



AUSTRALIAN ASSOCIATION OF

GERONTOLOGY

NSW Notes



AUTUMN

MARCH 2004

Beyond the Boundaries

Ageing in Rural Areas, the Future and the Imagination

This conference was organised by the NSW Division, AAG in cooperation with the Hunter Chapter. It was held at Kurri Kurri TAFE on 11 and 12 March 2004. The Hunter Chapter is to be commended for their major input and development of the program which significantly contributed to the success of the conference. 160 delegates from all parts of the State attended.

Jill Hall MP, Federal member for Shortland and Deputy Chair, House of Representatives Standing Committee on Ageing, opened the conference. She commented that current policy directions appear to overlook the people factor and older consumers need to be at the centre of policy development.

Professor John McCallum spoke on *The future of ageing: will it be the rich and the poor in a two-tier system?* Professor McCallum concluded from the Dubbo longitudinal study, that older people did get access to the services they required and this was not related to their income or status in the community. The Dubbo study showed that the poor often died earlier and had more diseases due to earlier life experiences rather than poor access to services when they aged.

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The response to the call for papers was very positive and allowed us to hold six concurrent sessions over the two days. The papers addressed recent research covering assessment, integration of community and aged care services, transitional care and research in a variety of clinical areas. Five workshops were held on Friday afternoon and these proved to be very popular allowing delegates to be more involved in the discussion.

The conference concluded on Friday afternoon. Dr. Heather Booth, the Australian National University, gave an overview of the recent demographic study on longevity in Australia. It was thought-provoking, raising the question of whether Australians are prepared for a possible long retirement and the financial implications.

The final presentation by Professor Donald Maclellan, Director of Clinical Services, Hunter Area Health Services was on *Health care quality: Rhetoric and Reality* and highlighted the fact that community expectations now demand that evidence be provided to demonstrate optimised quality outcomes.

The conference dinner was held at Lindeman's Estate, which provided an ideal setting for networking and catching up with old friends. Professor Margaret McMillan gave the 2004 Hunter Heritage Oration in honour of Marie Findlay, who founded the first community nursing service in the Newcastle area.

COMING AAG EVENTS IN NSW

Date: 20 August 2004

Venue: Penrith RSL

Subject: *Transport for older people. Is it driving you crazy?*

A one day seminar followed by the NSW Division AGM. For further details see page 12.

The RM Gibson Travelling Fellow this year is Doctor Ladislav Volicer, Medical Director of the Dementia Special Care Unit, Edith Nourse Rogers Veterans Hospital in Massachusetts USA. He is noted for his work on innovations in End-of-Life Care for patients with Alzheimer's disease

Dr Volicer who is speaking at the AAG National Conference will be in NSW from Monday 22 November to Friday 26 November. Current plans are for him to speak in Sydney 22 & 23 November, Newcastle on 24 November and Tamworth on 25 November. Further details will be in the next issue of NSW Notes.

The Australian Association of Gerontology (NSW Division) and Hunter Chapter thank our main sponsors NSWHealth, Hunter Health, Kurri Kurri TAFE, DADHC, National Relay Service, Cessnock City Council and six additional supporters. Their generous sponsorship contributed to the conference success.

SUMMARIES OF PAPERS

Opening Address

*Jill Hall MP, Federal member for Shortland and Deputy Chair,
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The Intergenerational Report that the Government prepared and presented in conjunction with the 2002 Budget identified three key areas where there was likely to be an escalation in spending. They were health, aged care and aged pensions. Methods to address these issues were outlined in the reports.

The long term strategies to address the ageing of the Australian population over the next 40 years were the subject of an inquiry by the House of Representatives Standing Committee on Ageing.

Key areas and the challenges they create are:

- Providing care for frail aged people within the community. The issues of capital funding, red tape, staff-related issues and the shortage of residential care beds were highlighted
- Associated issues ranged from the inability to obtain and maintain adequate staff to the ongoing training needs of staff. These problems were more severe in regional, rural and remote areas.
- Communities identified the shortage of both high and low care beds on the approval process.
- It was glaringly obvious in the current system that by omission, the aged person is secondary to accountability and red tape – it would appear that it is not the person that is important but the paper trail and the system.

The Committee received evidence that:

- Contributions made to the community through the unpaid and volunteer work performed by retirees was not adequately recognised
- The importance of social inclusion, connectiveness and physical activity in active and healthy ageing was overlooked
- More targeted research is needed. Strategies to address an ageing population need to be based on empirical data.
- Training is needed in all areas, be it delivery of aged care services within a community, residential facility or the acute hospital sector. This need is not limited to the health and aged care sector but also extends to community organisations, government instrumentalities and employment providers.

The challenge for government and Australia as a whole is to develop strategies that promote equity and are based on fact. These strategies need to be inclusive and designed to enhance quality of life for all Australians.

Keynote Address

The future of ageing: will it be the 'rich and poor' in a two-tiered system?

*Professor John McCallum, Dean, College of Social & Health Sciences, University of Western Sydney
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The recently reported findings from the Dubbo Study over 14 years reveal no major issues of equity of access for older Australians to hospitals and nursing homes. People with various illnesses are admitted to hospital regardless of their education or income. Access to nursing homes is driven by care needs such as incontinence, disability, impaired respiratory function and depression, not by social status.

US work indicates different results in this area, which may be related to different welfare systems. Are we beginning to 'trip down the slippery slope' to an American two-tiered welfare system? In Australia the availability of publicly funded services for older people is currently extensive and, consequently, there are few issues of inequitable access. The major policy issues are about the appropriate type and level of publicly funded services for the growing older population. The Australian system, based on careful gatekeeping and access determined by care need, seems to be working as designed for the Australia elderly.

This system is coming under severe stress in areas such as hospitals in South Western Sydney and in the pricing of aged care generally. The Australian style in welfare is to set a high safety net (not a low one as in USA), to mix private and public provision and payments (not mostly public as in Scandinavian countries), and to use targeting to make sure scarce resources go to the most needy rather than universal provision. Can we recreate the aged care system using these important values or are we bereft of bold, new ideas?

Beyond the individual learner: promoting organizational change through education and training programs

*Chris Shanley, Centre for Education & Research on Ageing,
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Most education and training programs in aged care aim to increase the knowledge and/or skills of individual learners. While it is important to provide the most positive and comprehensive learning experience for each program participant, educators should take every opportunity to stretch their gaze beyond the individual, and take account of the organizational setting in which the learning is to be implemented.

Having a well-developed and comprehensive education program will have little effect if the learner has to return to a workplace where:

- the new learning is not supported by managers or other staff;
- existing systems, procedures, and protocols are opposed to or are inconsistent with the new learning;
- work practices inconsistent with the new learning are actively encouraged because they "have always been done that way" or are seen to save time;
- there is insufficient time and other resources (e.g., equipment allocated to implementing the new learning);
- the learner is given no feedback or not required to introduce the new learning;
- there are no opportunities to educate other staff members
- there is underlying conflict or lack of direction and cohesion within the organization.

This presentation will outline a number of characteristics of staff education and training programs that attempt to incorporate an organizational change perspective. The rationale for taking this perspective is to promote a workplace environment that will support the new learning of the individual.

Limits to imagination and innovation system boundaries: the politics of assessment

*Penne Mattes, coordinator Mona Vale ACAT
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This presentation is about boundaries of the system and of the language we use, which bar, or limit, our contact with elderly people who need support in, and by, the community. A brief history of the development of the Aged Care system since the 1970s is given, including the development of boundaries to restrict entry to the system. This has led to the employment of gatekeepers and the development or expansion of assessment of the elderly, and the accompanying "tools" and language.

There is a brief look at the differing emphases of individualistic and community responsibility models of aged care.

Respect for the service user is examined in the context of the often alienating ways learned by professional people and the various concepts of the use or misuse of power.

The film provides a graphic representation of some of these issues, with a consumer starring in Part 1 of the film and consumers and service providers speaking of their experiences in Part 2.

“Integrating Community Aged Care; the Wentworth Area Health Service Experience”

*Kath Harrison Area Director, Stream of Chronic & Complex Care, Wentworth Area Health Service
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Wentworth Area Health Service is situated on the urban fringe of Greater Western Sydney, and comprises the Penrith, Blue Mountains and Hawkesbury Local Government Areas. The Area Health Service is one of the largest metropolitan Area Health Services by geography (4,617 sq kms), and one of the smallest by population. The diversity within the Area Health Service is reflected in areas of large urban centres with the commensurate infrastructures, coexisting with areas of identified rurality and physical isolation.

Wentworth has an ageing population 4.6% below State average with the exception of pockets within the Blue Mountains, however the population is ageing at a rate 5% faster than State average. In 2001, the population of Wentworth Area Health Service over 65years of age was 26,814, 25% of this population lived alone.

In line with NSW Health initiatives and reforms targeting chronic illness, effective discharge, patient flow and safety, the needs of the older person within the health care system continue to be highlighted, particularly the need for integrated and coordinated care and a strengthening of the interface between the community and acute care settings. In 2001, the Wentworth Area Health Service implemented the Stream of Chronic & Complex Care, an initiative designed to ensure an integrated, coordinated and consistent approach to the care of the ageing population locally and a consolidated, interdisciplinary approach to the care of people with chronic & complex conditions across health service delivery spheres, recognising the nexus between the two.

The aim was to significantly reduce the investment of cross service negotiation, duplication, fragmented resource distribution and varied approaches to service delivery from a number of differing health ideologies, and to ensure timely access to appropriate community based services.

This paper will explore the experiences, successes and failures of this Area Health Service in integrating pivotal community based services i.e.; Aged Care Assessment, Community Health Extended Care Services, Palliative Care Secondary Consultative Services, Aged, Dementia & Complex Needs Day Centre and Day Hospital Services, to achieve the cited aims of an integrated, coordinated and managed approach to community care of the target population, reflected by improved service access, a reduction in unplanned and crisis admissions to acute facilities, and an increase in individuals being restored to and maintained within their community environments.

Concepts and themes to be discussed, related to our experience at an organisational, service and individual level, include:

- Population focussed model for integrated service delivery
- Structural reconfiguration required to achieve the Stream aims
- Cultural and emotional economies impacting on the change management process
- Impact of the pre- eminent acute care culture on sustainable community driven change
- Enhancing community capacity
- Partnerships
- Sustainability
- Measures of outcome

Ageing population – ageing workers.

A need for strategic human resource interventions

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There are many trends in the modern health workforce that are contributing to workforce ageing with most of the discussion centring on population ageing. The consequences of an ageing health workforce presents as a genuine crisis for those involved in aged care who are concerned amongst other things that the organisational performance of aged health services may become compromised by a lack of available staff to do “hands on” work, a smaller pool through which to select managers and clinical leaders. Human resource professionals have been slow in responding to the challenge of an ageing workforce. A workforce analysis of the Hunter Health CARE Network will be presented to identify the challenges of an ageing workforce. It will be argued that:

- more emphasis needs to be placed on retention
- recruitment efforts need to be better targeted
- there is a need to better understand the motivations of staff in aged care who leave or stay
- Human resources practitioners must better understand the needs of clinical managers and the clinical environment.

If aged care organizations are to respond to the needs and expectations of current and future cohorts of older people, the workplace environment and the employment policies and practices will need to change substantially. Human resource professionals must adopt a more strategic approach and become more actively involved and help lead these changes.

Evaluating the effectiveness of a regional Telecross service

*Claire Giles, Occupational Therapist Honours Student,
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Objectives: To evaluate the effectiveness of a regional Telecross service in meeting the needs of elderly, medically dependent clients living independently at home. Australia's growing, ageing population highlights the need to support elderly individuals to maintain their life choices.

Method: A two-phase approach was used. A Delphi technique was employed with 12 Telecross workers to develop an appropriate survey. This anonymous postal survey was sent to 265 Hunter Regional Telecross clients over the age of 65.

Results: From 166 returned surveys, results indicated high client satisfaction. Telecross was identified as benefiting clients by maintaining their sense of security and well-being within their homes while promoting their independence and confidence. Telecross did not play a role in falls prevention or act as an initial point of contact to other services.

Conclusion: This study indicated that Telecross appears to achieve its aims of promoting independence and quality of life for clients in this region.

Key Points The Hunter Region Telecross service is highly valued by clients. Telecross can be seen to promote independence and quality of life for clients. Evaluation of community based services and knowledge of factors that impact on independence and quality of life are crucial for health professionals in providing effective service delivery

Not bigger but better

*Leeanne Dove, Hostel & Self Care Unit Services Manager,
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Big is not necessarily best – remember the old adage... “good things come in small packages”. As a stand alone facility, and the smallest facility in Newcastle, we aim to think outside the square to find ways that a small facility can not only survive but be a leader in the aged care industry.

The management of Maroba have considered ways of making Maroba a preferred provider for our area. One way to forge our place in the market is “boutique” style living. While we may not be able to be the biggest, we can still be at the forefront of aged care and providing a “boutique” style of living will be the area we make our mark.

We have a dream... a new nursing home which will include building shop facilities, nursing home and apartment living for independent and assisted living. This will give a tiered approach to care, meeting the needs of the residents within the apartments as needed and allowing them to age in place. We envisage that this type of care will extend to high care while the resident remains “at home” in their new apartment with their spouse / loved ones able to continue giving care and companionship.

Whatever we do with that old building will ultimately be determined by the almighty dollar, however, what will guide us will be our

desire to provide services and accommodation that will meet the needs and desires of our current and future residents. So we will never be the biggest and probably will never be the best but our “boutique” service will go beyond the legislated and traditional boundaries in giving individuals real choice in how they spend their most vulnerable years.

Rural Area Aged Care Facilities, while facing difficulties with extremes of distance for families and care workers, shortage of supplies, cost of supplies due to distance, as well as drought and the harsh nature of Australian weather would also, of necessity, have learnt to think outside the square. Perhaps we can learn from each other and so aid in the survival of the “smaller” facility in the aged care industry.

Falls injury protection: taking prevention nationwide

*Professor Fred Ehrlich, Royal Australasian College of Physicians
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Falls injury in the elderly can have disastrous consequences in the form of pain, disability and mortality. It also constitutes an enormous burden for the tax payer, the cost of femoral neck fracture alone having been estimated as being the second highest item in NSW hospital expenditure. Preventing such injury should therefore be considered to be an essential task, particularly as there is strong evidence that the problem is largely ignored. For example, in spite of it being well established that an elderly person who has sustained a fracture from a fall is highly likely to have another such event, the majority of such patients presenting with a first fracture receive no further investigation of risk or preventive measures beyond the immediate treatment of the presenting injury. It is against this background that the Royal Australasian College of Physicians has developed a national campaign of educating key stake-holders through initially educating its own Fellows. It is this program which will be described in the paper to be presented.

Mature and Resilient

*Professor John Macdonald
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Western medicine focuses on “what is wrong” in order to fix it up. Of course, every health system must involve dealing with illness. But in western health systems, there is an undue focus on disease rather than on health and well-being. This pathologising focus is made worse in the context of some groups, like older people in mainstream western society which honours money, youthful good looks, status and possessions, ageing is not as valued as it is in other cultures, rather it tends to be pathologised. The damage is doubled when older people see themselves through such lenses.

Health systems can be influenced by such values also. There is a need to move away from a preoccupation with the negative. We have to learn to SEE and to FOSTER wellbeing, in this case, of older people. Sometimes this calls for a re-orientation of perspective of all health workers. The notion of salutogenesis from Antonovsky can help us move forward even in very practical ways.

Initiatives in Promoting Healthy Ageing

*Neil Tucker, COTA NSW
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The presentation notes that “one size does not fit all”. There is a great diversity amongst older people, which cannot be categorized by gender, age, educational level, location, style of accommodation, health nor family support.

- There are bed-ridden folk who are themselves providing telecross-type services to other elderly people.
- There are blind persons recording stories and reading books on tape and using computers.
- There are seemingly healthy people watching television.
- There are others aged up to 90 and beyond riding motor bikes, traveling overseas, providing volunteer services and studying at university towards doctorates and other degrees.
- There are arthritis sufferers, who weight-lift; there are 95 year olds for whom a hostel or nursing home is inappropriate.

For the purposes of this paper we will assume however that people may, for convenience, be grouped in the following broad ways:

- Those living in their own homes or in retirement village units or public housing units or similar, i.e. they are engaged in “independent living”, even if partly supported by a community aged care package or home and community services.
- There are those who are fully capable of independent living and travel outside their places of residence – whether by public or private transport. These are capable physically of accessing community centres and services, public and private health services, educational services, shopping for themselves and so on.
- Those who are highly dependent on support services and are typically in some form of “institutional” living: respite care, high hostel care, nursing home or in full-time care of a relative.

The paper will argue that even in relatively extreme cases in the third group, spoken voice, smile, “Radio Blue Skies” tapes, physiotherapy, chiropractic and massage, group therapy and exercise, have a health impact.

In the case of the first group, typically, encouragement by visitation or external contact tends to be the catalyst for social participation, whether by telephone, computer, letter, media, and/or belonging to a club activity. Programs encouraging physical movement, self-learning, structured learning, external public program participation all have a positive impact on health, self-esteem, social participation. The middle group is a very diverse group of those variously who travel, take part in veterans athletics, ride motor bikes, engage in gardening, belong to seniors clubs and centres, undertake volunteer work or continue in part-time employment. This last group is more readily found amongst those who are self-employed or engaged in the professions or who can undertake continuing work in a home office situation.

The recent emphasis of the Federal Treasurer through the “demographic challenge” has given political focus to the potential of retention of many older people in the workforce in flexible ways. It is now possible to offer anecdotes of successful employment models. Some of these will be given.

The second part of the paper will outline some of the initiatives that COTA (NSW) is taking with respect to promoting healthy ageing and the capacity of older people in the community. These will include:

- Healthy ageing and medications management.
- Mature employment
- Continuing education and IT access
- Older men
- Grandparents
- Suicide and depression inhibition.

How do different professional groups conceptualise risk in the elderly

*Dr Catherine Regan, Director of Education,
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This paper looks at evidence for professional boundaries in terms of how health care providers conceptualise the risks for adverse outcomes in the elderly. This could have implications for the way health providers work together and how resources and services are allocated to individuals. The research is part of a PhD project.

GP’s and specialists were interviewed regarding factors regarded as important in contributing to frailty or vulnerability in the elderly. There were many similarities but some differences in emphasis were noted. Questionnaires were mailed to medical and allied health providers asking them to rate 35 items in terms of their importance in predicting adverse outcomes. Rankings were similar, with differences in a small number of items which could be related to professional emphasis. A surprising result was the lower ranking given to items describing activities of daily living. When submitted to factor analysis a moderate number of factors emerged with a small number common to three of the groups. The GP group were notable for their lack of obvious structure compared to geriatricians and allied health.

A large proportion of geriatric care occurs in the community, provided by GP’s, particularly in rural areas. It is important to realize that they are a diverse group who may not always share the philosophical framework of geriatrics. Although subtle, these differences may be important in regards to communication between providers and provision of care to the elderly.

Images of ageing and beyond

*Laraine Dunn, Managing Director, Welldunn
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Objectives: The object of this study was what to find out what were the perceptions of ageing and body image by a group of over fifty year old exercisers. It explored the experiences of ageing and body image by the participants of an over fifty exercise program and how they felt about the experiences in order to provide insight into cognitive barriers associated with older people.

Methods: The concept favoured a phenomenological critical perspective as the major research approach adopting a co-operative model and a high level of involvement for the exercise participants. Three instruments a questionnaire, a focus group and one on one interviews were designed to inform the study. Qualitative methods of data analysis were used to manage the data, describe the experience, discover themes and commonalities, look for the meaning and finally to interpret the research.

Results: Within the focus group there was lively discussion and a range of issues were explored. They agreed that the role of the older person in society today had a lot less limitations than that of their grandparents. In relation to the experience of ageing, all were accepting of their age but felt they were still young inside. They had all experienced discrimination against themselves as an aged person and most had also experienced caring and attentive service.

Discussion: Older people are not that different to any other stage. Most felt happy and satisfied with their body image and experience of ageing. They felt fulfilled and in control of their lives and were willing to work towards this.

Impossible Places: the forces that shape

*Niko Leka, PhD Student, University of Sydney
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"The forces that shape. milieux do not arise in them, nor are they controllable by those sunk in them" (Mills, The Sociological Imagination).

In acute psychogeriatric care, buildings are put to the ultimate test of meaning. This paper draws on 20 interviews with psychogeriatric nurses. How are their immediate concerns about building, related to the forces that shape building?

Twenty interviews were conducted at three sites in different states. Nurses across sites consistently spoke about the built environment mainly in relation to patient needs. In relation to this, they distinguished patients as being either "with it" or "not with it". The needs of these groups differed, and often posed dilemmas to each other. "Not with it" patients posed risks to themselves, others and the environment. Managing these risks entailed strategies of surveillance and access. Providing privacy was important in the care of "with it" patients. The built environment facilitated or hindered the ensuing conduct of care.

When nurses speculated on the broader nature of the built environment, profound differences between sites emerged. In an old and openly condemned site, they considered a new site would "better suit what we do". In Milduria, a decaying purpose-built unit, they were disillusioned with the promises of the "new". In Tempuria, a unit that had moved four times in seven years, staff wanted a return to their "permanent" unit. The paper concludes with discussion on how we grope for a sense of the forces that shape milieu.

Merging the boundaries of aged care and mental health

*Anne Moehead, Psychogeriatric CNC, Richmond Valley ACAT
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Older persons' mental health continues to provide many challenges for service providers, particularly in rural areas where long term, well-established psychiatric resources are scarce or non-existent. Often the boundaries between aged care services and mental health services are blurred and ill defined. As a result, demarcation disputes regarding management of the client occurs between these two services. Unfortunately in the middle of this dispute is a person, who is mostly unwell with complex physical and mental health problems. This practice creates an unsatisfactory outcome for the client and carer and causes confusion and frustration when attempting to navigate through the health care system.

A genuine attempt to break down these boundaries is occurring on the Far North Coast of NSW in the Northern Rivers Area Health Service. A group of local professionals from ACAT, Mental health, Division of General Practice, Residential Aged Care, Acute Care, Dementia Outreach Services and Telehealth have met with a shared vision of trying to improve older persons mental health services from a promotion, prevention and early intervention model. Further issues of customer focused service delivery, strengthening partnerships, developing best practice guidelines, hosting educational forums and providing a platform for area health policy direction all form part of the groups' endeavors.

An overview of the Older Persons Mental Health Working Group's action plan, value statement, achievements to date and vision for the future will be presented.

Dentistry outside the dental chair

*Dr Shirley Fong-Yang, Senior Dentist – Community Dental Health, Sydney United Dental Hospital
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The elderly population unlike the younger generation presents dental problems that do not usually involve soft active caries requiring the traditional "drill and fill" technique. This elderly group usually presents with erosion loss of tooth substances on cervical neck of teeth resembling a smooth concave excavation. The incisal surfaces of teeth also appears worn down. The gums recede, resulting in the gingival or gum attachment to be lowered down the root. With the gradual wearing down of tooth structures due to a multitude of factors such as dry mouth, acid reflux, patient's diet, and others, which we will discuss later, the contour and anatomy of the tooth is changed, thereby affecting partial denture retention and stability if these remaining teeth are to support a denture. All these will go on in a vicious cycle. It is essential to prevent this from happening on a massive scale, not just on a one dentist, one patient chairside basis. We have therefore outlined a model of care to reach as many patients involved as possible.

- Oral Health Awareness using digital media, seminars, scheduled visits of dentists and hygienists to rural areas through partnership with aged care facilities, health groups and associations, as well as patient and their carer education.
- Through current minimal intervention / remineralization techniques and the introduction of new materials such as high concentration fluoridated toothpastes, enamel improving creams, mouth moisteners, and calcium replenishing chewing gums, effective desensitizing agents.
- Good nutrition
- General good health maintenance through proper diagnosis and treatment of the problems.

Pain Management in aged care: the need for leadership for new models of care

*Dr Isabel Higgins, Assistant Dean, Faculty of Health, University of Newcastle
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While there is a large body of research into the mechanisms of pain and pain management and improved techniques for pain control, elderly people (65 years and over) have been largely excluded from pain studies (American Geriatrics Society panel on Chronic Pain, 1998; Farrell, 2000).

As a result, our knowledge about pain in elderly people is limited. It is the lack of knowledge and other factors that have contributed to the situation where elderly people live in nursing homes with chronic, unrelieved pain. Indeed, the incidence of pain in this setting is very high. In nursing homes in Australia (Madjar & Higgins, 1996) the incidence of pain may be as high as 70 percent. It seems incongruous that while scientific research has uncovered many of the biochemical and neurobiological processes of pain, along with the development of sophisticated treatments for its control, that many elderly people continue to live with unrelieved pain.

In institutionalised elderly people however, there are several factors that contribute to this situation including the knowledge, attitudes, and beliefs of health carers, and the elderly person's beliefs about pain as a normal part of ageing. What is needed is leadership in order to ensure that elderly people do not spend their dying days with relentless and unrelieved pain. In this presentation, I review the literature on pain management in elderly people and provide an argument for the need for leadership for new models of care.

Measurement of the needs of residents of Aged Care Facilities

*Dr Lynne Parkinson, Senior Research Fellow, Faculty of Health, University of Newcastle
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Residents of nursing homes are characterised by chronic medical diseases, multiple co-morbidities, functional dependency and poor perceived health. In recent years, there has been a plethora of studies on quality of life and satisfaction with care in this setting. However, these types of approach are limited by their focus on the problems of patients, often as perceived by family or care givers, rather than the issues that are perceived by patients to be most important to them.

Needs assessment is a measurement technique that can provide a direct index of patients' perceptions of issues with which they need help. This research project aims to develop a tool which directly assesses needs across a range of domains (physical, daily living issues, social, psychological, interpersonal, health information, access to services), using qualitative and quantitative measure development methods. The first, qualitative phase of the project, involving in-depth interviews with care providers, residents and family members from three Hunter nursing homes, is now complete. The results of these interviews and how they will be incorporated into measure development will be presented and discussed.

Mum and dad's money – where are the boundaries?

Jennie Peut, School of Social Work & Applied Human Sciences, University of Queensland jpeut@social.uq.edu.au

The management of older peoples' assets is increasingly being negotiated within the context of a complex range of competing interests, including those of the older person, family and government. With the balance of wealth distribution across the Australian population having shifted from younger to older people over the last two decades, and government policies placing greater emphasis on independent retirement and user pays systems of care, there is a growing imperative that the issues involved in asset management be understood both in terms of the needs of older people and family members and government providing such assistance.

In addition to the clear implications for personal resource and care boundaries, inter-sectoral boundaries are being increasingly challenged with allied health, medical, financial and legal practitioners all having an interest in providing effective service to older people and those assisting them with asset management.

Drawing on data from a research program exploring the prevalence and nature of family asset management, the paper will focus on the experiences of people living in regional and rural Australia who assist an older person with asset management tasks.

A longitudinal study to assess change in needs of men diagnosed with prostate cancer

*Janine Duke, CCEB, University of Newcastle
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Background. The aim of this study was to examine the change in need experienced by men diagnosed with prostate cancer and to identify factors associated with change in need.

Methods. 650 men with prostate cancer in the Newcastle and Hunter Area of NSW who had visited their Urologist during the period of two years prior to the study were invited to participate and complete the self-administered Prostate Cancer Needs *Questionnaire* (PCNQv1.1). The PCNQv1.1 was presented in sections: Section 1 addressed issues associated with diagnosis, treatment decisions and treatment and Section 2 addressed current issues. A response rate of 385 (77%) was obtained at baseline. This cohort was re-administered the PCNQv1.1 Section 2 at 12 month follow-up with response from 270 men (70%).

Results. Change in perceived needs associated with current issues were assessed over six domains: role limitations, GP ongoing support, impotence, incontinence, personal integration and control and Specialist ongoing support. At follow-up approximately 30% of men experienced unresolved need and 10-15% experienced an increase in need across all factors. Multinomial logistic regression modeling revealed factors 'symptoms at diagnosis', 'stage of cancer', 'location of residence', and 'social support' to be predictive of unresolved, increased and decreased need with time.

Conclusions. Needs experienced by men with prostate cancer are not static. Medical and other health providers need to acknowledge the changing needs experienced by this group of men and focus appropriate support to meet these changing needs.

Golden Oldies – a holistic health program for older men in Canowindra

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Goal A holistic health program for older men in Canowindra

Issue Analysis Prior to the commencement of Golden Oldies many older men in the community did not access health and community services and did not participate in social activities. Available services and social activities were inappropriate for these men, for a variety of reasons including cultural. Day Centre was considered to be mainly for women, sporting clubs and self-organised social

activities beyond the physical abilities of the men, and pubs and clubs focused on alcohol and tobacco. In addition the wives and carers of the men had no respite.

Baseline data: 23 older men in the community were known to be isolated/not participating in any activities.

Customer needs and expectations: the target men had few expectations, but required any activities/services provided to be inexpensive, not too feminine, easily physically accessed, not physically demanding, with transport provided. Carers' needs were for time out.

Evidence Base: Social interaction and health are closely linked, and for many men the social environment of paid work is not replaced after retiring. Being in a rural area adds difficulties, due to economic hardship, lack of adequate transport, and centralisation of services. Isolation has been linked with depression, and while older men are less likely to identify themselves as depressed, they do have high suicide rates.

Stakeholder input: Stakeholders were involved in the planning of the project. Volunteers, target men, carers, potential sponsors, health service management were all consulted. Regular meetings are held between volunteers and the Diversional Therapist organizing the program.

Goal: To rehabilitate or prevent deterioration in the social, emotional, mental, spiritual and physical health of older men and their carers in Canowindra and surrounds

Objectives

- To increase the socialisation opportunities available to older men, catering for the frail and physically impaired
- To provide activities that interest older men, and do not require a high degree of self motivation
- To provide health promotion activities suitable to older men
- To empower men to address their own social, emotional, mental, physical and spiritual health needs
- To cater to different capabilities amongst older men, encouraging some to be carers, organisers, and drivers
- To provide time out for carers
- To develop partnerships, infrastructure, and sustainability to build capacity

ACATs: Aged Care Assessment Teams or Aged Care All Together Somehow

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There are many challenges when working in aged care services. Some of these challenges are common to rural and urban settings, others are unique to the rural sector.

This paper, from the perspective of someone who has worked in Aged Care Assessment Teams (ACATs) in both rural and urban settings, will discuss some of the common problems, but also highlight some of the issues specific to rural areas. The value, in either setting, of high quality assessment and of effective teamwork with a client-oriented, problem-solving approach as a way of enhancing quality of care and enabling staff to achieve realistic outcomes, is examined.

Some anecdotes to illustrate the shared problems and differences are offered, and a review of the literature on patient-oriented/ client-oriented interventions, showing evidence of improved outcomes in chronic illnesses such as diabetes and asthma is presented.

In aged care the importance of expanding the definition of "client" to include carers is considered, so that interventions should target the needs of patients and carers. The concept of teamwork is explored in theory and in practice.

In conclusion, the need to clearly identify "treatment" goals, as agreed upon by "clients" and service providers, in order for "care" to be effective, and to recognize possible "traps" in the process, is described.

The paper is offering an opinion about an effective approach to use in ACAT setting, based on personal experience, and with support from literature review.

Patient, family / carer goal attainment scaling: health outcomes that mean something

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Convincing others that aged care inpatient service did a good job in aged care has always been difficult because the needs of our patients are so diverse. The success of what our service does for people in hospital is critically dependent on family carers but we don't consider what we do for them when reporting our outcomes. We consider patients and their family carers as a single "unit".

Goal setting in aged care is not new. Goal Attainment Scaling is a way of finding out how well we perform with the infinitely diverse needs of our patients and that is not new either. We studied the value of Goal Attainment Scaling using only the goals of the patient, family/carer unit.

This process shifts the locus of control towards patients and their family carers. We will show that this not only benefits patients and their family carers but benefits staff and the service as well.

We present the process, the outcomes we achieved in our Acute Geriatric Medical Unit and the Elderly Rehabilitation Unit, how useful those outcomes are, patients and family carers' responses and the costs and sustainability.

Transitional care in the Hunter

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Transitional Care programs have been running successfully in the Hunter since 1997. The Pacific Care Transitional Centre, a partnership between Baptist Community Services and Hunter Area Health, was the first jointly run private and public service of its kind anywhere in Australia and ran from June 1999 to December 2002.

Statistics and outcomes for this innovative service will be presented, along with information on the current programs being run jointly by Baptist Community Services and Hunter Health i.e. the NICE project and the Resident Placement Service both located within the Royal Newcastle Hospital.

The Rural Stroke Team: a new model of service delivery to improve stroke management, awareness and prevention in the Rural Hunter

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Introduction: Stroke incidence and stroke management have been identified as concerns in the Rural Hunter. This presentation will outline a new model of service delivery implemented as a strategy to address these issues.

Method: An inter-disciplinary (Allied Health and Nursing), rural-based stroke service was established in 2002. The team's focus is on education, consultation, stroke awareness/ prevention and data collection/ research. The team's development, challenges and achievements will be presented.

Results: Establishing baseline information, via a stroke audit (1) and needs assessment, and the implementation of evaluation processes have been an integral part of the service development.

A range of projects has been undertaken. These include the development and implementation of stroke resources tailored to the Rural Hunter ("Surviving Stroke" guide; "Stroke in the Rural Hunter: Management Prompt") and a multifaceted program that includes evidence-based stroke management tools and education.

Stroke education programs have been undertaken with community service providers, rural health staff and community groups.

Many projects have involved collaboration with the rural communities, health and community service providers and liaison with key stroke organisations. This includes involvement in the joint National Stroke Foundation/ Hunter Stroke Service "VISITORS" project.

Conclusion: This model of service delivery is changing stroke management in the Rural Hunter. The team is impacting on the management of stroke survivors across the continuum of care, improving the knowledge and skills of health professionals as well as increasing stroke awareness and prevention in the community.

The frail aged: who are they?

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The terms frailty, frail elderly and the frail aged are increasingly used in clinical practice and research studies with little agreement on their definition or clinical markers. Yet frailty is something we all recognise and which lies at the heart of geriatric medicine and aged care. Ken Rockwood, a Canadian Geriatrician, describes the joy of geriatrics as understanding and embracing the complexity of frailty. The term "frail" was first recorded in Medline in 1968 in

an article by O'Brien and colleagues in *Gerontologica Clinica* entitled "Some aspects of community care of the frail and elderly: the need for assessment". Only 27 articles have used the term "frail aged" since 1981 and 8 were Australian and 9 South African. It is clearly an antipodean term, little used elsewhere in the world.

Multiple markers of frailty have been used in these studies including: age over 75 or 80 years which is a good proxy for frailty; broad, but crude definitions - such as disability, institutionalisation or multiple chronic disease, or dementia alone - are important markers of severe frailty; but they are likely to miss a large proportion of at-risk older people, who are not yet disabled, institutionalised or demented and conversely younger people with multiple pathology are not necessarily frail.

However frailty is defined, it leads to poor outcomes under stresses such as acute infections, medication changes, dehydration or operations. It does this clinically by causing deconditioning, often presenting as the multi-factorial geriatric syndromes reduced mobility and isolation, increased instability and falls, increased confusion, delirium and incontinence. These syndromes result in adverse outcomes such as longer hospital stay for reconditioning or formal rehabilitation increased service use, earlier residential care and increased mortality. So it is important to get a good handle on frailty to prevent adverse outcomes.

We all have a general idea of what we mean when we talk about the frail aged. They are an identifiable group of impaired older people who are likely to have poorer health outcomes, when stressed, than their non-frail peers whom we define as the 'healthy aged'. This paper will discuss how we can arrive at a working definition of frailty in at least one large and important group of frail aged - those who look frail to the clinician and to their peers.

The diminishing boundaries of the hospital Directors of Nursing

*Dr Betty Capper, retired nurse educator & PhD at 75
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The popular belief is that the development of the position of the matron, as a significant leader in Australian hospitals, originated with the work of Florence Nightingale. This overlooks the development and work of a unique and vigorous group of women who shaped the Australian context, which began to emerge from the middle of the nineteenth century.

This paper addresses the socio-political impact the matrons had on nursing, nurse education, and the management of the general hospital in Australia by exploring and analysing their professional development from housekeeper to manager between 1868 and 1980. It concerns the rise and decline of one of the most significant figures of female authority ever established - the hospital matron. How did they build, consolidate, and finally lose a great deal of their control in the Australian hospital system?

The history of these radical and adventurous women is an extraordinary inventory of public and private vicissitudes to build and maintain the tradition of the hospital matron. Their history is part of a persistent pattern rooted in women's history in which two

social processes – invisibility and stereotyping – confine them. A central focus is the extent to which the discourse of the ‘woman’s sphere’ was meaningful for such single, employed, middle-class women in the specific context of hospitals and professional health care. This paper argues that such a discourse informed the matrons’ challenges to male medical/hospital administrators’ professional power and their bids for authority and recognition in their workplace

The roots of the matrons’ role are found in the Crimean and other wars of the mid- nineteenth century in Europe. Later developments of curative medicine in the burgeoning new hospitals, and more recently in two world wars has both tested and advanced the matrons’ position and confirmed their capacity to carry demanding and complex administrative responsibilities. The manipulation of history writing by some health professionals is also challenged and discussed. The paper charts the Australian matrons’ development, their attempts to professionalise domesticity, and the progression of their power from the Nightingale era to the end of the Second World War and into the last half of the twentieth century. Finally, the paper charts the decline of matrons’ power in the battle with male medical/hospital administrators, and state intervention in the post-war reconstruction of the health care system.

Thus, the central focus of the paper is the hospital matrons who merged the 19th century ideologies of domesticity and professionalism, which was analogous to the evolution of their role as a formal occupation for women. They achieved so much under at times difficult, disruptive, and painful circumstances. The succinct quote is apt for these trail blazers: *Do not follow where the path may lead, go instead where there is no path, and leave a trail.* Anonymous

Mature men matter

Roslyn Foskey, Project Director, Institute for Rural Futures, ÚNE, with Grant Dodwell, Innerplay; Alison McConnell-Imbriotis School of Professional Development and Leadership, UNE and Bill Crocker, Armidale based senior actor rfoskey@metz.une.edu.au

“Mature Men Matter” workshops around the theme of life change, wellbeing and retirement were held in sixteen communities across the New England / North West region of NSW between November 2002 and November 2003. The team involved in organising, facilitating and filming these workshops came together across geographical, professional, sectoral and organisational boundaries in a creative and innovative process. This presentation will explore the multiple layers of this process.

Firstly, it will feature a live presentation of the interactive drama “Jack’s Dilemma” by Grant Dodwell and Armidale based actors Bill Crocker and Alison McConnell-Imbriotis. Secondly, it will explore the way in which the drama was able to engage the workshop participants in an empowering learning process. Thirdly it will explore the experiences of the team involved in the script development, production and presentation. Finally, it will highlight the ripple effects from the use of drama within these workshops, as people across a range of sectors have become more aware of the potential of interactive drama as a learning tool. The presentation will include brief extracts from footage filmed during several of the Mature Men Matter workshops by Armidale based ethnographic filmmaker Patsy Asch.

Transitional Care

Tony Dobson, Coordinator of NICE Project, Pacific Care Baptist Community Services tony.dobson@hunter.health.nsw.gov.au Carmel Weston, Hunter Area Health Service

The workshop offers an opportunity for participants to exchange experiences and discuss the practical issues of working towards best practice in transitional care.

Sexuality and older people

Elaine White, CNC, Geriatrics / Aged Care Education, Hunter Area CARE Network Lorna Davin, Professional Education & Development, Hunter Stroke Service ewhite1@hunter.health.nsw.gov.au lorna.davin@hunter.health.nsw.gov.au

Sexuality is a complex concept which is not easily defined, and which means different things to different people. You may be asking, why have a workshop dedicated to sexuality and the older person, when there are so many other competing areas of need. Despite being bombarded by imagery of sexuality, for many people to openly discuss issues of sexuality is still a taboo subject; add to this the formal clinical setting, the dimension of ageing and/or disability and you compound an already high level of discomfort.

Unfortunately, for many patients/clients/residents or carers the issue of sexuality is often only addressed when ‘problems’ are manifested. This workshop will focus on the issues many clinicians confront when a person in our clinical care expresses, or manifests, their sexuality in a way in which is deemed inappropriate.

During this one and a half hour workshop we will explore, in brief, the meanings of sexuality, the socio/cultural influences on sexuality and how our sexuality is interwoven into every aspect of our lives regardless of age or disability. It will be tailored to health professionals who work in the acute, rehabilitation, aged care or general practice context and will explore how we address sexual behaviours which are perceived to be inappropriate due to cognitive, developmental or physical impairment or disability. We will explore what qualities we as health professional require to be an effective advocate for the sexual needs of the older person in our care or person with a disability.

Themes will include: defining sexuality, the language of sexuality, the myths and misinformation of sexuality as you age and Sexual behaviour in the clinical setting – is it a problem? and whose problem is it?

Note this workshop will not encompass the detailed explanations of sexual physiology as we age, while this is important, it is beyond the scope of this brief workshop. However, a manual will be provided to workshop participants that will include articles on this topic and comprehensive references for further enquiry.

The purpose of this workshop is not to turn participants into sex therapists. Rather it is to reflect on our roles as health professionals; how our own experiences influence the way in which we respond to the sexual needs of patients, clients or residents, specifically the older person; and finally to explore solutions to potential problems in the clinical setting. Consequently a range of case scenarios will be presented where behaviours were perceived to be inappropriate across a range of clinical setting. Problem solving solutions will be discussed.

Therefore, the aim of the workshop is for participants to reflect on how they can contribute to the enhancement of an older person’s sexual needs being met in a clinical setting.

Emphasis will be on practical application of knowledge, skills and attitudes for participants to take back and apply in their particular workplace in order to enhance patient/client/resident or carer outcomes.

Research design

Professor Julie Byles, Director, Centre for Research and Education in Ageing, University of Newcastle
Dr Lynne Parkinson, Senior Research Fellow, University of Newcastle
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The workshop is for those now doing research or those who have thought about doing research but haven't dared try. It will explore participants' research ideas and assist in development of research questions and methods.

The workshop convenors have experience in clinical research, population studies, and qualitative methods, and have run many workshops and courses on research protocol development.

Taking education into the community

Professor Kichu Nair, Director Geriatric Medicine, John Hunter Hospital and University of Newcastle
John Ward, Clinical Director, CARE Network, Hunter Health
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john.ward@hunter.health.nsw.gov.au

The health care workers of this century are more likely to work with older people with chronic diseases and disabilities. However health professional education is mainly based in teaching hospitals, where the stress is more often on the care of the young with acute problems.

Our educational systems must be responsive to the needs of the society and must adapt to the needs of the community. All professionals will need to acquire knowledge, skills and attitudes to effectively manage older people with chronic diseases and disabilities. Education of the future health care professionals should stress more on caring, rather than curing. Health professional education should shift from tertiary hospitals to residential care, community settings and general practice clinics. Clinicians also need to have competency in communication, advocacy and team work as described in the Can MEDS 2000 document 2.

Older patients will need problem based management 3 and multidisciplinary approach to their care needs 4. Multidisciplinary learning will prepare the graduates well for the future.

This will be an inter active workshop where we will present some background data. We will underline the need for these various approaches and discuss some of the recent innovations. Out of the discussions, some directions to improve multidisciplinary education in community settings will evolve

Longevity in Australia: Past, Present and Future

Dr Heather Booth, Demography and Sociology Program, The Australian National University
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The longevity of Australians has increased significantly over the last century. Life expectancy at birth was 57 years in 1901-10 and is now about 80 years. This increase shows no signs of slowing down. This presentation will explore the patterns of past change in mortality and survival and expectations for future change. It will address some of the questions raised by the prospect of increasing longevity:

- * How long can a current 80-year-old or a baby boomer expect to live? What are the chances of surviving to 90 or 100?
- * Will women, on average, always outlive men?

* Is there a limit to human life expectancy and, if so, how soon will it be reached?
If 'demography is destiny', are we prepared for what the future holds?

Health care quality: Rhetoric and reality

Professor Donald MacLellan, Director of Clinical Services, Greater Newcastle Sector, Hunter Area Health Services
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"In the race for quality, there is no finish line" (David Kearns)
Medicine is currently experiencing a revolution. Until recent times, it has been accepted that high quality health care emanates from the profession of clinical staff and that poor outcomes are the result of the vagaries of the disease processes.

Community expectation now demands that evidence is provided to demonstrate optimised quality outcomes. Both at national and international levels health facilities and services are being challenged to develop integrated, organizational systems incorporating quality improvement. The importance of quality improvement is highlighted by the fact that its modern term is clinical governance:

"The term resonates with that of corporate governance and is intended to have the same elements of rigour and accountability" (Donaldson, Muir Gray, 1998)

Governments, health departments and health organizations all require health facilities and services to have systems in place to develop, support and report on quality improvement programs. The era of clinical governance has arrived!

It is indisputable that the pace of clinical governance in some health facilities is far greater than in others. Indeed, it is apparent that in some health institutions, there is considerable rhetoric but little action in quality matters. However, clinical governance is neither a management accessory nor a clinical accessory to the normal working environment. It is an essential element for health care improvement. The community and governments will not accept the alternative,

Organisations have been described as a dynamic balance between the authority and autonomy of the individual, the control that exists in formal structures and the cooperation that occurs within and between teams (Keidel, 1994). Improving the quality of care in a health organisation requires that the whole of the organization moves in the same direction and achieves change through the learning process. The learning process occurs at the level of the individual health professional as well as at an organizational systems level and all parts in between (Firth-Cozens, 2001). This learning process is the essence of clinical governance.

Clinical governance does not inherently take a macroscopic view of health organizations. It is reliant on a mosaic of specific quality of care issues that reveal aspects of patient management relevant for the planning of quality improvement. One such quality of care issue particularly of relevance in aged care is wound management including pressure ulceration. How this clinical challenge is currently being tackled in Australia will predictably describe hurdles for the journey beyond the boundaries!

In order to set the appropriate perspective for pressure ulcer management in aged care within Australia, it is necessary to review trends in Australia health and the quality of health care leading into the 21st century.

Advance Notice of AAG Seminar

DATE: August 20, 2004 TIME: 9.00 - 4.00 pm

COST: \$55 non-members, \$45 members, \$30 concession

VENUE: Penrith RSL Club (Plenty of free parking.)

The seminar will be followed by the AAG (NSW Division)

Annual General Meeting at 4pm

Transport for older people: is it driving you crazy?

The aims of this seminar are to:

- Highlight issues in public, community and health transport systems that impact on older persons
- Showcase examples of innovative transport programs
- Develop and put forward proposals to address issues raised in the seminar

To make sure you receive a registration brochure send Adelaide Bornmann your name and address by email

abaust@smartchat.net.au or fax: 9523 4026

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DIARY DATES

22 Jul '04 SYDNEY
Academic Consortium
Satellite Forum *Multidisciplinary Ageing and Aged Care*
The Sutherland Room, USYD
Contact: events@vcc.usyd.edu.au

5 - 6 Aug '04 SYDNEY
ACS Residential Care Conference
Novotel Brighton-Le-Sands
"Redefining Aged Care"
Phone: 9799 0900 R Whitfield

20 Aug '04 PENRITH
AAG (NSW) Seminar Penrith RSL
Transport for older people: Is it driving you crazy?
Phone: 9523 1715 A Bornmann

17Sept '04 SYDNEY
ACS Retirement Village Conference
Novotel Brighton-Le-Sands
Phone: 9799 0900 R Whitfield

4-5 Nov '04 SYDNEY
ACS Assoc OHS & HR Conference
Novotel Brighton-Le-Sands
Phone: 9799 0900 R Whitfield

17-19 Nov '04 MELBOURNE
AAG 37th Annual Conference
Hilton on the Park
Maturing Assets: appreciating an ageing Australia
Phone: 08 8302 1051

22-23 Nov '04 SYDNEY
24 Nov '04 NEWCASTLE
25 Nov '04 TAMWORTH
RM Gibson Travelling Fellow
Dr Ladislav Volicer,
Innovations in End-of-Life Care
Phone: 9523 1715 A Bornmann

25-26 Nov '04 TAMWORTH
ACS Northern Region Conference
Powerhouse Hotel, Tamworth
Phone: 9799 0900 R Whitfield

11-13 May '05 SYDNEY
Alzheimer's Australia Nat Conf
Living with dementia-positive solutions
Sydney Convention Centre
Darling Harbour
Web: www.alzheimers.org.au

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