



AUSTRALIAN ASSOCIATION OF GERONTOLOGY NSW NOTES

AUTUMN

APRIL 2005

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CROSSING BORDERS:

Multidisciplinary approaches to ageing

The 2005 Rural Conference for the Australian Association of Gerontology (AAG) NSW Division drew 140 delegates to the Albury campus of Charles Sturt University to hear some fifty speakers address different aspects of the ageing process. The focus was on multidisciplinary approaches and coordination of care services and local delegates took the opportunity to showcase some of the excellent work being done in the border region and surrounding areas. Delegates evaluated the presentations as very relevant to their work and of a high standard. Summaries of all the presentations are included in this edition. Delegates also had the opportunity to participate in a choice of our interactive workshops and many rated their workshop as the most beneficial part of the conference.

We received excellent support in organising the conference from Charles Sturt University which proved to be a first class venue and received high rating from delegates' evaluations. The support of Greater Southern Area Health Service and NSW TAFE Community Services and of our cheerful and efficient organisers from East Coast Conferences, is also gratefully acknowledged.

COMMITTEE MEMBERS

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*Please address all
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COMING AAG EVENTS IN NSW

Date: 9th September 2005

Venue: Clinical Sciences Building, Concord Hospital

Subject: WORK TILL 100? *'The Labour Market of the Future'*

This Seminar will be an enlightening journey on the future of the ageing workforce. This is an area that concerns everyone, and the more discussion and information we can generate, the better our transition into 'the labour market of the future'. We have some excellent speakers to educate and entertain, so it should be a very rewarding day. (Brochure will be out soon)

Our new Executive Office is Janet Gilchrist who is under contract with the Centre for Education & Research on Ageing at Concord Hospital to provide administrative support for the NSW Division. You can generally contact Janet at the above office details – between 9am and 1pm Monday to Thursday, with voicemail to cover other times, and email as the prime contact.

The Australian Association of Gerontology (NSW Division) thanks our main sponsors the Greater Southern Area Health Service, TAFE NSW Community Services, Aust. Communication Exchange, Charles Sturt University, Webstercare, Dept of Veteran Affairs, Elsevier Publishing & Continence Foundation of Australia. Their generous sponsorship contributed to the conference's success.

Abstracts

Future of Ageing research in Australia

Professor Hal Kendig, Research Professor, Faculty of Health Sciences, the University of Sydney
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New opportunities for ageing research arose when 'Ageing Well, Ageing Productively' was identified in the National Research Priorities for Australia in 2003. The aim is to foster research which informs the development of better social, medical and population health strategies to improve the mental and physical capacities of older Australians. The National Strategy for an Ageing Australia states that research will underpin the strategy, fine tune its implementation, and provide a good evidence base to support policy.

This paper will outline how the ARC-NHMRC Research Network on Ageing Well is working to develop and support interdisciplinary, high quality research that can address the information needs of an ageing Australia. The Network aims to build scale and focus on Australia's research strengths in ageing, promote collaborative research, enhance research capacities, and nurture developing researchers. It will strengthen international collaboration and involve and inform end-point users. It aims to foster research which responds to the aspirations and needs of older Australians and informs action that can improve experiences of individual and population ageing.

This paper will present the early research development and communication strategies being set for the collaborative efforts of the Ageing Well Research Network. It will raise priority research questions in the areas of Independence and Social Participation, Productivity and Economic Security, Healthy Ageing, and Population Research Strategies. This will help set action priorities and communicate them to the individuals and organisations that make and implement policy decisions.

The Network is formed by seven core University partners, 50 foundation participants, and a number of associates. It will build partnerships between researchers and key constituencies including the AAG, COTA/National Seniors, ACSA, and Australian and State Offices on Ageing. Examples of research directions will be given including developments in New South Wales.

Ensuring the needs of rural older people are heard in government decision-making

Dr Dawn Linklater, NSW Ministerial Advisory Committee on Ageing
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Community participation in decision-making is an important part of the democratic process. However governments often struggle to find appropriate models that will include more voices in decision making,

especially those most directly affected by the decisions, at the same time not undermining the legitimate roles of elected representatives and government departments.

In NSW the Ministerial Advisory Committee on Ageing is one such model. Its primary role is to advise the NSW Government, through the Minister for Ageing, on matters affecting the needs, interests and well-being of older people in NSW.

The Committee is a committee of "experts" rather than a representative body, and is comprised of older people and professionals from a range of backgrounds.

The Committee uses different mechanisms in order to inform its advice to the NSW Government. The paper describes the ways that the Committee has operated to ensure that the views of older people in rural NSW are heard and examples of how it has operated to influence Government decision-making to the benefit of older people in rural NSW. Policy areas include access to specialist services by older people who live in rural areas, improving the transport options of older non-drivers in rural areas and the protection of older people who live in residential parks.

Models that work: improving older people's access to specialist medical services in rural and remote Australia

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Rationale: Australia is not unique in the challenge of ensuring that older people living in rural and remote areas of the country have access to prompt, high quality specialist medical care. A coherent response to the problem has been mired in problem analysis rather than policy research and coherent strategy and program formulation, but some recent progress is evident.

Research Objectives: The authors examined policy and program models that have been evaluated shown to work – in Australia, New Zealand, Canada and the US – and could be applied to improve access to specialist medical care in rural and remote NSW.

Results: Among the key findings are:

1. Stop-gap measures are still not bridging the gap, with services such as The Royal Flying Doctor Service increasingly called on to fill serious shortages of doctors and health facilities in large country centres.
2. Initiatives aimed at improving access to specialist medical services in rural and remote Australia tend to be short-lived pilot projects with time limited funding and no evaluation, rather than programs that are known to work,
3. The emphasis in Australia has been on programs that are skewed to outreach ("Fly in-fly out") service models.

4. Solid cost data are not available so it is difficult to judge the cost-effectiveness of the programs.

5. Few systematic attempts have been made to evaluate and compare pilot projects – in contrast to Canada, which made a 5-year investment into developing models that work. These models are now being rolled out.

6. More than a dozen models that work were identified through the research, in 3 major categories:

- **Extenders:** Models that extend the reach of existing medical specialist providers. Chief among these models is the outreach model, ideally within a “hub-and-spoke” framework.
- **Enhancers:** Models that enhance the available medical specialist services, often by upskilling GPs or other clinicians; sometimes by training nurses or other clinical staff in skills in high demand in rural and remote areas.
- **Enablers:** In particular, e-health and telehealth programs that facilitate access in a “virtual” sense.

The models are described in more detail in the report, along with recommendations for NSW.

Disclosure Information:

This research was commissioned by the NSW Ministerial Committee on Ageing, with funding from the NSW Department of Ageing, Disability and Home Care, by Health Innovations International Pty Ltd., an independent, private company specialising in health policy and strategy. Neither author has any conflict of interest with regard to the research.

Mentoring GPs in care of the older person

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All general practitioners have older patients and about 1 in 4 consultations are in people over the age of 65 years. About 1 in 3 older people have seen their general practitioner within a two-week period. Increasingly the training of general practitioners and their remuneration is taking their role in aged care into consideration. However, as with many specialties, there is considerable difficulty in obtaining specialist geriatric medicine support for regional and rural areas. Therefore the Greater Southern Area Health Service developed a medical mentorship programme to fulfil an unmet need for medical supported for their aged care services. This involves upskilling of general practitioners through the visits and support of city-based geriatricians over a period of 1-2 years. The approach was successful in Wagga and is now being applied in Griffith. Success is dependent upon resources, commitment as well as the availability of suitable general practitioners

Dementia and elder abuse

Robert Bunt and Patrick Livermore, Central Coast Health
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Abuse of older people is a significant social issue in Australia. Recent research has identified a number of factors which contribute to elder abuse. The dependency of an older person has been shown to place them at higher risk and dementia has been recognised as a major contributing factor in terms of rendering older people vulnerable to abuse.

Our study focuses on the problem of elder abuse among ACAT clients and carers on the Central Coast of New South Wales. We focus on the relationship between dementia and elder abuse and comment on this in cases where the client is abused and also in cases where the carer is abused. Carers of people with dementia in particular, are identified as having specific needs in terms of elder abuse.

Suggestions regarding the need to assess and identify potential cases of abuse are offered, as are methods of focusing specifically on clients with dementia and carers of people with dementia, in an effort to provide increased support to those at risk of abuse. The presentation highlights differences in responses and outcomes for people with dementia and their carers, depending upon the nature of the abuse. The role of service providers at a number of levels is also discussed.

The presentation aims to increase awareness of elder abuse and to highlight the importance of dementia within this context.

The Central Coast Primary Dementia Care Network

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The Central Coast Primary Dementia Care Network (CCPDCN) was a pilot project funded for two years by NSWDOH in response to the World Health Organisations challenge for governments to develop primary health care initiatives to better meet the needs of even the most marginalised groups in society. People with dementia are one such group and they should benefit by the establishment of a Primary Dementia Care Network. However, in the absence of guidelines of what a network might look like or how it might be established, the Central Coast had a huge challenge ahead of it when it successfully bid to pioneer this project.

The literature search was attended, consultation, service mapping and a local needs analysis followed and an inclusive network model was created. Its effectiveness was evaluated both internally and then externally by an independent evaluator appointed by NSW DoH.

The model, its successes, outcomes of working groups, lessons learned and its portability to other regional areas will be discussed today.

The CCPDCN provides a vehicle for PWD, families and carers, and the services that support them (including

GPs, non-govt., private for profit, community services, consumer representatives and Govt. agencies) to work on local needs together. It also promotes: information sharing, professional development, joint planning and service development, education and improvement of dementia services on the Coast. Six working groups report back to the network at regular meetings. The CCPDCN significant achievements continue past the pilot phase and building in methods of sustainability from the onset will be a recurrent theme of this presentation.

DBAMS a multidisciplinary approach to managing dementia behaviours

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DBAMS is an innovative pilot program for managing dementia behaviours (BPSD's) in a rural setting and involved collaboration between the Commonwealth Government and Greater Murray Area Health Service (NSW).

The Greater Murray Area Health Service covers 120,000 square kilometres with an elderly population of 32,000 served by a 16 bed CADE (Confused and Disturbed Elderly) Unit, Yathong Lodge, in Wagga Wagga. The aim of the pilot was to improve the management of BPSD's in the region by:

1. Providing a multi-disciplinary team focus
2. Psychogeriatric nurse outreach (x 3) for assessment and management in a community setting and to provide specific dementia behaviour education to carers, aged care services and residential aged care facilities
3. A shift in CADE Unit operations towards a time limited assessment and management unit for BPSD's for those clients of the program unable to be managed in the community
4. A doubling of visiting psychogeriatrician input to the area and development of telepsychiatry

The program has been in operation for 18 months and has enrolled 183 clients and discharged 115. It utilises the services of a wide range of health professionals including psychiatrists, geriatricians, nurses, social workers, diversional therapists, physiotherapists, occupational and speech therapists. The inpatient unit, Yathong Lodge, now has only one of its original residents, the remainder having been successfully placed in more appropriate settings. The average length of stay in the Unit is 8 weeks. It hosts three interdisciplinary meetings per week to focus on admission and discharge planning, medical and nursing concerns and behavioural strategies and has treated 75 clients with only three re-admissions.

We have found this multidisciplinary approach highly creative and successful in the development of management strategies, facilitation of appropriate discharge destinations and in the provision of rapid access to both community and inpatient care. It has also enhanced the competencies of residential aged care staff in their ever increasing role of dementia behaviour care.

The Home from Home pilot program

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BACKGROUND: The Commonwealth Departments of Health and Ageing and Veteran's Affairs and the ACT Department of Health have jointly funded the Carers ACT Inc. to operate this new and exciting initiative. This model was developed in response to difficulties identified in the ACT with meeting the needs of the carers of people with dementia and challenging behaviour and in particular, meeting the needs of specific sub-groups, for example:

- people newly diagnosed with a dementia who exhibit distressed and confused behaviours when they are away from home;
- people with challenging behaviours;
- people with dementia from culturally and linguistically diverse backgrounds, for whom mainstream or dementia specific services are often inappropriate; and
- gender specific groups where programs of more appropriate domestic and social activities can be developed to meet individual needs.

A report "Future Directions" by Bird and Parslow prepared for Alzheimer's Australia, outlines the difficulties experienced by carers of people in the early stages of dementia. The report speaks about the well-known phenomenon of 'challenging behaviour which arises in an otherwise calm person because they are distressed and confused by being away from home'. The report also discusses the inappropriate nature of day and respite care provided for physically fit people in early stage dementia who need programs which are specifically targeted to their needs. This is a group of carers who have not been able to access adequate respite because the people for whom they care will not access or continue to attend programs "which they found patronising or uninteresting" (Bird & Parslow:2002:Pg 38).

THE HOME FROM HOME PILOT PROGRAM

The pilot commenced on 01 July 2003 originally as a 12 month pilot. Extra funds have been successfully gained to continue this program to the present day. The program is currently seeking recurrent funding.

The aim of the program has been to:

- test the effectiveness of flexible day programs in a small, domestic environment for people with dementia and challenging behaviours; and
- coordinate and pilot a small "host families" program, based on a successful model implemented in Western Australia.

The Home from Home pilot program offers flexible respite care in a conventional-style cottage that accommodates up to 6 people. The program is available from 8am to 8pm Thursday morning to Sunday evening, which is outside the hours of most community-based respite care services.

The coordinator of this program also manages a 'Host Family' program. The Host Family Program funds and supports three families to care for three to four people with dementia in their own home. This provides an alternative respite option for carers.

The focus of each group's program and activities has been on meeting the specific physical, social and emotional needs of clients of similar background, diagnosis and/or dependency level. The coordinator assesses each client and develops an individual program of care that capitalises on their skills and stimulates cognitive function and social interaction. Although the program operates from 8am to 8pm, there is the potential to provide overnight care in the future.

There is a wealth of evidence to support the view that people with dementia need to be cared for in small domestic environment, to mix with small numbers of people and to participate in supported, appropriate activities in a non-threatening environment. This pilot has been evaluated extensively and has received excellent feedback from all stakeholders.

Men's Health Peer Education Program

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The Men's Health Peer Education (MHPE) Program is a national program, which commenced four years ago. It was the result of the Department of Veterans' Affairs (DVA) Vietnam Veterans Health Study (1998) recognising that the ageing Vietnam veteran population were experiencing higher rates of substance use, obesity, high blood pressure and cholesterol, leading to a greater incidence of heart disease and diabetes than the general population.

The aim of the MHPE program is to raise the veteran community's awareness of men's health issues by encouraging members of the veteran and ex-service community to share the responsibility for managing their own health and well being.

Volunteers are trained to become MHPE Facilitators and to provide information to their peers about their health and well being. As men are much less likely to see their doctor than women, and less likely to listen to anyone as much as they do their peers, the program has been most effective in achieving successful improvement in veteran health and social capacity building.

MHPE Facilitators work in conjunction with DVA, local community organisations, including government and non-government, ex-service organisations, and their peers and families to encourage an improvement in their quality of life.

Following the MHPE National Conference in October 2004, which was attended by the ten State/Territory

MHPE Representatives and by DVA staff, there will be an increase in focus on networking among the various groups, and marketing the program more broadly in 2005.

Mates building community – men's sheds, social connectedness and community building

Anthony Brown, Men's Health Information and Resource Centre, University of Western Sydney
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In keeping with the theme of "Crossing Borders" this paper will reflect on the "border crossings" between older men and community organisations. In other words, the "fit" between older men and the organisations they volunteer their time to.

Older men are noted in many community settings mostly by their absence. Even those organisations established to provide social support for older people (for example Senior Citizens' Clubs and Centre) attract a mostly female clientele. Aged Care services (such as Day Care and Residential Aged Care) also report that men are not always drawn to the activities on offer.

In recent years there has been a rise in activities and programs which specifically target older men. In particular Older Men: *New Ideas* (OM:NI) and the various Men's Sheds.

The services that older men are drawn to, not surprisingly, are those which utilise these preferred "male" way of socialising. This paper will look at these different services and compare them to existing literature on how older men socialise. Findings from a recent study of older men's social connections will also be presented.

The session will end with examples of various models of Men's Sheds, operating in both rural and metropolitan areas.

Older men: making connections

Margaret Dalmau, Aged Suicide & Depression Prevention Worker, GSAHS and Stephen McCrohan, Dept of Veteran Affairs
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Suicide is an issue across the lifespan. In 1994, 82 percent of suicides were in males. Suicide death rates were highest amongst young men aged 20-24 and older men aged 75 years and above (NSW Health 1997).

The development of suicide prevention initiatives for older people, particularly older men, has received far less attention than for other age groups. Social isolation, grief and loss, retirement, and depression are common risk factors for suicide in this age group. The literature shows that increasing a person's connectedness to their community, as well as their levels of support and self esteem goes a long way to increasing a person's resilience and thereby reducing the risk of developing depression and suicide.

Recognition in the human services sector has grown regarding the need to increase support for older men generally. The Greater Murray Area Health Service (GMAHS) has actively facilitated the development of older men's groups across the region for several years through its older men's suicide prevention project.

A Riverina Murray Muster of Older Men's Groups with the theme Older Men: Making Connections was held in February 2004, and jointly organised by GMAHS, Age Concern Albury / Wodonga, and the Department of Veterans Affairs. The aim of the Muster was to bring groups together to share ideas, identify common issues, provide networking opportunities, and build their capacity.

This paper will explore the strategies involved in working collaboratively to increase the support, connectedness, and social wellbeing of older men in rural areas. It will also discuss outcomes and future possibilities for the continued support of older men.

Subjective realities of older farmer's lives: self-perceptions of ageing and work

Judith Gullifer, Generalist Counsellor, GSAHS / Anthony P Thompson (Charles Sturt University)
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This study explored the meaning of ageing and farming for older male farmers using a phenomenological design. A homogenous sample of eight middle-class Australian men ranging in age from 65 to 80 years participated in audio taped interviews. Thematic analysis revealed four prominent themes, 1) the narrative of "toughness", 2) a down-to-earth view of ageing, 3) attachment to place and 4) the importance of feeling productive and useful. The themes are potently portrayed in selected comments from the interviewees and linked to relevant issues in the ageing literature.

Physical therapy pilot study

Penny Temple / Nikki Barnes, Care Manager, Warmington Lodge, Yass
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Resident A is 68yr old diabetic with advanced dementia. We began her physical therapy program on the 06/12/02. At this time she weighed 74kg her B.P. was 160/80 and B.S.L.13.0. The aim of the physical therapy program was to reduce all three readings without an increase in medication. The program involved one staff member walking the resident around the facility courtyard once a day. The courtyard is 120 paces. As the resident became more mobile we increased the number of paces. We involved the local G.P. who stated he would like the resident's waist measurement to be less than 90cm. The resident's waist measurement as at 20/01/03 was 120cm. 01/12/03 measured 108cm. Weight at present is 65kg, B.P. 141/80, B.S.L. 7.3. As the resident has dementia the staff member in charge of her physical therapy finds the resident benefits more from several short periods of

therapy. The total would be 30-45mins a day, but over three sessions.

The facility has gone on to target all overweight diabetics.

Guidelines for the physical therapy program were based on the National Prescribing Service Newsletter No. 29/2003: Lifestyle modifications to reduce cardiovascular risk.

A staff member using a pedometer walks residents. Walking takes place either within or outside the facility. Within the facility resident's walk around the courtyard, usually (unknowingly) at the encouragement of their fellow residents, as there is an unofficial competition to be the resident who has walked the most steps in a day!

Benefits have been;

1. Reduced poly-pharmacy.
2. Reduced depression.
3. Increased socialisation
4. Lowering of BSL & BP'S.
5. Falls reduction.
6. Increased strength & muscle tone

A user-friendly nursing care plan is not an oxymoron!

Lyn Morgan, Care Manager, Horton House, Yass
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Historically nursing care plans used in aged care have been cumbersome, labour intensive tools essential to meet regulatory and funding requirements, but generally falling short of effective, individualised plans of care. They are a necessary evil!

Here was an opportunity for improvement to develop a nursing care plan that was easier to create, use and update. Horton House's involvement with the Business Excellence Awards (BEA) Aged Care Pilot some three years ago introduced staff to flow charts and to Microsoft Visio. The General Manager and the Care Manager had long had a dream of a "one page" nursing care plan and as a result of the commitment by our Board of Management to continuous improvement through the BEA the dream became a reality. A one page computerised nursing care plan was developed by the Care Manager in a flow-chart format using the nursing process (assessment, planning, implementation and evaluation) covering the 8 care domains of;

- Communication/Comprehension
- Mobility, Meals & Drinks, ADL's
- Bladder & Bowel Management
- Behaviour
- Social & Human Needs
- Medication
- Specialised Nursing
- Therapy & Other Services

Over the past 3 years the Care Manager has developed the nursing care plan into a concise, timely and colourful format that care staff can easily understand. These individualised care plans have received positive

comments from 3 teams of Accreditation auditors regarding their innovation and effectiveness leading to positive outcomes for the residents.

Quality of care has improved due to the ease of use of the tool. The care staff actually want to use it! The format allows for the development of templates for like diseases or behaviours; similar to that of DRG's in the public system. This allows for a degree of predictability and a further reduction in workload.

This is a new and innovative way of approaching an age-old problem and we would like to share our dream with other facilities!

Care in nursing home: an exploratory study of services providers

Hui-Wen Chien, PhD candidate, University of Sydney
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The aim of this study is to explore the phenomenon of nursing home care from the perspective of those who provide it. In particular, it examines how service providers interpret the 'standards of care' component of the quality assurance framework that regulates the residential care sector in Australia.

The specific research objectives are to:

- Document the beliefs, attitudes and worldviews of staff, relatives and resident in regard to the experience of a nursing home
- Elicit the range of meanings and evaluations that staff attach to their work
- Describe their constructions of 'care' and 'quality of care' and the organisational factors they believe impact upon their ability to provide it.

The study adopted an ethnographic methodology involving participant observation and in-depth interviews. Data were collected and analysed using the constant comparative method in order to generate a grounded theory of nursing home care. The process was also informed by the philosophical framework of hermeneutic inquiry in acknowledging the participation of the researcher in making data.

The presentation will briefly describe the study site and fieldwork process and present major findings. Seven key interrelated factors in the production of care within the nursing home have been identified: economic, internal and external accountability, management and training, staff conditions, the accreditation system, environmental stressors, and the work/care styles of individual staff. The latter can be broadly categorized into two main types – 'tortoise' and 'hare'. This typology and its significance for the production of nursing home care will be elaborated.

Residential care 2005: the year ahead

Jill Pretty, Manager Consultancy and Policy Unit, Aged and Community Services (NSW & ACT)
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Residential Aged Care has undergone numerous changes since the introduction of the Aged Care Act in 1997. The boundaries between hostels and nursing homes have become more blurred with the introduction of a common funding tool, an accreditation system and the philosophy of ageing in place.

These changes have had a significant impact on residential aged care, with facilities struggling with financial viability, ongoing workforce issues and meeting the future building requirements. In response to these concerns, the government commissioned a pricing review of residential aged care in 2004 which was conducted by Professor Hogan. In response to this review, the government made some major announcements in February 2005.

The year ahead will raise further challenges for residential aged care in a year when most facilities need to commence their preparations for round three of accreditation.

This presentation will outline these significant changes, the implementation strategies and discuss the possible impact for providers and prospective residents.

The home care mental health project

Margaret Dalmau, Aged Suicide & Depression Prevention Worker, and Pauline Kelly, Co-coordinator, Community Health Residential Support Service, GSAHS
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The fostering of partnerships and collaborative responses from services in a number of settings is vital to improved mental health care for older people.

A partnership was formed between GMAHS Mental Health, Aged Care, Community Nursing Services, Home Care Service NSW Wagga Wagga Branch, Riverina Private Nursing Service, Wagga Wagga RSL Sub Branch, and Veteran's Affairs. This developed the Home Care Mental Health Project to investigate and trial options for increasing the support of older people with mental health issues and their carers living in the community.

A 2 pronged pilot project funded through the DVA Value Added Service Program commenced in February 2003. This involved education of Home Care staff regarding aged mental health issues and the provision of care packages to 8 older Veteran's and their carers with mental health issues.

The external evaluation results indicate that:

- The Home Care workers have increased their understanding, skills, and confidence in working with older people who have mental health issues, and
- There have been positive outcomes and improved quality of life for the clients involved in the project.

The expression of chronic pain in older people. Do we really understand?

Margaret Gartrell, PhD student, Charles Sturt University
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Chronic or persistent pain is a complex phenomenon. The experience of chronic pain is highly individual and is influenced by a range of factors. The prevalence of chronic pain is significant among older people, with the most common cause being musculoskeletal conditions. Chronic pain in older people is often under-diagnosed, under-treated and poorly managed, resulting in disability for those who suffer. Older people are often expected to (and sometimes do) accept chronic pain as a normal part of ageing. Whilst a multidisciplinary approach is the ideal in effective pain management nurses can play an important role in the identification, assessment and management of chronic pain in older people.

Research was undertaken to gain a better understanding of the way older people construct and express their chronic pain, whilst comparing this to the way nurses understand and respond to the communication they receive from older people who experience chronic pain. The manner in which nurses express their beliefs and attitudes about pain in their patients was also explored. A qualitative research project utilizing a mixed-method approach (descriptive and interpretive) was conducted. The findings of the research will be presented, and recommendations for improving health interventions made.

Say it as you see it – understanding the psychology of age and illness: enhancing communication for improved health care outcomes

Beryl Shaw, Another Life Services
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A belief seems to have become common throughout society that as we grow older, we grow more alike and less flexible. That living in a city, or a rural area, defines our mind-set. And that having the same illness creates the same experience for everyone. This flies in the face of one's own experience of difference from one's peers.

For example, cancer becomes more prevalent with age, but is different depending on its site, stage, and the life experience of the person in whom it lives. Age is only one variable. However, both age and cancer are likely to be more difficult to cope with in a rural area.

Obviously, most health professionals will be younger than those they are treating for age-related illnesses, so cannot truly know this experience.

This can result in an unnoticed one-size-fits-all approach to older patients, causing deterioration in their emotional state, which will affect their physical health and sometimes cause resistance to treatments offered.

As Dr David Spiegel has reported, patient's lives are enhanced or degraded, depending on the quality of care

extended to them. Importantly, a high level of communication maximises outcomes.

Beryl Shaw's 20 years of professional experience as an author, public speaker, researcher and designer / presenter of courses for people in life altering situations, has allowed her to go beyond many previous assumptions. Her own age and experience of cancer have added even greater knowledge.

Beryl will outline difficult scenarios from real life. Then, using her wordsmith skills she will present options and offer strategies readily inculcated for a change in communication styles that translates to an immediate easing of tensions, leading to improved health outcomes for these older ill patients and less frustration for the health professional.

Suicide and ageing

Jo Dennison and Sandra Bolack, Illawarra Institute, TAFE NSW
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Suicide is not related only to the young and middle aged. As the number of elderly people in the community and nursing homes increases so does the incidence of suicide. Overseas trends confirm that this is not just a phenomenon occurring in Australia but one common to many countries. In Hong Kong for example suicide rates for the aged are the highest in the country.

LivingWorks Applied Suicide Intervention Skills Training (ASIST) and its suicide intervention model are the core contributions to suicide prevention. The program enables those who have completed the ASIST workshop to become aware of the potential for suicide in older people and informs them on a model that gives direction and help with intervention. The LivingWorks program is the most widely used program in the world. For more than twenty years LivingWorks education has been providing evidence based suicide first aid programs.

There is a need for coordinated action to assist with the prevention of suicide in rural communities. To be effective prevention requires intervention from areas outside the health sector and calls for a multi-disciplinary approach that includes education. The community needs to feel that they have a model to implement in areas where suicide may be an issue.

Suicide is a major community health problem. Preventing it requires the efforts of all caregiver groups; health, mental health and social support. A key part of prevention is the need for suicide first aid training for both formal and informal caregivers.

Aged Services Emergency Teams (ASET)

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The ASET is a new initiative of the NSW Department of Health, being established in 2002 to improve the care of older people with the service located in the Emergency Department of 34 hospitals throughout the state.

The purpose of the ASET is to conduct a comprehensive geriatric assessment to identify issues and then respond and to advocate and promote an awareness of specific care needs of the client.

ASET's adopt a multi-disciplinary approach to ageing in assessment and service provision which enables the implementation of appropriate supports to improve or maintain the health and independence of each client. The plan of care is developed in consultation with the older person, carers and the multidisciplinary team.

The differences between rural and metropolitan demographics and resources impacts on the ASET service provision. The rural team is actually a sole practitioner, though in conjunction with aged care teams, and is reliant on community based services and developing networks to access supports for the clients.

There has been a positive response to the role of ASET's from health colleagues, Emergency Department clinicians, doctors, service providers and most importantly the clients and their caregivers.

The presentation will describe the service, discuss the referral screening tool, assessment and planning process and then examine the individual experiences of two rural ASET's.

A formative evaluation of an innovative rural rehabilitation program

Joan Nankervis and Dr Briony Dow, Research Fellow, National Ageing Research Institute and Jill Dunbar, Dept of Human Services
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This paper presents an analysis of the formative phase of a three-phase evaluation of a new rehabilitation program in rural Victoria. This phase involved working with program management and direct service providers to clarify program design and identify any program design limitations prior to implementation. Conclusions about the usefulness of the formative evaluation are discussed, illustrating improvements achieved in program implementation.

The population targeted by the new rehabilitation program had poor health status, relative to regional Victoria. The rehabilitation program aimed to improve consumer access and utilisation of rehabilitation services, using the existing infrastructures of five district health services. The health services were to establish mechanisms to integrate allied

health workforce planning, training and recruitment. The service commenced in July 2004.

A regional planning committee and staff from the Regional Department of Human Services Office compiled the initial design. Interviews with program managers, allied health personnel, GPs and other service providers were conducted to see whether their perceptions of the program concurred with this design. Analysis of these interviews identified areas where stakeholders held different perceptions about the proposed model. These differences were fed back to the people responsible for program planning, enabling modification of the program prior to implementation. Some outcomes of the formative evaluation were:

- Broad consultation and education about the proposed program;
- Clarification and negotiation of expectations;
- Alteration of program design; and
- Strengthening of links within the multi disciplinary workforce.

These outcomes are applicable to rehabilitation program development in other rural areas.

Early notification of complex clients and mandatory falls reporting

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Dareton Community Health Centre services a vast rural and remote area in New South Wales (NSW) which borders on the Murray River adjacent to the Mildura region. Hospitals on both sides of the river are utilized by NSW clients. Dareton Community Health Centre is a Primary Health service which endeavours to deliver holistic and self managed care to its clients and community.

The aim of this initiative was to develop two notification tools that would create a collaborative approach, between community and acute care, enhancing discharge planning, promoting self management, reducing the risk of inappropriate hospital admissions and, therefore creating better outcomes for the client.

The notification tools were developed to provide a multidisciplinary approach of shared responsibility in regard to complex care clients the tools were in the form of facsimiles. Both faxes can be used in accident and emergency and wards alike accompanied by these tools are representative of the primary health care team attend weekly ward meetings in the Mildura Base Hospital. The facsimiles themselves are simple and have all the information required including criteria for referral. The hospital refers within the first few days of admission or presentation, the primary health team respond to these facsimiles within 24 working hours.

The impact of these tools has been outstanding primary health describes their relationship with the hospital as vastly improved, primary health are now an integral part of the clients management in an acute setting. The acute service providers report that the outcomes are positive

and that awareness of the importance of community involvement has increased substantially. These tools supported by regular consultation with community and acute care service providers has created better outcomes particularly in regards to continuity of care.

(A detailed power point presentation and report can be forwarded at any time upon request.)

An anthology of students' rural undergraduate interprofessional education experience of interprofessional approaches to ageing

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Introduction: This presentation will identify the existing and potential linkages between rural undergraduate interprofessional education and practice.

Approach: Two undergraduate programs provide interprofessional education for Victorian health students. **Rural Interprofessional Education (RIPE)** has operated for four years and is open to all health students at any Victorian University. This activity is extra-curricular, with students choosing to spend two weeks, paired with a health student from another discipline, experiencing rural health practice. The **Rural Health Module (RHM)** has sent final year medical students to placements in Koorie, regional and rural settings over a four week period for the last 18 months.

Findings: While RIPE and RHM operate in similar rural health settings, students bring differing attitudes and skills to the learning tasks. Students in earlier years of their courses, those still forming their orientation and commitment to their discipline, are universally receptive to the challenges of IPE. Later year students, more entrenched in their professional roles demonstrate some variability in engagement and participation. With regard to the task of appraising rural health practice, most produce insightful analyses. However, some question the value of operating outside the comfort zone of their own discipline.

Conclusion: Interprofessional approaches to health practice require that health professionals are exposed to the principles of interprofessional practice in their formative years. Undergraduate education needs to build interprofessional education into the early, middle and later years of curricula. Such a policy would have implications for health service providers, professional bodies, teaching institutions, students and clients.

Day Centre, Day Hospital, Domiciliary Care Health Service

Arthur Baxter, AAG Fellow

Over the past ten years there has been a trend towards home care as a substitute for Hospital Aged Care. There now appears a breakdown in that care, which only the Hospital can provide.

Let me propose to you a proven and satisfactory care for the aged.

Hospitalisation. Patient has been hospitalized and discharge pending Case Conference. Patient discharge discussed with Geriatrician – Nurse. Guarantee of readmission in event of Medico Social breakdown is expected. Follow up care, most essential. Patient to their own home environment to their family circle in the community thus enabling them to cope within the limits of their disabilities. Help keep out hospital longer return their dignity, live independently for a longer period.

This is seen in three stages.

DAY CENTRE where patients receive social activities, express their wishes by discussion, quiet games lunch.

DAY HOSPITAL staff from Geriatrician to Nurse Rehabilitation Unit facilities as within the Hospital. Transport provided patient home to Day Centre and return. Day Hospital care is a follow up after discharge approx cost 1/3 of inpatient care. Complete domiciliary care service.

Remember statistics show people living longer 2050 age 120 years.

Tai Chi for Arthritis

Deanne Drage, Health Promotion Unit, GSAHS
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Introduction: A number of barriers exist to offering appropriate physical activity options for older people, especially in rural communities e.g. lack of appropriately trained and accredited physical activity leaders, lack of facilities, escalating costs and the lack of programs that motivate and encourage participation on a long term basis. The Tai Chi for Arthritis program addresses these issues offering an accessible, affordable, quality and sustainable program for older adults in rural communities

Description: The GMAHS Rural Falls Injury Prevention Program (RFIPP) was established in 2001. The aim of this program is to increase the access of older people living in rural communities to appropriate fall-safe activities designed to improve their muscle strength, flexibility, balance and fitness, whilst at the same time reducing social isolation.

The Tai Chi for Arthritis program is sponsored by the GMAHS RFIPP and aims to increase the number of Tai Chi for Arthritis leaders in the GMAHS conducting classes that specifically target older adults living in the community as participants.

Our Tai Chi for Arthritis leaders are from a wide variety of backgrounds, from health professionals to volunteers within the community.

Development: In April 2003 the first Tai Chi for Arthritis training course was conducted for the GMAHS, by Dr Paul Lam. Thirty six participants attended the course. During November 2003 a one day update course was conducted to refresh and energize the trained leaders and these leaders advanced to Level II in August 2004 and an additional 46 new leaders completed Level I training.

The Tai Chi for Arthritis program is conducted at the highest possible quality to ensure a safe and effective program for the participants, the leaders and the GMAHS. To ensure sustainability, the Health Promotion Unit is

committed to supporting our Tai Chi for Arthritis leaders by developing a Leaders Kit, and having in place a quality assurance process with newly trained leaders.

Evaluation: The training was course was evaluated by a survey of all participants. The overall program is being evaluated as part of the RFIPP.

The identification of barrier and opportunities in multidisciplinary management of medication use in the ageing population of rural Victoria

Dr Arthur Pappas and Dr Barry McGrath, School of Rural Health, University of Melbourne
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Background: It has been estimated that Australia will have a significant aged population (65 years and over) within the next twenty years. It is known that average health expenditure rises sharply with advancing age. More than half of all health expenditure on the diseases such as dementia, stroke, arthritis and vision problems are spent on persons aged 65 years and over (AIHW, 2000). It is not clear what impact this trend will have in the provision of pharmaceuticals services to the aged, particularly those living in rural areas.

Objectives: This presentation will outline the background to issues affecting the multidisciplinary management of medication use in the ageing population of rural Victoria in both institutionalised and community-based settings. The views of key stakeholders in the field (physicians, pharmacists and nurses) will be sought during 2005.

Methodology: The design of the mail questionnaire used for data collection will be discussed.

Results: The main aims of the project are to collect data about the current systems of medication and information provision to aged people in the rural sector and to what extent they meet the diversity of needs. The research will also seek to identify potential areas for improvement in the multidisciplinary approach and propose models for implementation.

Time to think about dementia: challenging behaviours and legal issues – for older people

Helga Merl and Dr Lyndon Baurer, Dementia Advisory Service, Central Coast Health
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Funding from the Department of Ageing, Disability and Home Care under the NSW Action Plan on Dementia 1996-01, enabled Helga Merl from Central Coast Health, Dementia Advisory Service and Dr Lyndon Baurer, local GP to create three educational tools (Two in partnership with the Central Coast Division of General Practice). They are titled:

1. Time to think about dementia! A dementia Care Guide for general Practitioners.

2. Time to Think about dementia: A Challenging Behaviour Care Guide for health care workers and legal Issues for older persons: A guide for general practical.

These CD ROMs are interactive, with extensive use of video, so they bring a virtual conference into the Health professionals work environment or living room.

Issues covered include early diagnosis, legal issues, driving, new medications, younger patients with dementia and a section on Care Plans, challenging behaviours, policies, Guardianship Tribunal, capacity and consent etc. Much of the content includes audible comments combined with transcripts. The addition of sound aids the memory and reduces the workload on the participant.

It is very visual, with information concentrated by video segments from a large number of Central Coast specialists and consumers. These key stakeholders have been heavily edited so that the information, advice and viewpoints that they deliver have the most impact on participants.

The content has been edited and prepared by a dementia care specialist, working with a GP, and is of the highest quality. Content “needs” were developed through research. The evaluation of these learning tools have been mostly completed and we are able to demonstrate resultant changes in GP and Health professionals attitudes and behaviours as well as an increase in their knowledge and skills.

There is a large amount of content for each CD-ROM, requiring about 3 hours to work through, but the high level of navigational freedom, combined with electronic bookmarks and search functions, makes the resource very user friendly.

There are lots of interactive features, buttons to press and links to related topics that can be accessed through the CDROM. Printed resources can be accessed on demand and there is a scroll bar and time line that you can use to fast forward, pause or rewind the video clips.

In this high-tech, fast paced age, information needs to be presented in an entertaining, efficient way to encourage broad involvement of target audiences, we have achieved these goals.

Perfecting health care delivery for older patients, the Maggie's story

Professor B Kichu Nair, Professor of Medicine, School of Medical Practice and Professional development, Hunter Health
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Care of the older patient is the core business of the majority of health professionals and health care facilities. However the health system is not user friendly towards older people. The myths of bed blocking and aged care blowing out the budget abound.

Consumer participation is minimal in our hospitals.

The Maggie program is an innovative project initiated by the Hunter Health. In simple terms, this project tracked a single patient through the acute hospital system and found where and when systems failed. Maggie was a typical patient with multiple system diseases and disabilities who ‘blocked’ the acute hospital bed.

This case study provided the Health system with various solutions and subsequently the systems changed to fit the patient needs.

After the successful introduction of the project, it has been rolled out to other settings including the emergency department and community care.

In this presentation I will discuss the inpatient program and tell the story of Maggie.

Across the great divides: care CAN be coordinated!

Professor Rhonda Nay, Professor of Gerontic Nursing, La Trobe University
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Gaps in services, finding appropriate services and co-ordination of services have challenged the experience of care for older people for years. It should not be that hard! Issues related to care co-ordination include professionals refusing to cross disciplinary boundaries, funding silos that prevent seamless care, services bounded by time and day, small fragmented programs, paper systems that encourage duplication of assessment and gaps in communication and Privacy legislation. It is possible to cross these great divides and this paper will offer examples and suggestions of where and how care can be co-ordinated.

Community issues and challenges

Celia Bevan, Course Coordinator Gerontology and Master Health Sciences, School of Community Health, Charles Sturt University
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An ageing society challenges values and policy responses. Ideology and public management underpins these responses and brings new advocacy concerns for older people. Community changes and workplace reforms change life and service expectations. The subtle shifts occurring for older people, carers and service providers suggest a different lens to view community and the complexity of responses required.

Active and able – staying 'Fit to Function' – putting policy to action

Colleen Wilson-Lord, OAM, Director, Healthy Lifestyle Health Promotion Services
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In August 2004, I attended and presented at the 6th World Congress on Physical Activity and Ageing, in London, Ontario, Canada. The theme for the Congress was "Research to Action for an Ageing Society". The Congress was attended by representatives from over 40 countries and there were over 400 papers presented. The Congress made a substantial contribution to the delegates' understanding of the importance of physical activity for the quality of life for older people all over the world.

During the seven day Congress, I spent considerable time talking and discussing issues with colleagues. It appeared that many had similar problems when it came to

the delivery of healthy lifestyle programs, both at a community level, and at residential care level. The same questions were raised on numerous occasions "How can we continue to put policy into practice when staff is limited? How can we encourage trained exercise leaders to run more programs in the community? How do we motivate people to do exercise, especially the frailer aged?"

It was agreed by all that much had been gained from the research presented at the congress and that delegates needed to continue to develop and provide programs that put the findings from current research into action. What, however wasn't addressed in any great detail at the Congress, was how to do this in a sustainable and manageable manner when health workers and others were constantly faced with the barriers of reduced funding for staff and ongoing training.

During this presentation I will share with you my thoughts and ideas on how to address these issues and hopefully work around some of the barriers and problems.

I will present some current programs that are up and running very successfully in the community with the support of volunteers, community health workers, and private companies.

WORKSHOPS

How to ask the right questions

Associate Professor Susan Quine, School of Public Health, Faculty of Medicine, University of Sydney
sueq@healthusyd.edu.au

This workshop will discuss and illustrate the importance of using appropriately worded questions in interviews and surveys in order to make informed decisions. Opportunities will be provided to enhance question wording skills.

Clinical supervision

Chris Shanley, Centre for Education Research on Ageing, Concord Hospital
cshanley@med.usyd.edu.au

This workshop will define and discuss recent and current initiatives in promoting supervision and explore how clinical supervision may be relevant to participants' work settings.

Suicide prevention initiatives

Margaret Dalmau, Chair, NSW ESPN,
Aged Suicide & Depression Prevention
Worker, GSAHS
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The Elderly Suicide Prevention Network (ESPN) provides a statewide preventative approach. This workshop will provide opportunities for participants to enhance their knowledge and skills in responding to depression and suicide in older people.

Education for Dementia Care

Elaine White, Dianne Ford, Fran Dumont, Hunter Area
Health Service
ewhite1@hunter.health.nsw.gov.au

This workshop will focus on providing dementia specific education to registered nurses within the acute care setting, based on the Dementia Resource Nurses education program which is supported by the Hunter Area Central Dementia Service.

AUSTRALIAN ASSOCIATION OF GERONTOLOGY
NSW DIVISION

"Expanding knowledge on Ageing"

WORK TILL 100?
"THE LABOUR MARKET OF THE FUTURE"

SEMINAR
9TH SEPTEMBER, 2005

This Seminar will be convened by Emeritus Professor Sol Encel, one of the leading authorities on mature age employment. We welcome your interest and invite you to join us as we explore all facets of this fascinating area of ageing.

Topics covered Include: Mature Age employment/unemployment, Superannuation, Abilities of older workers, discrimination & more.

Information; Janet Gilchrist, AAG Executive Officer Phone: 02 9767 7158 Fax: 02 9767 5419
Email: janetg@med.usyd.edu.au
Address: CERA C25/Building 18, Concord Hospital, Hospital Road, Concord 2139

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DIARY DATES

- 19 July 2005 - RM Gibson Oration – NEWCASTLE**
AAG Hunter Chapter presents this year's Oration by Professor Rhonda Nay from la Trobe University. Her presentation will be on "Headlines: Crisis in our hospitals as the brightest and best demand work in aged care". - 6.30pm at Newcastle Panthers, Cnr King and Union Streets, Newcastle.
Contact Elaine White on e-mail: Elaine.White@hnehealth.nsw.gov.au
- 9 Sept 2005 - Seminar - SYDNEY**
AAG NSW Div. – "Work Till 100? The Labour Market of the Future"
Phone: 02 9767 7158 Janet Gilchrist
- 5-7 Nov 2005 - Visit by RMGibson Travelling Fellow, Prof. Jon Pynoos. Details of seminars in Sydney and Wollongong TBA**
- 9-11 Nov 2005 - AAG National Conference – SURFERS PARADISE**
"Exploring The Meaning of Ageing through Research, Policy & Practice" (*Details below*)
- March 2006 - Rural Conference – TAMWORTH**

If you wish to obtain the full paper for any of these summaries, please email your request to the author

AAG NATIONAL CONFERENCE - 9 to 11 November, 2005

Gold Coast International Hotel, Surfers Paradise, Queensland

EXPLORING THE MEANING OF AGEING Through Research, Policy & Practice

Keynote speakers are Professor Jon Pynoos from Andrus Gerontology Center, University of Southern California who has interests in housing for older adults including aging in place, and Dr. Norman Swan the multi-award winning medical journalist.

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