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We need to Empower Health Prevention of Aged People with Intellectual Disability

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Much is known about health promotion and disease prevention in the general geriatric population, yet far less is known about those in older adults with intellectual disability (ID). Moreover, the rapid growth in the number of individuals with ID along with their increased longevity present challenges to those concerned about well-being of this unique population. People with ID are affected by much more health problems than the general population and are much more in risk to have age-realted diseases [1]. While promoting good health among people with ID is recently discussed as a psychsocial worldwide priority [2], evidence suggests they are not receiving the same level of health, social education and health promotion opportunities as other members of society.

Effective and efficient health promotion and disease prevention strategies need to be developed and implemented for improving the health and quality of life of older adults living with ID. The ideal health promotion and disease prevention strategies for older adults with ID should be tailored to the individuals' health risks, address primary and secondary disease prevention and prevent avoidable impairments that cause early onset of institutionalization. Areas of intervention should include cognitive, mental, social and physical health in general and in more specific thsy should include accommodations, workplace considerations, assistive technology, physical and recreational activities and nutrition.

The policy objectives are require to develop a "multi element approach", meaning any future interventions should include medications [3], psychotherapeutic [4], psycho-sensory-motor therapy [5], environmental management [6], social support [7], family education [8], and universal infrastructures such as skilled nursing facility, transportation and job opportunities [9].

The enormous chanlleges the society faces in health promotion and disease prevention are due to the following 12 facts relate to older adults with (ID):

- Many older adults with ID are living with family and may outlive their parents. Older adults with ID and their ageing family are two vulnerable groups [10].
- The majority of older adults with ID live with their family or in a community home, while others live in private or governmental residential care centers [11].
- Over the next 20-40 years, more adults with ID will be living longer into their seventies and eighties [12].
- Older adults with ID are exposed to a range of health problems and social inequalities.
- For clinical service and planning purposes, the ageing process should be conceptualized as beginning at a younger age (approximately 45 years of age) in individuals with ID (adults with Down syndrome (DS) or adults with severe and profound ID [13] are more likely to develop early-onset dementia and consequently are more likely to die at a younger age.
- As longevity of people with ID increases it is likely that there will be a consequent increase in the number of these people suffering from age-related diseases such dementia [14].
- There is a recognized co-existence between older adults with ID and mental health problems, such as affective disorders, aggressive behavior, psychotic conditions, and eating disorders [15].
- Obesity is a significant health problem for people with ID, with a higher prevalence among females and individuals with Down syndrome [16].
- Individuals with ID are more likely to develop "pre-aging phenomenon" such as dementia and anxiety [17], and to develop poor balance and gait difficulties, and consequently will require closer care.
- Older adults with ID are one of the most deprived population in the society in terms of job opportunities and have the lowest employment rate [18].
- Providing training to mental health care staff can yield a better competence in management of mental problems which is also important for improving the quality of life and reducing the prevalence of those mental disorders [19].
- More research is needed on: a) the ageing process of adults with ID (early detection, systematic screening; assessment instruments and tests); b) their co-morbidities; c) their need for long-term care and day care facilities; d) potential for having educational (accesses to college) and work opportunities, and supporting models; and e) the use of observation methods to understand the social interaction of adults with intellectual disabilities

Summary

People with ID often have multiple morbidities along with a number of unrecognized or poorly managed medical conditions as well as inadequate health promotion and disease prevention. Moreover, aged individuals with ID have difficulty getting social and health services. Therefore, policy makers need to have a multi-faceted and comprehensive programmes that faciliate, help and ensure that they will be access to this population. Despite these challenges it is our obligation to improve health promotion programs for the benefit of the people with ID.

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References

1. van Schrojenstein Lantman-de Valk H, Linehan C, Kerr M, Noonan-Walsh P (2007) Developing health indicators for people with intellectual disabilities. The method of the Pomona project. J Intellect Disabil 51: 427-434.
2. Oppewal A, Hilgenkamp TI, van Wijck R, Evenhuis HM (2013) Cardiorespiratory fitness in individuals with intellectual disabilities-A review. Res Dev Disabil 34: 3301-3316.
3. Emerson E (2011)Health status and health risks of the "hidden majority" of adults with intellectual disability. Intellect Dev Disabil 49: 155-165.
4. Newman DW, Beail N (2010) An exploratory study of the defence mechanisms used in psychotherapy by adults who have intellectual disabilities. J Intellect Disabil Res 54: 579-583.
5. Heller T, McCubbin JA, Drum C, Peterson J (2011) Physical activity and nutrition health promotion interventions: what is working for people with intellectual disabilities? Intellect Dev Disabil 49: 26-36.
6. Hammel J, Jones R, Smith J, Sanford J, Bodine C, et al. (2008) Environmental barriers and supports to the health, function, and participation of people with developmental and intellectual disabilities: report from the State of the Science in Aging with Developmental Disabilities Conference. Disabil Health J 1: 143-149.
7. Lippold T, Burns J (2009) Social support and intellectual disabilities: a comparison between social networks of adults with intellectual disability and those with physical disability. J Intellect Disabil Res 53: 463-473.
8. Wilkinson J, Dreyfus D, Cerreto M, Bokhour B (2012) "Sometimes I feel overwhelmed": educational needs of family physicians caring for people with intellectual disability. Intellect Dev Disabil 50: 243-250.
9. Sinai A, Bohnen I, Strydom A (2012) Older adults with intellectual disability. Curr Opin Psychiatry 25: 359-364.
10. Wang KY (2012) The care burden of families with members having intellectual and developmental disorder: a review of the recent literature. Curr Opin Psychiatry 25: 348-352.
11. Irazábal M, Marsà F, García M, Gutiérrez-Recacha P, Martorell A, et al. (2012) Family burden related to clinical and functional variables of people with intellectual disability with and without a mental disorder. Res Dev Disabil 33: 796-803.
12. McConkey R, Mulvany F, Barron S (2006) Adult persons with intellectual disabilities on the island of Ireland. J Intellect Disabil Res 50: 227-236.
13. Krinsky-McHale SJ, Silverman W (2013) Dementia and mild cognitive impairment in adults with intellectual disability: Issues of diagnosis. Dev Disabil Res Rev 18: 31-42.
14. Strydom A, Chan T, King M, Hassiotis A, Livingston G (2013) Incidence of dementia in older adults with intellectual disabilities. Res Dev Disabil 34: 1881-1885.
15. Bishop KM, Robinson LM, VanLare S (2013) Healthy aging for older adults with intellectual and development disabilities. J Psychosoc Nurs Ment Health Serv 51: 15-18.
16. Stancliffe RJ, Lakin KC, Larson S, Engler J, Bershadsky J, etal. (2011) Overweight and obesity among adults with intellectual disabilities who use intellectual disability/developmental disability services in 20 U.S. States. Am J Intellect Dev Disabil 116: 401-418.
17. Lin JD, Wu CL, Lin PY, Lin LP, Chu CM (2011) Early onset ageing and service preparation in people with intellectual disabilities: institutional managers' perspective. Res Dev Disabil 32: 188-193.
18. Stephens DL, Collins MD, Dodder RA (2005) A longitudinal study of employment and skill acquisition among individuals with developmental disabilities. Res Dev Disabil 26: 469-486.
19. Kroese BS, Rose J, Heer K, O'Brien A (2013) Mental health services for adults with intellectual disabilities--what do service users and staff think of them? J Appl Res Intellect Disabil 26: 3-13.