around 1800 Aboriginal and Torres Strait Islander people working in direct aged care in residential facilities nationally, 10% of whom are registered nurses.ⁱⁱ Additional requirements for staffing at a jurisdictional level are likely to exacerbate workforce challenges for ACCOs and risk a reduction in numbers of service providers.

Conclusion

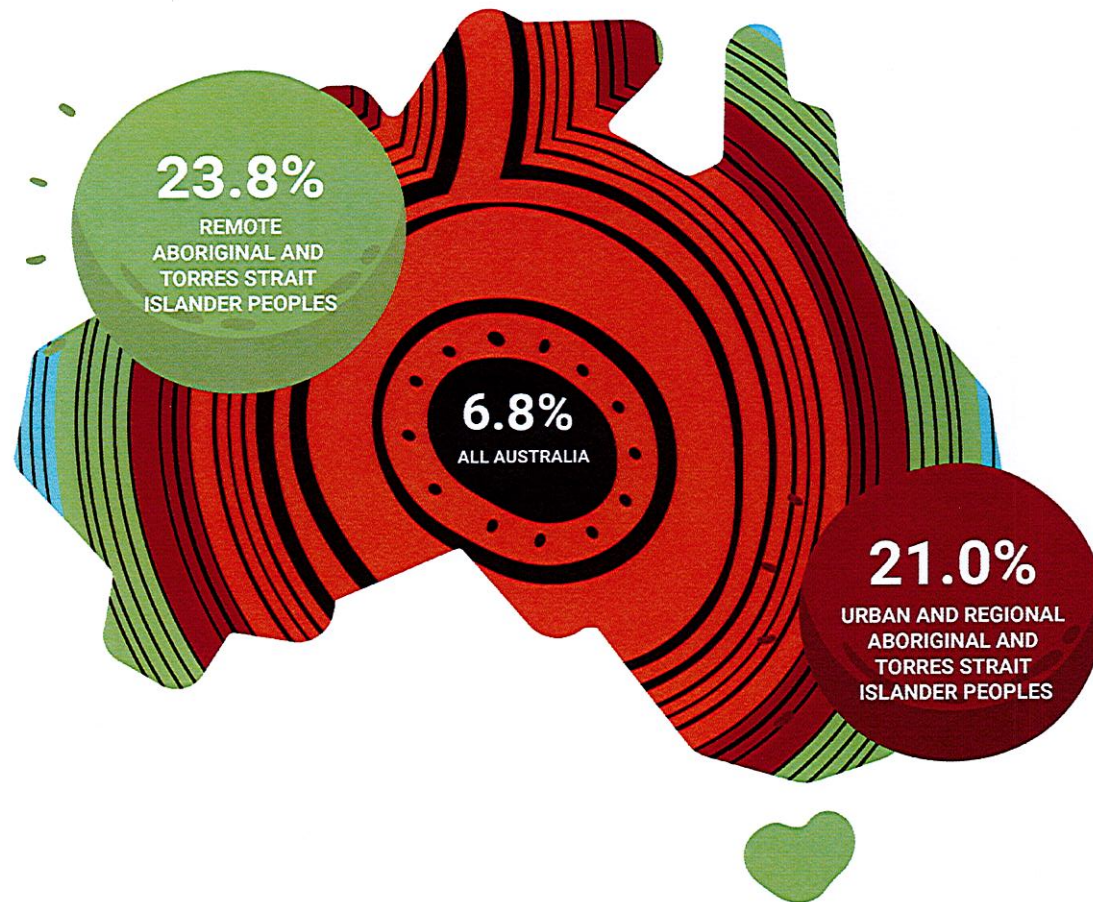
There are already significant challenges for ACCOs to deliver residential aged care services, including registration requirements and workforce. The limited number of ACCO providers prevents older Aboriginal and Torres Strait Islander people exercising their right to receive services from these organisations. The limitation of this right contributes to the lower access rates of Aboriginal and Torres Strait Islander people to residential aged care. Additional jurisdictional staffing requirements that are not supported by regional and flexible implementation plans will further exacerbate the lack of culturally safe residential aged care options for Aboriginal and Torres Strait Islander people, ultimately leading to worse health outcomes.

ⁱ NAGATSIAC, 'Our Care. Our Way: Transforming care pathways for Aboriginal and Torres Strait Islander Elders', 2020

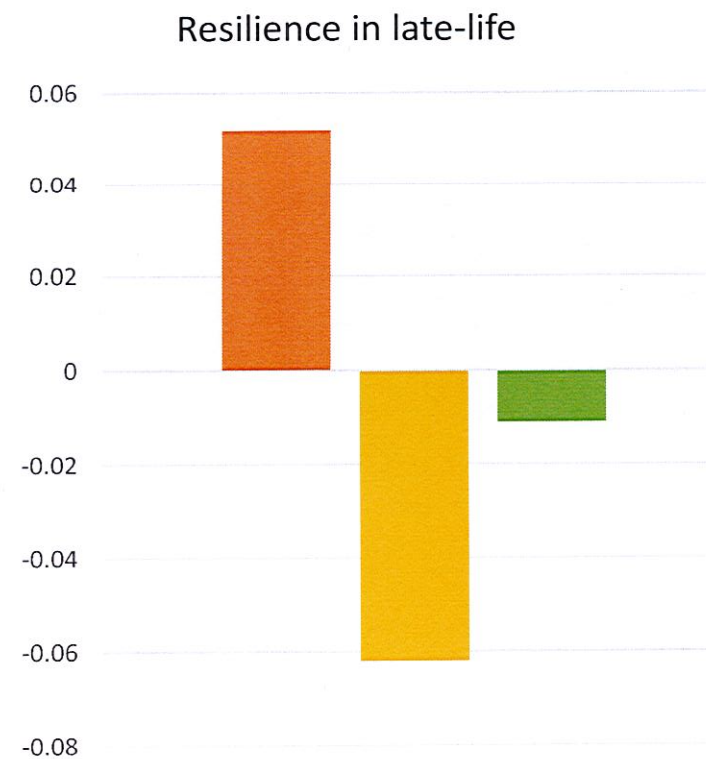
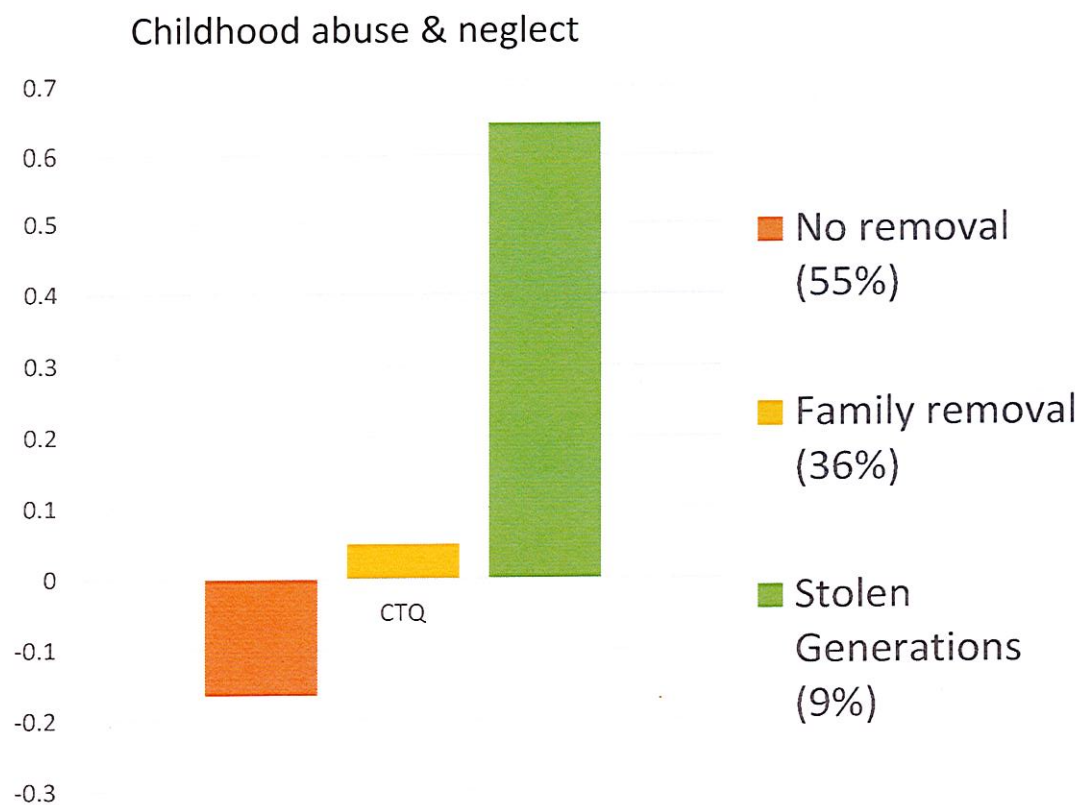
ⁱⁱ Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, vol. 3A The new system, <https://agedcare.royalcommission.gov.au/publications/final-report-volume-3a>



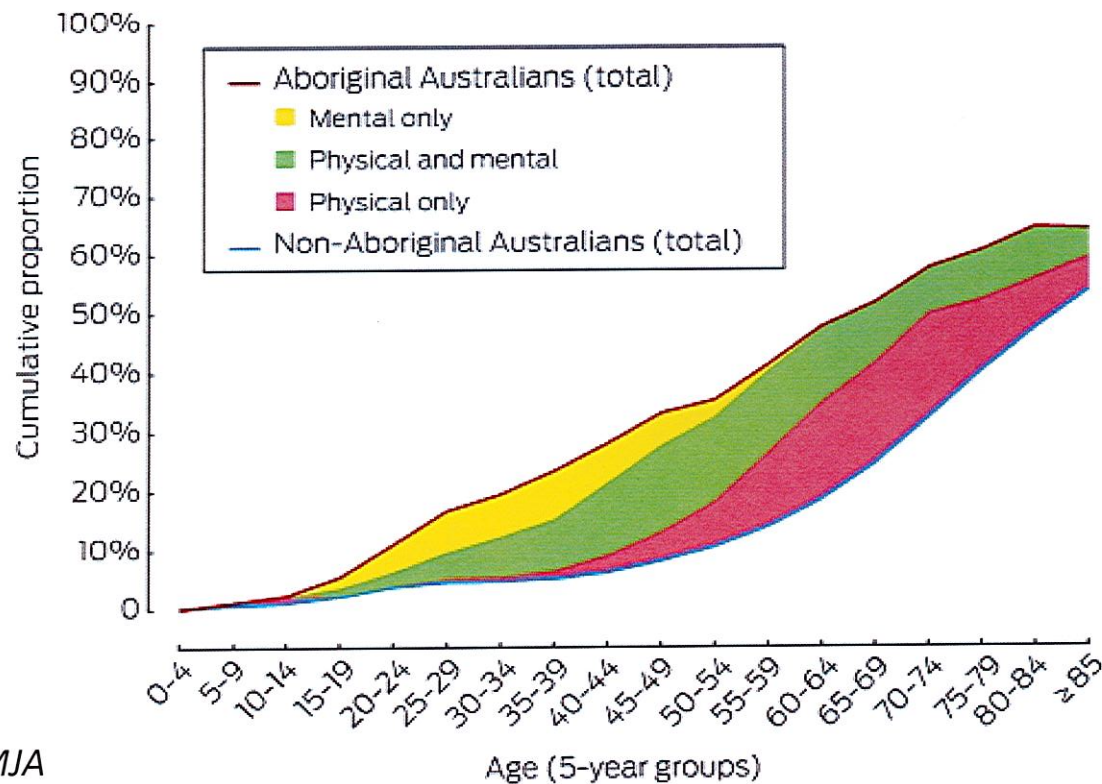
Higher rates of dementia in older Aboriginal & Torres Strait Islander peoples across Australia



Stolen Generations: lasting impact on communities



Mental Health and Multimorbidity across the life-course in Aboriginal Australians (NSW)



Randall et al., 2018, *MJA*

Australia, and the world generally, is ageing rapidly as the birth rate declines globally and lifespan **increases**. With world-wide Population Ageing, the brain is becoming the focus of research in life-course prevention of late disorders of ageing – particularly mobility disorders and dementia. However, to plan the **Health Care of Older People** it helps to consider that the task is for two major age groups with different clinical presentations and very different Community Hospital and Residential care needs: - the young-old (60 – 79) with chronic systemic diseases (heart, lung, metabolic etc) who need acute hospital interventions and chronic ‘preventive’ care in the community; and the **old-old (80 – 100)** with declining mobility, reduced self-management skills & cognitive decline, who will need improved community-hospital liaison and family support at home as frailty accumulates. However, both older age groups will also come to dominate episodic Hospital care as the Australian population ages.

Chronic Care: Young-Old - Management of Chronic Diseases

The young old (60 to 79) - *as a group* - are mobile, independent and cognitively intact with preserved judgment and decision making. A large *sub-group* of the young-old have chronic diseases and multiple co-morbidities, without being generally ‘frail’. Their chronic diseases - heart, lung, diabetes, renal, arthritis, mental health - need a consistent preventive & self-management approach in Local Community Primary Health Networks (aka Community Health Centres) with strong GP prevention, Community Nursing and Allied Health Teams. This is not met by the current system of GP episodic care in **Local Primary Health Networks**. The young-old also need acute management in Hospital for clinical exacerbations of heart& lung diseases and for major interventions – on **hearts, joints, plumbing**. However, a minority of young-old need complex Aged Care and Disability systems across Hospital Community and Residential Care.

Hospital Aged Health Care – Coordination with Community Care & RACFs

The old-old (80 to 100+) in contrast become increasingly ‘frail’ with advancing age particularly over 85 years. From the **“Sydney Older Persons Study”** we know that 80% need some assistance with domestic tasks (cooking, housework, shopping) & more than 30% are dependent for some aspect of personal care (mobility, bathing, feeding, dressing, toileting) - due mainly to

Commented [TB1]: 2000+ – Brain Disability overtakes ‘Body’ Disability

- World Av Lifespan at Birth up 35 to 71 1900-2000 World Population up 1 billion to 7 bill - 1900-2000
- World Population Growth to peak at 10 Bill 2060

Commented [TB2]: • 2020 to 2050 - 350% increase in old-old 85+

- Old-old 85+ from 350,000 to 2+ million by 2050
- 80% will have Gait Slowing & Balance disorder
- 60% will have Cognitive Slowing or Dementia

Commented [TB3]: Local Primary Health Networks

- LPHNS – Now mostly Episodic Care & Fee for Service
- LPHNS – Must expand for Chronic Care & Prevention
- Nurses - handmaidens to GPs – Ratio 1 N to 6 GPs
- Ratio needs 6 RN to 1 GP + Clin Nurse Specialists
- LHPN Multi-disciplinary team – SW/Therapists etc
- Chronic Disease: Self mgmt. of Multi-morbidity –
- Prevention Vs Episodic Care (> 4000 NHS items)

Commented [TB4]: Young Old – 60 yrs - 79 yrs

- Will fill our Hospitals
- Heart + lungs + diabetes + renal + mental health
- Heart, joints, plumbing surgery
- Return home rapidly < 2% go to Residential Care

Commented [TB5]: Old-old - 80 yrs to 100+ yrs

- BRAIN – Cognition + Gait & Balance + Mobility
- Home Care is Number one need – ACAT/CHSP
- For ADL - Cooking, Housework, Shop, Wounds
- For IADL – Bathe, Feed, Dress, Toilet, mobility

early impairments in cognitive capacity, gait, balance and movement from pre-clinical neurodegenerative brain frailty. They also need acute care in **Public Hospitals** for their clinical exacerbations - by Geriatric & Medical Units - for acute confusion, cognition, falls, fractures, bladders, mobility, infections & rehabilitation. They need to return home quickly with coordinated community support; in fact, 85% of this frail old-old group do return home from hospital - rather than go to RACFs. If not managed well in the hospital, rehabilitation and then community, Residential Aged Care is a likely outcome.

Chronic Care: Life-course Public Health and Prevention of Chronic Disease

Health system reforms clearly require social and health interventions across the life-course - with promotion of **flourishing brains in infancy and childhood** - knowledge provision assists prevention of chronic systemic disease in the "young old" and mobility and cognitive decline in the "old-old". Late life attention to known risk factors such as smoking, alcohol, hypertension, heart disease, mental illness, diabetes - are important but not sufficient. Our ageing society itself is the product of a longer term process of "healthy ageing" and in particular healthy brain growth with delayed onset of the bulk of chronic systemic diseases (heart, vascular, lung, renal disease etc.) to older ages (Olshansky, J. Milbank Memorial Quarterly 1986) and with strong evidence for later onset of dementia in the "old-old" as child brain function improves with revolutions in parenting attitudes and education.

Rapid population ageing in Australia is in part the large baby-boom generation coming of age over the next decades and world-wide population ageing. In the world wide ageing stakes we are second only to Japan - relieved to a degree by our active immigration policy. We need commitment to **systems of care** that: firstly, promote healthy ageing through early life flourishing and brain growth; secondly prevention and management of chronic disease for the young-old; and thirdly, provide care across the hospital-community interface as outlined in the Royal Commission on Aged Care for the old-old. It is a truism that - we have to get hospital aged health care right to enable public hospitals & specialty services to function well for the acute care of the rest of the population. Increased beds in the private sector for the young-old and diversion of Public Systems of care to private and NGO responsibility cannot

Commented [TB6]: Old-Old

- Will also fill our Hospitals & RACFs
- Cognition, falls, infections
- Need coordinated community support
- Need rapid discharge home
- Need LPHNs to be Community Health Centres
- 85% of admissions of old-old return to home
- 98% of Young-Old return to home

Commented [TB7]: Life-course Public Health – Healthy Brain Ageing

- Flourishing pregnancy, infancy, child, teens
- Parenting and Education
- Prevention of Child Social & Emotional Trauma
- Lifelong growth of Social Capital & Adult Brains
- Prolong Lifespan – Delay dementia

Commented [TB8]: Rapid popn ageing – baby boom gen + fertility down

- Early life flourishing – Maximise Brain Growth
- Life course neuroplasticity
- Prevention & Self-Management Chronic Disease
- Aged Health Care and Aged Care of Old-Old
- To get Acute Care right for everyone

solve the needs of the 'frail aged' & can only exacerbate the task for Public Hospitals and Public aged care services in the health care of the old-old. Aged Health Care is a hard job – but someone has to do it. It will be your mum and soon enough yourself – as we all age more successfully.

Professor Tony Broe AM, BA, MB.BS, FRACP, FACRM

Senior Principal Research Scientist (emeritus)

Neuroscience Research Australia

Conjoint Professor of Geriatric Medicine

University of NSW

NHMRC: Our MOB (Mind Our Brain) Study: Year 3 - Translation of knowledge to action
Indigenous Ageing and Dementia Prevention Roundtable
Early life Determinants of Healthy Ageing & Dementia: the First 1000 Days to Adulthood

Background

For the majority of Australians lifespan is increasing and health status is improving. During the 21st century a majority of the world peoples will live longer lives and human numbers will gradually reduce. The human world is ageing rapidly; with increasing lifespan *healthy ageing* is becoming synonymous with *healthy brain ageing*. Dementia prevention is now a national and global priority; the brain is becoming the focus of research in ageing and in the disorders of the old-old - particularly the dementias.

This Indigenous Roundtable will examine why the lifespan gap, and many indices of health and welfare for Aboriginal Australians, have not improved compared with the non-Indigenous settler or colonising Australian population, with Aboriginal people having the highest rates of dementia in the world despite what is generally seen as major efforts to close the lifespan gap and improve health status during this century (Radford et al 2019; Smith et al 2008; Zann 1994).

Indigenous Roundtable

The focus of public health and prevention from the mid-20th century, for non-Indigenous and Aboriginal Australians alike, has been on what is termed *The New Public Health* – essentially a focus on “biological” determinants of systemic (body) diseases - particularly later life vascular risk factors: hypertension, obesity, diabetes, heart disease, diet, cigarettes and alcohol. With population ageing, dementia research has also centred on these adult life vascular risk factors and later life accumulation of abnormal brain proteins such as β Amyloid as markers of specific dementias – e.g., Alzheimer’s disease.

The Roundtable will consider the additional role of early life “social” determinants of brain growth and brain development in the following areas: 1). As predictors of success or failure in adult life, employment and entry to the criminal justice system (Weatherburn D & Lind B. 2001); 2). As potential determinants of mid-life vascular risks; 3). Importantly, the Roundtable will examine the evidence that early life determinants of brain growth predict lifespan, late-life cognitive decline and dementia - hence where to direct potential early life interventions to reduce and eliminate the lifespan gap in Indigenous survival.

Koori Growing Old Well Study, Early Life studies and Adult Outcomes:

The NHMRC Koori Growing Old Well Study (KGOWS Wave 1) has shown that early life social and emotional trauma and neglect are associated with the high late-life dementia prevalence (demonstrated in all four Indigenous dementia studies across Australia). Age, childhood trauma, unskilled work as well as stroke, and head injury were independent predictors of all-cause dementia in KGOWS (Radford et al, 2017; Radford et al, 2019).

Non-Indigenous research studies using the Adverse Childhood Events Scale (ACE) and the Childhood Trauma Questionnaire (CTQ), with mid-life follow-up, correlate early life social determinants with mid-life risk factors such as cigarette and alcohol use, hypertension, obesity, diabetes, anxiety and depression (Felliti et al, 1998; Sapolsky R, 2017). The Nun

Commented [TB1]: In the 20th century there has been a massive increase in average life span (from around 35 years to over 70 years) and in world population numbers (from around 1 billion to over 7 billion) – called the **Demographic Transition**.

However, from around 1970 the rate of population increase has slowed and population ageing commenced with total numbers of people in many westernised countries now falling.

Commented [TB2]: While dementia is a disorder of very old people and is increasing in prevalence with their large total numbers, the incidence (rate of new cases) of dementia is falling in those over 80 years, correlated with improvements in healthy brain ageing and longevity.

Commented [TB3]: Brain growth, size and function is largely established in childhood by good parenting, upbringing and education. This early life brain growth then largely determines healthy adult life, healthy ageing, longevity and reduced dementia incidence in late life.

Commented [TB4]: *The Old Public Health* in the 19th C aimed at control of epidemics and infectious diseases with increased child survival the main initial beneficiary. *The New Public Health* from the mid-20th C. aimed at reducing adult and late life chronic systemic (body) diseases, particularly heart and lung disease.

Commented [TB5]: *Life-course Public Health* is aimed at human intellectual and emotional flourishing across the whole lifespan from pregnancy to old age incorporating: early life social determinants of employment and entry to the criminal justice system; of healthy brain ageing; of mid-life bio-medical (vascular & mental health) risk factors for ageing; to improve late life cognition and social and emotional well-being; lifespan and reduced dementia incidence.

Commented [TB6]: This section outlines evidence for the role of brain growth and early brain development: in childhood flourishing; in adult systemic (body) health; in adult social and emotional well-being (mental health); and in longevity and healthy ageing.

Study on early life linguistic ability (Snowden J et al 1996) and the Scottish School Children's Study (Deary IJ et al 2004) on childhood intelligence, correlate early life cognitive factors with late-life onset of dementia. Education is a strong predictor of late-life dementia in multiple studies (Brayne et al 2010); however, parenting and upbringing predict educational outcomes and require further study as predictors of adult cognition, lifespan and decline.

Neuroscience – the Science of Brain Growth and Function:

A revolution in knowledge and understanding of brain anatomy and function has occurred over the past half-century. This has happened in parallel with the end of 20th century rapid acceleration in world population growth (in 1951) and the start of world population ageing (in 1971) (Dorling D 2013). This revolution in neuroscience has been accompanied by rapid general progress in scientific knowledge and communication; however, the science of ageing remains largely defined as “biological”. What is studied in biological neuroscience is largely determined by what can be accurately, rapidly and easily measured - initially and predominantly functions like brain memory and cognition - rather than by attempting to examine the social and emotional functions of the brain that are of equal importance to humanity and the survival of the species: feelings and empathy, drive and emotional control, society and community. Such factors tend to be downgraded as ‘social science’ by biologically oriented researchers, despite their immense salience and current recognition of their origin in brain biology (Broe, G.A. 2003; Churchland, P. 2002. Hume, D. 1748; Hume, D. 1751; Smith, A. 1759; Smith A.1776).

The Neurobiology of Ageing, Health, Community, Culture:

The relevant concept to be examined in the Roundtable is that brain growth has been the primary social and biological determinant of 19th–21st century human development through serial revolutions in thought and action that have grown the size of our brains and improved brain function (Schaie K.W. 1996; Broe G.A. 2003). Revolutions against blind acceptance of Church dogma enabled the growth of ideas, literacy, trade and the Enlightenment; revolutions in science; industry; feminism; educational methods; parenting methods; information technology; globalization; artificial intelligence have all contributed to brain growth. It is conceptualised that consequent population growth, population ageing and human longevity resulted from this historical cascade of social, behavioural and political revolutions, interacting primarily through selective growth of the human brain. (However, the ‘progress’ of the human species is now threatening the survival of other planetary species and ultimately humanity itself).

The Roundtable will examine the concept that humans are largely governed by brain development and by its connections with an external world of experiences and actions within communities and societies. The body is closely integrated with the brain; whatever the body does is brain connected and brain dependent including - for example - attention, planning and decision making in the pre-frontal network; emotion and feelings in the limbic-insula network; learning, memory, thinking and intellect in the hippocampal-posterior cingulate network; action and movement in the motor network. Child development and brain growth, lifelong neuroplasticity, social and emotional integration with an external world - are also centred in the myriad of cells, synapses, structures, networks and neural extensions that make up the human brain, nervous system and its connections. Much of this structure is set up in

Commented [TB7]: This section addresses the revolution in knowledge about the brain and ageing in the 20th-21st C. It stresses a relative bias in research on ageing and cognition towards later-life bio-medical and physical risk factors (the amyloid hypothesis; cardiovascular disease and stroke; role of physical activity). While physical factors are of great importance in accelerating the ageing process (*The New Public Health*) there has been a lack of recognition and research in equally important early life social and emotional determinants of ageing and dementia.

Commented [TB8]: Brain Growth – Revolutions in Thinking

- Church control of our thinking
- Literacy and Vernacular
- Trade and Communication
- Science and Technology
- Schools and Education
- Parenting - love and support
- Feminism – equality, education, employment
- Information Technology
- Colonisation vs Globalisation
- Government and Politics

Commented [TB9]: Global warming and Pollution

Commented [TB10]: The Brain controls and directs the body's actions:

- Individually for each human being
- Collectively in community & culture

the first few years of life, when language and attitudes are shaped, as the template on which we build the developing brain, the future of the individual and the community network of brains (Lewis M and Lupyan G, 2020). The body provides monitoring, warning systems and the nutrients, metabolites and hormones that support brain function - oxygen from the lungs, blood from the heart, glucose from the gut; movement from the musculoskeletal system. The brain controls and directs the body's actions, both individually and also collectively through the formation of society and community, which are themselves conceptualised as multiple interconnected brains of the individuals that compose them (Damasio A, 2019).

The Roundtable will further explore the Indigenous concept that culture, the Land, its stories and its pathways are the expression of a communal brain; culture is the historical expression of a 60,000-year old society; its collective consciousness an expression of commonality within the cultural diversity of some 300 individual nations and languages.

Lifecycle Public Health:

The concept to be examined is that healthy ageing results from multiple inputs across the life-course, which improve health by increasing brain growth (Schaie 1996; Whalley & Deary 2001; Sapolsky 2017; Danese & McEwen 2007; Broe G A, 2003). These processes commence and have maximal impact in early life; they continue, albeit at a slower rate, through adult life with neuroplasticity and synaptic brain growth into old age. The roundtable will consider whether growing brains well, from the embryo through the first 2000 Days and into adolescent years, sets the child up for a long functional adult life, a healthy ageing process and delayed onset of cognitive decline and dementia in late life. Keys to early brain development are safe pregnancy and good parenting, enriched early childhood, equal access to education and to employment, absence of childhood trauma and equality of opportunity.

Further Issues to be Explored in the Roundtable:

1. Settler colonial attitudes towards recognition and respect for Indigenous culture and communities; a voice and self-determination for Indigenous people; and achieving settler and political acceptance of the aims of the Uluru Declaration.
2. The capability and community strength of Indigenous Australians in early life - mothers and their pregnancies, Indigenous infants and their parenting, a flourishing childhood and adolescent brain development
3. Social and Emotional Well-being during Indigenous childhood
4. Early life language and frontal executive systems development in Indigenous childhood and its determining consequences for subsequent knowledge.
5. Law Reform to halt the early criminalising and subsequent incarceration of Indigenous children and young adults
6. The trans-generational role of settler child removal on Aboriginal parenting, kinship systems and communities; consider the role of the non-Indigenous parenting revolution on brain development - not available to a stolen generation of Aboriginal parents.
7. Access of Indigenous parents and Indigenous children to the revolution in quality and quantity of supportive education available to non-Indigenous children
8. Employment – promotion of job readiness and access to higher and continuing job education and creation of social capital with Aboriginal adolescents.

Commented [TB11]: Culture, the Land, its Stories and its Pathways
- the expression of a communal brain

Commented [TB12]: Life-course Inputs to Adult Ageing

- Motherhood – Parent-craft
- First 1000 Days - to 3 yoa - Karabena
- First 2000 Days - to 7 yoa – NSW Health
- Next 2000 days - to Teens & lock-up -
- Adolescence & Neuronal culling
- Frontal Systems Drive and Control
- Adult neuroplasticity - Synaptic Brain Growth

Commented [TB13]: To be reframed as potential Roundtable Objectives?

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