Changing perspectives: testing an ageism intervention

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Australian Human Rights Commission

a contribution to the Decade of healthy ageing

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The research was undertaken, and the report was drafted, by Joanna Maxwell and Maria Ko.

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July 2023

Australian Human Rights Commission

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The Hon Dr Kay Patterson AO

Age Discrimination Commissioner
Australian Human Rights Commission

Message from the Commissioner

During my seven years as Age Discrimination Commissioner, my key areas of focus have been elder abuse in the community, age discrimination in the workplace and older women's risk of homelessness.

Ageism is at the base of all these issues.

Ageist attitudes, such as perceptions of older age as a burden on society and older adults as inferior, contribute to a climate where elder abuse is undetected and even implicitly tolerated. In the workplace, negative age stereotypes are associated with a lower preferred retirement age among older workers, influence hiring decisions and deter older people from applying for jobs. The intersection of age and gender presents additional barriers for older women. Around the world, women tend to find it more difficult to find a job than men, are far more likely to be in low-paid, insecure, or casual work, retire earlier, and have less superannuation than men. These disadvantages combine to contribute to older women's risk of homelessness.

Yet, ageism remains the most accepted and normalised form of prejudice in Australia. In 2021, the Australian Human Rights Commission released its *What's age got to do with it?* report about perceptions of age and ageism among adults in Australia. This revealed the pervasiveness of ageism in Australian society: 90% of the national sample surveyed by the Commission agreed ageism exists in Australia, 63% reported they had experienced it in the last five years, and 83% saw it as a problem. Despite this, 60% of those surveyed also reported they have stereotyped others or made assumptions about people based on their age, and 52% believed making jokes about age is more socially acceptable than making jokes about other things like race or gender.

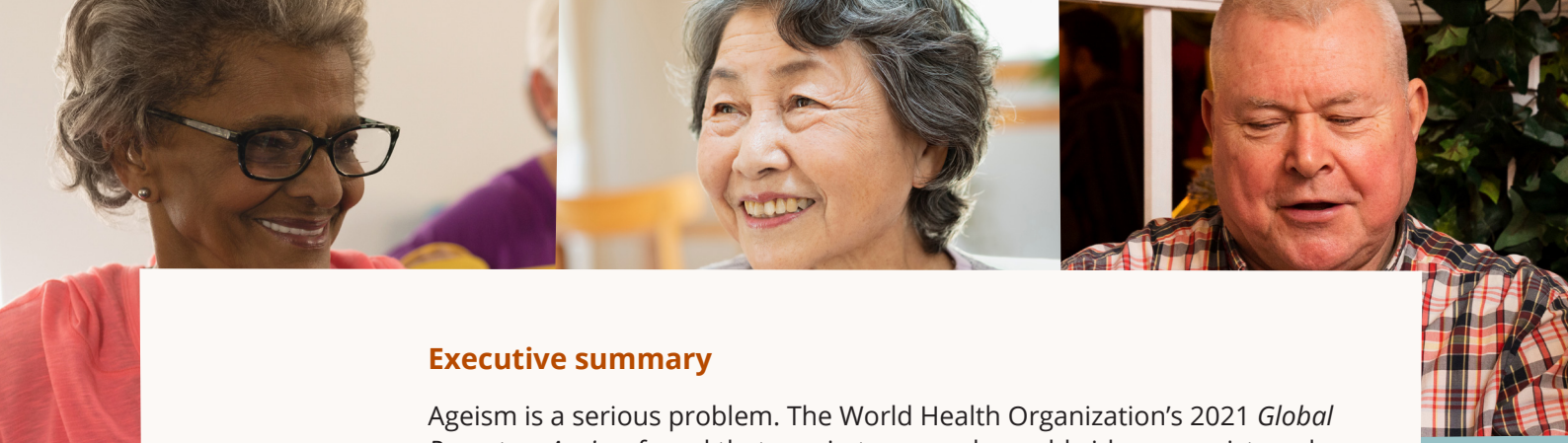
These findings highlighted the need for improved understanding of ageism within Australian society. The Commission's current research evaluates the effectiveness of an educational intervention in reshaping perceptions regarding ageing and older adults among workers in aged care and community settings.

I am encouraged to see the results clearly demonstrate the potential of a single educational session to reduce ageist attitudes and behaviours, sustained over time. Surveys conducted before and after an awareness session found significant improvements in ageist attitudes and ageing expectations among participants immediately following the session. These improvements remained stable in a follow-up survey conducted 2–3 months later, suggesting the workshop may have lasting effects.

These findings support my long-held belief that ageism may be the most accepted form of prejudice, but it is also the easiest to shift. I was also pleased that the participants recommend the workshop to a broad range of individuals, reflecting its relevance and applicability across various contexts.

Ageism is an urgent social issue which demands evidence-based interventions to increase awareness, break down stereotypes, and challenge ageist behaviour. The Commission's findings provide solid preliminary evidence for the effectiveness of educational interventions in combatting ageism within Australian society and set the groundwork for further research.

As one workshop participant said, 'ageism is everyone's business', and I encourage everyone to consider what they can do to challenge ageist stereotypes and promote a more inclusive society for people of all ages.



Executive summary

Ageism is a serious problem. The World Health Organization's 2021 *Global Report on Ageism* found that one in two people worldwide are ageist, and called ageism 'prevalent, ubiquitous, and insidious'.[1]

It is also widespread in Australian society. The Australian Human Rights Commission's 2021 *What's age got to do with it?* report found that 90% of adults agree ageism exists in Australia, 83% consider it to be a problem, and 65% believe it affects people of all ages.[2]

Ageism – particularly against older adults – is so deeply ingrained in our societal norms and values that it can be difficult to recognise within ourselves and our surroundings. For example, ageist language is often hidden behind humour and good intentions, and used without any intent or awareness of implicit bias against older adults.

Sometimes it is the way age is absent from discussions that reflects devaluation of older adults. A global survey of 6,000 employers from 36 countries found age was missing from the diversity and inclusion policies of more than one in two businesses.[3] Early in the pandemic, devaluing of older people's lives was evident in media coverages of coronavirus-related deaths. Younger people who died from complications of COVID-19 often attracted individual focused media attention, while the deaths of older adults tended to be aggregated and reported as numbers.[4]

Ageism has serious consequences for older people's health and wellbeing. Studies have consistently shown links between ageism and adverse health outcomes such as shorter lifespan, reduced quality of life and wellbeing, physical and mental health conditions, and cognitive impairment.[5]

While there is a body of evidence demonstrating that interventions such as educational and intergenerational programs can be effective in reducing ageism, most existing research has been conducted in the United States or in formal education settings.[6] In view of these gaps, the Commission set out to evaluate the effectiveness of a brief, one-off educational intervention in reducing ageist attitudes among workers in aged care and community settings. Ageism among this population is a particularly serious concern, as it has the potential to directly affect the wellbeing and quality of life of the older adults they support.

The Commission's research aimed to contribute to a greater understanding of how negative perceptions of ageing and older adults may be shifted. The idea was not to replace negative views with positive ones, but to encourage participants to recognise the multidimensionality of ageing and avoid overly simplistic and generalised views of older adults.

The results provide support for a brief, targeted intervention to drive positive changes in attitudes and behaviour that may be sustained over time.

Data sources

The findings presented in this report are based on data collected through:

online surveys

- pre-workshop (n=271)
- post-workshop (n=247)
- follow-up (n=149)

post-workshop discussions (n=42)

- 9 x focus groups
- 4 x individual interviews
- 1 x email

desktop research

- Australian and international research.

Direct quotes from workshop participants (obtained through post-workshop discussions and open-ended survey responses) are included to illustrate the experiences of individuals in their own words. The quotes from post-workshop discussions are attributed to participants, along with their age (if known) or their assigned focus group. The quotes from open-ended survey questions are categorised as 'survey responses'.

The case studies included in the report provide detailed information about specific learnings and changes that participants experienced following the workshop. Pseudonyms are used for all participants featured in the case studies.

Findings

Key finding

A brief, one-off educational intervention can be a powerful tool in creating lasting positive changes in attitudes and behaviours towards older people.

The Commission's findings demonstrate the potential of a brief, one-time educational intervention to generate attitudinal and behaviour changes that are sustained over time.

Participants attended a 2.5-hour interactive age awareness workshop and completed pre- and post-workshop online surveys, which used validated tools to assess their attitudes towards older adults and ageing and track changes over a 2–3-month period.

The results showed overall decreases in age-based biases and assumptions immediately following the workshop, which were maintained at a follow-up conducted two to three months later. Responses to questions in the follow-up survey about changes in behaviour revealed that the workshop served as a catalyst for positive changes in the vast majority of respondents' thoughts and behaviour. For example:

- 90% reported rethinking the way they communicate with older adults
- 87% had discussed ageism with others
- 86% actively considered actions they could initiate to address ageist attitudes in their workplace
- 82% reconsidered their attitudes towards ageing.

Post-workshop focus group discussions further indicated that participants had taken various actions because of the workshop, such as changing the way they interact with older adults, adopting new work practices or approach, sharing the learnings with others, and calling out ageism in their workplace and community.

These findings suggest that while ageism may be the most normalised and socially accepted form of prejudice, it is also malleable and amenable to change. Moreover, there were similar outcomes for participants who attended an online workshop and those who participated in person, suggesting that online interventions may be a low-cost and convenient alternative to face-to-face interventions.

Participant perspectives[7]

I never thought about ageism at all [before the workshop].

I feel more confident to have conversations with others about their attitude towards not only others but themselves about ageism. The content in the course on research provided information to start these conversations, which I have already used.

No more assumptions about someone's ability to do something, no matter what age – including my own.

I am now more aware of the biased thinking about aged people and their looks and try to avoid the stereotyped thoughts. I like to see older people and respect them for who they are, not how they may look. I will be more conscious about wording too!

I want to check myself for prejudices when meeting new people, I want to be aware of my language, attitudes, and subconscious limitations I may put on people due to their age.

The session has changed my perspective on how to think re: ageing process.

There were a few things that came up, one in particular is that I always write the person's age on some of my paperwork, when there is no need to do this. I do this to know what their age is, as marker for what I might think their cognitive awareness might be. So wrong I know.

I will try to not make assumptions on any of our clients that they are not able to do certain activities and instead always ask.

I'm being more mindful and respectful to older people on how they view ageism. Taking into consideration their past experiences and how they view themselves and me as one of their nurses.

My personal confidence has really escalated, and I can tell I'm drawing more information from the client because of my new approach.

Seeing the breadth of people and the change that's happening in the sector is great.

[The workshop] has encouraged me to think that I'm part of a movement now.

Insight 1.

People's perceptions of ageing and older adults are shaped by a multitude of life experiences accumulated over time.

The existing research suggests perceptions regarding ageing and older adults are formed and shaped by a complex interplay of personal and social factors.[8] Participants in the Commission's research shared various experiences and interactions that have influenced their perceptions. These included childhood observations, familial relationships, education, career paths, social connections, and broader cultural influences, such as media portrayals and societal attitudes.

Insight 2.

Age-based stereotypes and beliefs, whether positive or negative, can shape our attitudes towards older people and interactions with them.

Baseline measures collected prior to the workshop revealed participants held varying degrees of age-based biases and assumptions. These were often benevolent in nature, such as the belief that older adults should always be offered help, regardless of their actual need or preference. Attitudes such as these are characterised by sympathy and compassion towards older adults but may also assume reduced competence and capability.

While benevolent ageism is often rooted in well-meaning and protective intentions, it may still have harmful consequences. The assumption that older adults are vulnerable and in need of constant assistance can be limiting and disempowering, and lead to older individuals internalising and conforming to the stereotype others hold about them.

Insight 3.

The views and beliefs aged care and community workers hold about ageing may influence the interactions they have with the older adults they support.

Whether consciously or unconsciously, our behaviour is often guided by stereotypes and assumptions.[9] For care and service providers, stereotypical beliefs about ageing and older adults can lead to differential treatment of the individuals they support. Such bias is often unintentional and occurs without the conscious awareness of the person who holds the view. Working under time pressure, which is a common condition for those working in the aged care and community service sectors, has also been found to increase the likelihood of stereotyping.[10]

In the post-workshop discussions, participants reflected on their past interactions with older clients and recognised situations where they had made assumptions about clients' preferences and abilities because of their age group – for example, offering or not offering certain activities or programs, providing assistance without being asked, and performing tasks on behalf of older clients instead of supporting them to complete the task independently.

Insight 4.

Increasing awareness of ageism and how it operates can lead to positive changes in attitudes and behaviour – particularly with implicit ageism, which occurs without conscious awareness or intention.

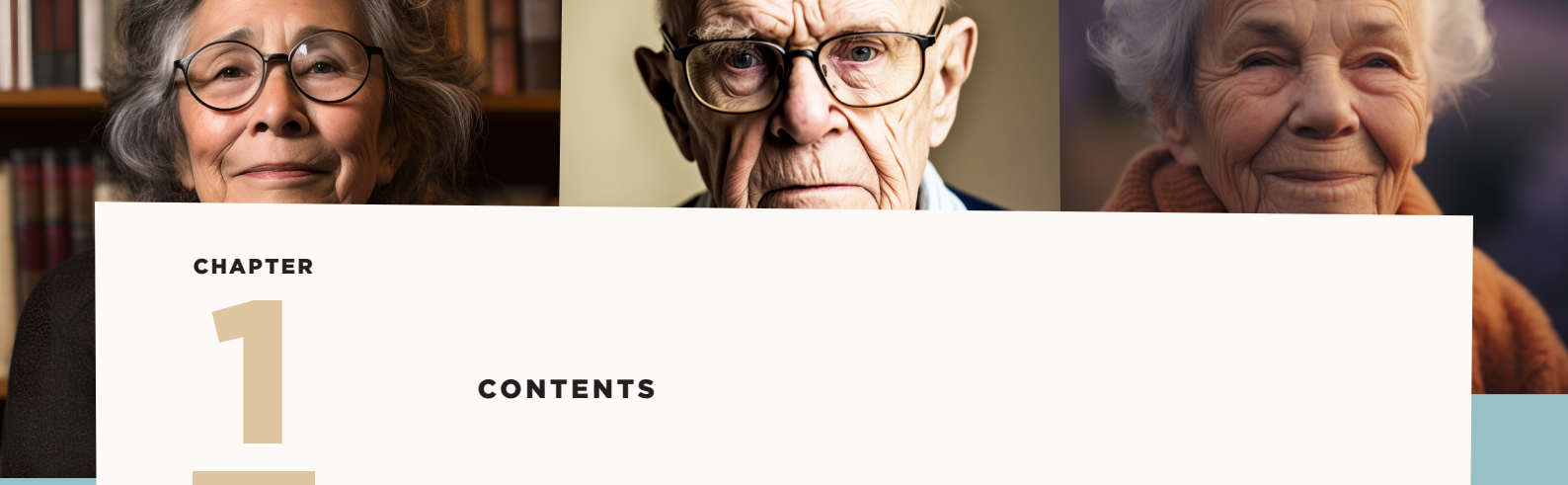
Language is one of the most common (and often subtle) ways in which ageism is expressed,[11] as are overprotective and overaccommodative attitudes and behaviours towards older adults. Usually, the individuals responsible are not aware that what they're saying or doing is influenced by age bias. On the contrary, their actions are often well-meant and intended as a compliment.

The Commission found that changes in language and benevolent attitudes towards older adults were among the strongest impacts of the workshop. Participants reported that the workshop helped to open their eyes to the ways in which ageism is normalised and perpetuated in everyday language. After the workshop, nine out of 10 participants reported they had rethought how they communicate with older adults. Likewise, participants' endorsement of ageist views showed significant reductions following the workshop, and these shifts were maintained over 2–3 months.

CHAPTER

1

Introduction



CHAPTER

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1.1 Why this research?

Have you ever told someone they look great for their age? Or perhaps you've been told by someone that you don't look your age. Sayings such as these are almost always meant as a compliment but are actually loaded with implicit biases about ageing. You only need to imagine replacing 'your age' with another social category, such as gender, cultural background, or socioeconomic status to realise that such a statement is not a compliment at all.[12]

Examples are widespread. The phrase 'having a senior moment' associates forgetfulness with older adults, thereby perpetuating negative stereotypes of cognitive impairment and incompetence. It is also all too easy to find birthday cards that make fun of ageing, reinforcing the idea that growing older is a source of shame, rather than celebration. 'Anti-ageing' is a global multibillion-dollar beauty market that rests on the fundamental notion that ageing is something to be resisted and treated.

As the examples above indicate, ageism is deeply ingrained in our society and in the language we use. For this reason, it is arguably the least understood, least recognised and most accepted of social prejudices. In Australia, the Commission's 2021 *What's age got to do with it?* report, which surveyed a national sample of adults 18 years and older, found that ageist attitudes are prevalent in society and underpin many of the stereotypes and assumptions people hold about life stages and roles, and about ageing itself.[13] The Commission found that most respondents saw age as 'just a number' – only 28% reported feeling their age, whereas 64% felt either older or younger than their chronological age and 8% didn't think about age at all. Yet, 63% reported they have experienced ageism and of these, 69% admitted they have stereotyped others based on their age.[14]

This disconnect between explicit (conscious) and implicit (unconscious) attitudes is not uncommon in the literature,[15] and points to the ways in which ageism is normalised and largely goes unrecognised and unchallenged in society. Stereotypes about older people may be activated automatically when we perceive someone to be 'old', which means we can be ageist against older people without awareness or intention.[16]

One of the most insidious aspects of ageism is that it can operate without conscious awareness, control, or intention to harm.[17]

As the Commission found in its 2021 research, ageist attitudes – even when not expressed consciously – underpin how people perceive different age groups and the expectations they have for the ways individuals of certain ages should behave and the experiences they are likely to have.[18] The Commission's finding of widespread, unconscious ageism in the community suggests that efforts to combat ageism need to focus first on raising awareness.

Informed by the Commission's earlier work, the current research aims to raise awareness of ageism and shift ageist attitudes among individuals who provide aged care or community programs to older adults ('aged care and community workers'). These categories of workers were selected due to their potential to exert significant influence over the lives of older adults.

1.2 Objectives

The objectives of the research are to:

- examine aged care and community workers' attitudes and expectations regarding older adults and ageing
- evaluate the effectiveness of ageism awareness training in shifting ageist attitudes and assumptions among a group of aged care and community workers
- contribute a more detailed understanding of how ageist attitudes and perceptions may be shifted
- assist in identifying and prioritising further research needs.

CHAPTER

2

Background

CHAPTER

2

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Overview

- Ageism can have serious consequences for older people's health and wellbeing.
- Ageism among aged care and community workers is a particularly serious concern due to its potential to directly impact the health, wellbeing and quality of life of the older adults they support.
- While educational and intergenerational programs have been shown to be effective in reducing ageism, most of the existing research has been based in the United States or in formal education settings.
- This research contributes to filling the current gaps in research and practice, by evaluating the effectiveness of a one-off educational intervention in reducing age-based stereotyping and prejudice among those working in aged care and community settings.

2.1 Ageism against older adults

Australia, like most countries, has an ageing population. Currently there are an estimated 4.4 million people aged 65 years and over, which is approximately 17% of the population, or one in six Australians.[19] This number is projected to double to 8.9 million by 2060–61, when it is expected that 23% of the population will be aged 65 years and older.[20]

Despite the rising number and proportion of older people in the population, older adults are often invisible to society. Interviews with older adults describe experiences marked by a lack of recognition – not feeling valued as people or for their contribution to society.[21] This form of invisibility-based stigmatisation, which manifests as indifference and inattention towards older adults,[22] was also evident in the Commission's *What's age got to do with it?* research. This research found a lack of identification of older adults with meaningful life roles by younger generations, who tended to perceive older adults as 'nice, frail onlookers to life', rather than active participants in society.[23]

The World Health Organization (WHO) defines ageism as 'stereotypes (how we think), prejudice (how we feel), and discrimination (how we act)' towards people on the basis of their perceived chronological age.[24] There are several ways in which ageism is expressed, including:

- against ourselves (self-directed)
- between individuals (interpersonal)
- on institutional or cultural level through established laws, rules, policies, norms, and practices.[25]

While ageism can be directed towards any age group, it tends to affect older people most severely. Ageist stereotypes of older adults may be prescriptive (how older adults *should* be), or descriptive (what older adults allegedly *are*).[26]

Prescriptive stereotypes stem from beliefs about how older people behave; they have been shown to exist in the domains of succession, consumption, and identity.[27] Succession-based stereotypes involve beliefs that older people should step aside from desirable positions and resources to make way for younger people. Consumption-based beliefs are concerned with over-use of shared resources by (and for) older people, such as the idea that older people are a burden on health or social welfare systems. And identity-based prescriptive stereotypes relate to the idea of 'acting one's age', that is, the idea that older people should not engage in activities or roles that are usually associated with young people.[28]

Descriptive stereotypes often involve assessments of age groups along the dimensions of warmth and competence, portraying older adults as warm but incompetent.[29] This perception of older people as warm but less capable than people of other ages is well-documented in the literature about ageism.[30] While high warmth perceptions seem positive, they can lead to overprotective or overaccommodative treatment, and undermine older adults' autonomy, particularly when coupled with low competence perceptions.[31] This type of benevolent or paternalistic ageism differs from hostile ageism, which involves more explicitly aggressive attitudes towards older adults.[32] Older people's experiences of benevolent ageism include condescending language,[33] receiving unwanted help,[34] and being treated as though they're incompetent.[35]

2.2 Drivers of ageism

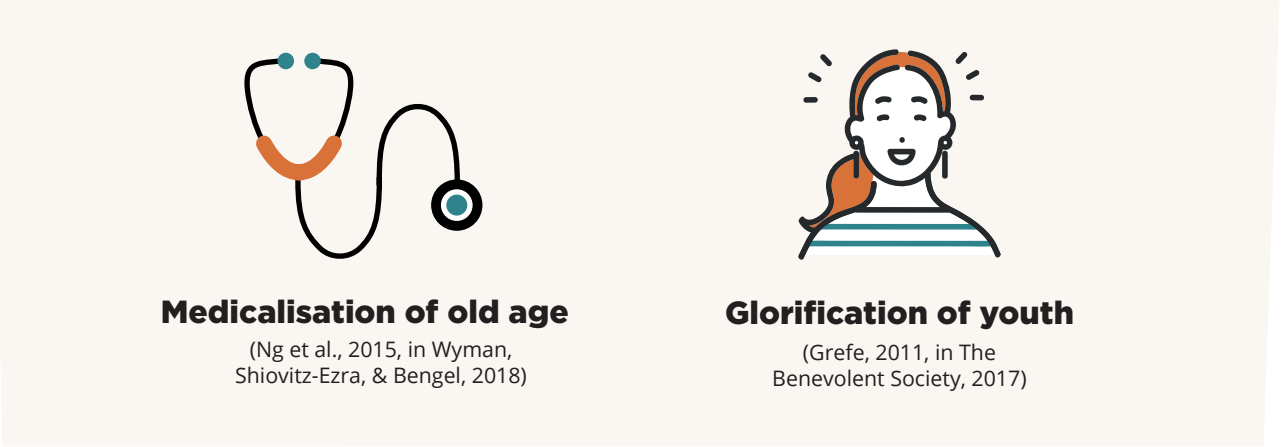
Unlike other social 'isms' such as racism and sexism, ageism against older people is something that we may all experience if we live long enough. This is why ageism is sometimes referred to by scholars as 'a prejudice against our future self.'[36]

Micro-level ageism – ageism that occurs at the individual level – is theorised to stem from fear and lack of understanding about ageing and older age.[37] In this view, ageing is associated with death, and older adults serve as a direct reminder of our inevitable mortality. Younger age groups cast older adults as the 'other' as a way of distancing themselves from older adults, who remind them of decline and death.[38] This incorporates not only a decline of the physical self, but also of the social self.

Ageism is also thought to develop over the life course from continuing exposure to negative stereotypes of old age, which eventually leads to such views being accepted by people, often implicitly. When ageist stereotypes and norms become directed inward towards oneself, this is described as 'internalised ageism'.[39]

In contemporary societies, anti-ageing discourses, such as the medicalisation of older age[40] and glorification of youth,[41] often underpin ageist attitudes against older adults.

Figure 1. Drivers of ageism



The medicalisation of older age refers to the 'increased focus on the medical aspects of being old – to the exclusion of other dimensions of older age',[42] while society's glorification of youth privileges youth over age[43] and attributes characteristics, such as physical beauty and strength, to being young.[44] Such narratives perpetuate negative stereotyping of ageing as undesirable and a period of decline and ill health, and contribute to the ageist rhetoric that portrays older adults as vulnerable and a burden to society.

2.3 Impact of ageism on older adults

Ageism has serious consequences for older adults' health and wellbeing. There is consistent and compelling evidence in the literature (which includes longitudinal, cross-cultural, and laboratory studies) demonstrating that ageism can affect people's health in profound ways. Being exposed to, or having, negative perceptions about ageing have been linked to adverse health outcomes, such as poor physical and psychological health, delayed recovery from disability, decreased memory performance, reduced quality of life and wellbeing, even earlier death.[45] Moreover, perceiving older adults as needing protection and treating them in a way that undermines their autonomy or independence – no matter how well-intentioned – can reduce feelings of self-efficacy and competence in older adults.[46]

One of the most damaging things about ageism is that negative stereotypes about ageing affect not only people's perceptions of older adults and behaviours towards them, but also how older individuals view themselves and their behaviour. Internalised ageism occurs when negative beliefs about older age become self-directed over time and operate unconsciously.

Attributes associated with the 'typical old person' tend to become incorporated into the elderly person's current and future self-views.[47]

Research shows that internalised ageism can become a self-fulfilling prophecy, in which older adults view themselves in stereotypical ways and act accordingly.[48] For example, older adults with internalised negative expectations of the ageing process may not seek treatment for health issues or engage in preventive health behaviours, due to their belief that ageing naturally results in deteriorations in health. This could lead to a more rapid decline in their health than older adults who do engage in healthcare-seeking and preventive behaviours.

In contrast, having positive perceptions about older age has been found to be associated with a host of positive health outcomes, including: reduced risk of conditions, such as dementia, cognitive impairment, diabetes, stroke, and heart disease; better functional health; psychological wellbeing; and increased longevity.[49]

2.4 Ageism among aged care and community workers

Aged care and community workers often have close and ongoing interactions with older adults. This makes ageism among this population a particularly serious concern, as it has the potential to directly affect the health, wellbeing, and quality of life of the older adults they support.

The Royal Commission into Aged Care Quality and Safety acknowledged the dangers associated with workers' assumptions about old age and the ageing process.[50] It was recognised, for example, that negative assumptions about the ageing process may contribute to older people's health issues being overlooked and attributed to 'old age', while assumptions relating to cognitive decline may lead to social exclusion and disrespectful treatment of older adults. Despite this, much of the focus of the aged care sector has been around the structural defects, regulatory gaps, and institutional practices, while micro (personal) factors, such as ageist attitudes and behaviours by workers, have received comparatively less attention.[51]

Most studies that examined ageism among workers in aged care focus on residents in long-term care facilities. This focus is likely because these settings tend to have the highest proportion of the vulnerable 'oldest-old' people requiring high-level, ongoing care, characteristics which potentially increase the possibilities for ageism.[52] Moreover, the focus in these facilities on older adults' impaired capabilities may lead to workers incorrectly assuming all residents are frail and dependent, and defining individuals primarily by their care needs.[53]

Ageism in long-term residential care settings includes residents – particularly those who are immobile or have cognitive impairment – being forgotten, avoided, spoken to using ageist language, cared for with substandard materials, and treated in an automated and undignified manner (eg, inappropriate uses of mixed or communal spaces).[54] Ageism in these settings does not just affect the older adults themselves, but can also have adverse outcomes for the workers. Among those who work with older adults, negative attitudes about ageing have been shown to adversely affect job satisfaction and commitment to work,[55] and contribute to burnout.[56]

When it comes to ageism in the community, existing studies tend to focus on everyday ageism or internalised ageism,[57] rather than specific aspects of community life. Studies of ageism among community workers are particularly scarce. Studies of everyday ageism by definition include everyday citizens and so extend to community workers. However, the frequency of contact these workers have with older adults may moderate or amplify their age-based beliefs and assumptions, as with other workers who have frequent contact with older adults, such as aged care and healthcare workers.[58]

Studies examining ageism in community programs have typically focused on recreational groups and discovered unintentional and typically well-meaning confinement of older adults to certain types of activities. For example, a Canadian study found that while older adults did not believe their age alone restricted their ability to participate in physical exercise, they felt constrained by others' ageist attitudes and a lack of programs for active older adults.[59] Participants reported that when they did take part in exercise classes, they felt they attracted attention and were treated differently – even revered as exceptional for what they were doing – because of their age, as though they did not belong or should not be present.

Research has also found internalisation of these ageist views by older individuals, who held stereotypical views of community groups for older people as being 'bingo, light entertainment, and chatting'.[60] Furthermore, stereotypes of ageing and older age held by older adults appear to influence how they choose to spend their free time. Research has found that among older adults, low levels of satisfaction with ageing and knowledge about it were associated with more time spent in passive, spectator activities, such as watching TV, napping or resting.[61]

2.5 Interventions to reduce ageism against older adults

Even small shifts in how we think, feel and act towards age and ageing will reap benefits for individuals and societies.[62]

When the Commission in its 2021 research asked adults in Australia how they thought ageism could be addressed, the most common response was for ageing to be seen as a positive experience.[63] It is possible to shift negative attitudes and perceptions even in a society such as ours, where ageing is typically viewed in a negative light. However, because ageism tends to be subtle and exist under the radar, we must first become aware of the negative messaging around ageing within ourselves and the environment.

Research points to the effectiveness of educational interventions to raise awareness of ageist attitudes and behaviours and to challenge them.[64] For example, a study in the United States found that a video-based educational intervention was effective in reducing ageism among aged care workers.[65] This study found long-term, positive changes in participants' attitudes, thinking, behaviour and language, following a single, video-based education session.

Interventions that aim to foster positive interactions between people of different generations have also been shown to be effective in reducing ageism against older adults.[66] However, intergenerational contact alone is not sufficient; the quality of contact plays an important role.[67] For example, 'home share' programs, which match older adults who live alone with younger people in need of accommodation, provide opportunities for sustained intergenerational contact and may have the added benefit of reducing ageist stereotypes and attitudes among those involved.

A third type of ageism intervention combines education and intergenerational contact. A systematic review and meta-analysis of ageism interventions commissioned by the WHO for its 2021 *Global Report on Ageism*, found that combined interventions, along with educational and intergenerational contact interventions, resulted in improvements in participants' attitudes towards older adults and knowledge about ageing.[68]

The review also identified notable gaps in the current ageism intervention literature. First, the majority of interventions that have been formally evaluated are from the United States, and while there is some translatability, it is important for interventions to be tested in other contexts. Secondly, most evaluations of ageism interventions have taken place in formal educational settings (ie, schools, universities) and targeted students, with only a small number delivered in non-formal learning settings (eg, workplaces or community centres).[69]

Given these gaps, the present research contributes to a greater understanding of the effectiveness of an educational intervention for workers in aged care and community settings in the Australian context.

CHAPTER

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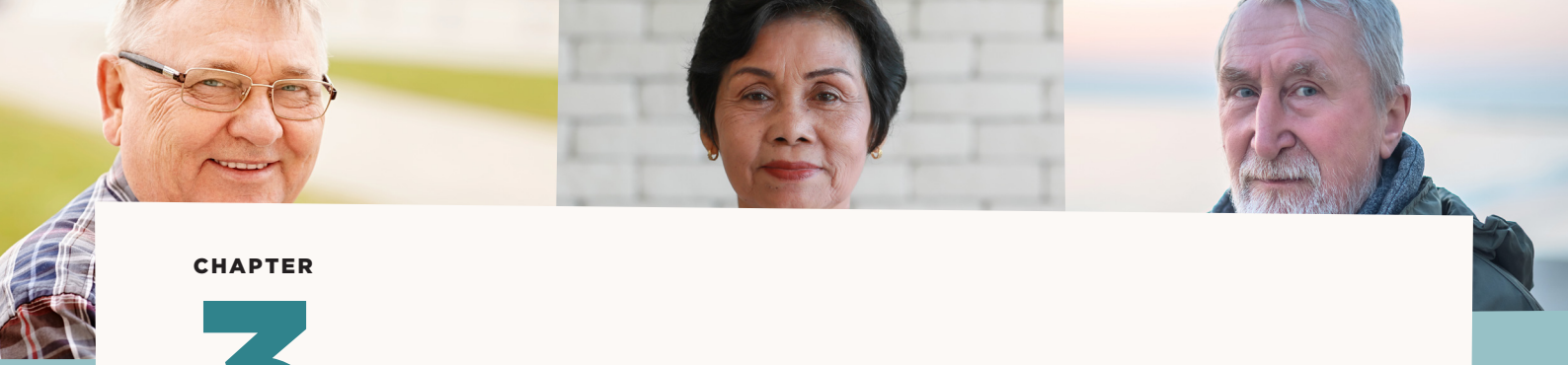
Methodology



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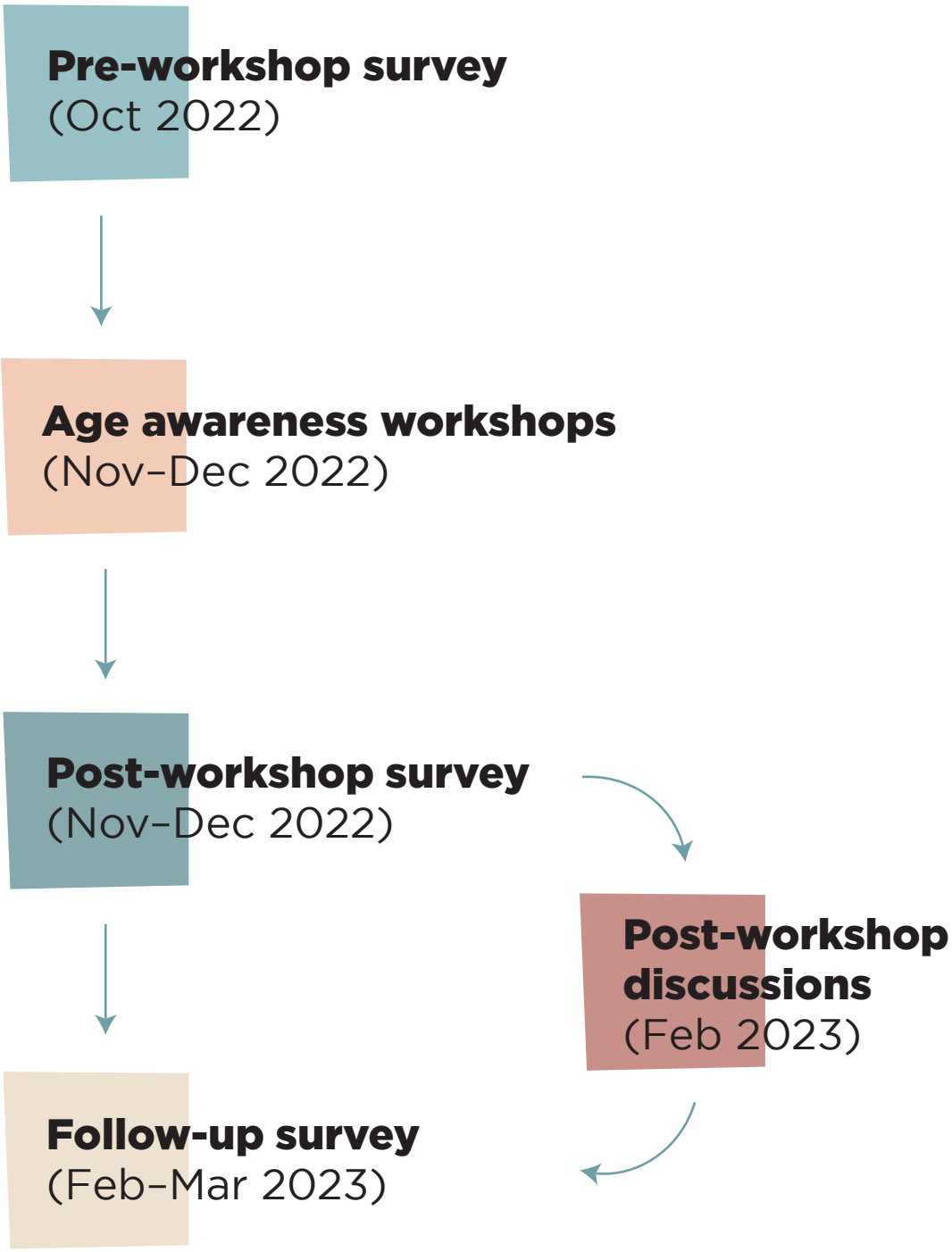
3.1 Design

This research involved a mixed methods design, consisting of a series of online surveys and a qualitative exploration involving a subgroup of participants. The surveys were conducted at pre-workshop and at two follow-up points: immediately after the workshop and 2–3 months post-workshop. For the qualitative exploration, all workshop participants were invited to attend a virtual session of post-workshop focus group discussions.

Figure 2. Research design



Fieldwork for the pre-workshop survey took place over a two-week period during the second half of October 2022. The workshops were delivered throughout November and early December 2022, with data collection for the post-workshop survey occurring simultaneously. The final survey was conducted during the final week of February and first week of March 2023.

The post-workshop focus group discussions were conducted in February 2023, before data collection commenced for the follow-up survey.

3.2 Recruitment

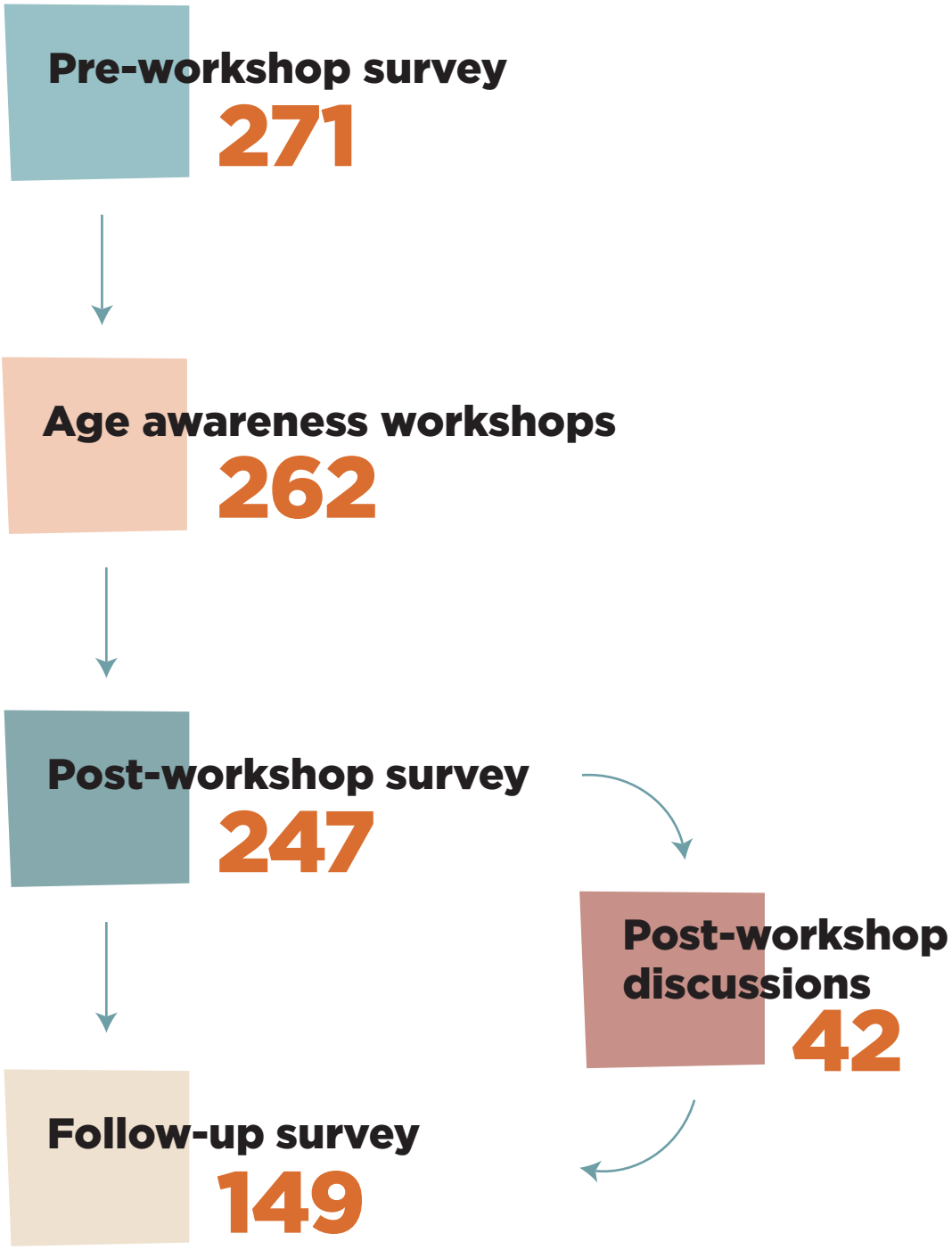
Various networks and modes of contact were used to recruit aged care and community workers, such as posting announcements in online newsletters and emailing local governments and key stakeholder groups in the ageing sector for distribution of information among their members and networks. The Commission also carried out web-based searches to identify community programs for older adults and contacted identified organisations via email to invite them to take part in the research. Additionally, those who expressed an interest in participating were encouraged to share information about the research with their contacts they deemed relevant. All potential participants were screened for eligibility to include only those who were currently involved in delivering aged care or community programs to older adults through work or volunteer activity.

All eligible participants were provided with a consent form regarding the research, including the type of information to be collected and how it would be used, and indicating their right to withdraw from participation at any point. Participants acknowledged their understanding and provided informed consent by returning a signed form. Incentives in the form of gift cards were offered to those who participated in post-workshop discussions and respondents of the post-workshop and follow-up surveys.[70] No incentives were offered for the pre-workshop survey or the age awareness workshop.

3.3 Participants

A total of 329 people participated in the research by completing at least one survey. There were drop-offs in the number of participants across the study, and a number of participants joined after the pre-workshop survey. The number of participants for each stage is provided below.

Figure 3. Number of participants for each stage

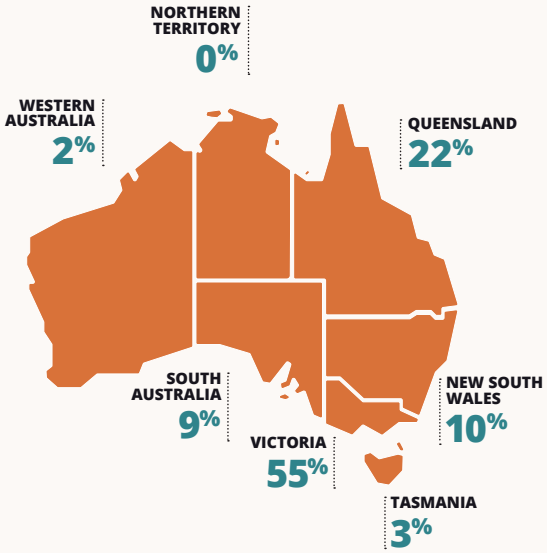


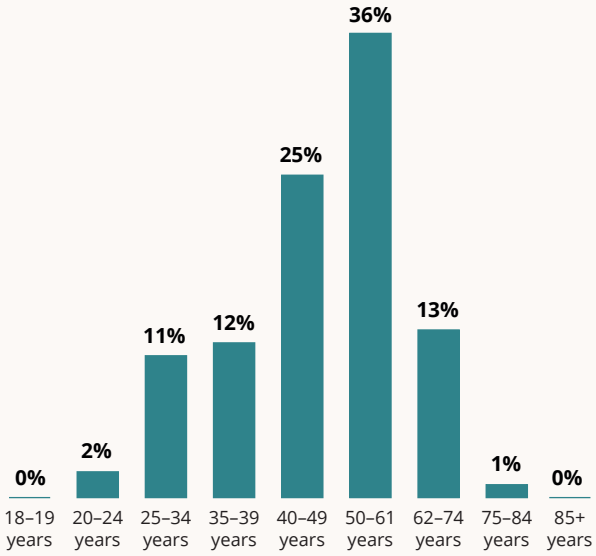
Participant attrition – loss of participants – in follow-up studies is common in research, with attrition rates of up to 70% reported in the literature.[71] Participant drop-offs may have occurred in this research, particularly between post-workshop and follow-up surveys, for various reasons – for example, loss of interest, time constraints, ceasing or changing employment, change in contact information, and difficulty accessing the online survey.

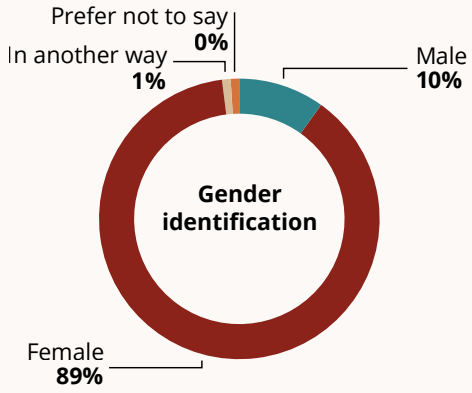
Figure 4.

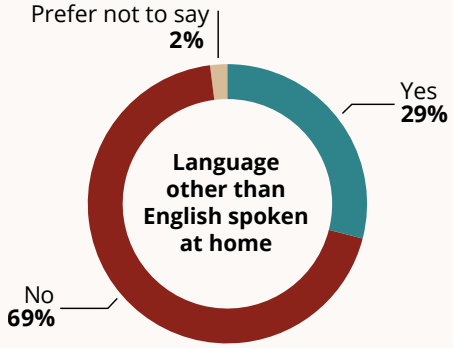
Participant demographics

(N=329)









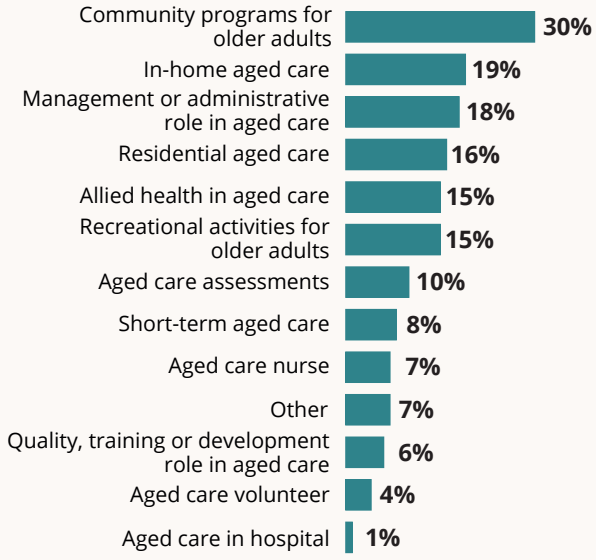
Education

Completed at least a bachelor's level qualification

Employment status

Employed full-time or part-time

Current role of participants*



*The total exceeds 100% as respondents were able to select all options that applied to them.

Years of experience working or volunteering with older adults

Duration	Current role	All roles
<1 year	11%	6%
1–2 years	11%	9%
3–5 years	19%	14%
6–10 years	17%	18%
10+ years	43%	52%

3.4 Age awareness workshops

The age awareness workshop was a single, 2.5-hour interactive session aimed at increasing awareness of ageism and promoting positive change. The workshop was made available in person and online via Zoom, with onsite face-to-face sessions offered to participating organisations, as well as organised in locations where there was sufficient interest from individual participants from different organisations to attend in person.

The workshop covered the following topics:

- age beliefs – what they are and why they matter
- ageism – definition and experiences
- common assumptions about ageing and older adults
- the language of ageism
- what we can do to reduce ageism.

In total, 18 face-to-face and online sessions were delivered. The online and face-to-face sessions were identical in content and structure, differing only in the mode of delivery. All sessions were delivered by the same facilitator.

The table below provides an overview of the number of sessions, participants, and locations.

Table 1. Overview of the workshops

	Face-to-face sessions	Online sessions
Number of sessions	10	8
Locations	**Queensland** • Brisbane • Ipswich **New South Wales** • Sydney **Victoria** • Ballarat • Melbourne	All delivered via Zoom
Total number of participants	139	123

3.5 Post-workshop discussions

Between the post-workshop and follow-up surveys, all workshop participants were invited to take part in a virtual session to discuss their thoughts on the workshop and its impact. A total of 42 people participated in the post-workshop discussions, which were conducted via nine focus groups, four individual interviews, and one email feedback.[72]

Those who participated in the post-workshop discussions:

- were based in regional and metropolitan Australia, across New South Wales, Queensland, South Australia, Tasmania, and Victoria
- ranged in age from 23 to 80 years, though skewed towards older with an average age of 52
- worked or volunteered in various roles delivering services to older adults across the aged care, allied health, and community sectors
- had varying levels of experience in working with older adults, ranging from those who were relatively new to decades of experience.

By taking place 2–3 months after the age awareness workshops, these discussions served as a delayed debriefing session and provided the participants with an opportunity to reflect on the training and discuss their experiences. For the Commission, the sessions offered a useful technique for obtaining more detailed information about participants' experiences and perceptions related to ageing, ageism, and the impact of the workshop.

3.6 Survey instrument

The questionnaire used for the online surveys consisted of the following three validated instruments.

(a) Ambivalent Ageism Scale

The Ambivalent Ageism Scale (AAS)[73] consists of 13 items across benevolent and hostile ageism subscales. The separate benevolent and hostile ageism subscales make the AAS a useful tool for understanding the often complex and nuanced attitudes people hold towards older adults.

(b) Fraboni Scale of Ageism

The Fraboni Scale of Ageism (FSA)[74] is one of the most used measurements for ageing research. It is composed of 29 items which measure ageism across three subscales:

- antilocution subscale (10 items) – measures the degree to which respondents endorse expressions of antagonistic attitudes and prejudice towards older adults
- avoidance subscale (10 items) – measures the tendency to avoid contact with older adults[75]
- discrimination subscale (9 items) – measures endorsement of statements about excluding older adults and other discriminatory behaviours.

(c) 12-Item Expectations Regarding Ageing Scale

Unlike attitudinal scales, the 12-Item Expectations Regarding Ageing (ERA-12)[76] is not designed to identify positive or negative attitudes towards older adults. Its purpose is to quantify the extent to which older adults expect age-associated decline for themselves over time, in three different health domains of physical health, mental health, and cognitive function. While designed to assess older people's expectations for their own ageing process, the ERA-12 is also sensitive to how younger people expect to age themselves, which can be more related to the stereotypes and age-based assumptions they hold.[77]

The same questionnaire was used for all three surveys, with additional questions about participants' intention to change behaviour and actual changes in behaviour added to the post-workshop and follow-up surveys respectively. Lastly, demographic questions were included to obtain information about participants' age, geographic location, occupation, years of experience working with older adults, primary language, and education level, as well as to enable analysis by subgroups. All additional questions were developed by the research team.

3.7 Limitations

(a) Selection bias

The aged care and community workers involved in this research volunteered to take part in the workshop. It is likely that at least some of these individuals had existing interest in the topic that influenced their decision to participate.

Because individuals chose to participate and were not selected at random, the participants of this research are not representative of all aged care and community workers. This means the findings may not be generalised to apply to all workers involved in providing services to older adults in aged care and community settings. Further research is recommended to confirm these findings with larger, more representative samples.

(b) Attrition bias

The post-workshop survey, which was administered immediately following the workshop, had a very high response rate of 94.3%. The follow-up survey, which was conducted 2–3 months later, had a considerably lower response rate, with 57.3% of workshop attendees completing the questionnaire.

Participant dropout is a common challenge in follow-up studies and raises the possibility of attrition bias, which occurs when there are systematic differences between participants who drop out of the study and those who continue.[78] This may result in a biased sample and affect the generalisability of the findings.

Several strategies were used to minimise attrition bias in this research, including: clearly outlining the requirements to participants from the outset; monitoring responses; sending follow-up and reminder emails; and providing incentives.

(c) Social desirability bias

Social desirability bias in surveys may occur when respondents are reluctant to admit to attitudes and behaviours that are considered socially unacceptable or undesirable.[79] This may lead to respondents providing answers they believe are socially acceptable or desirable, rather than reporting their true beliefs or behaviours.

To reduce the potential impact of social desirability bias, participants were reassured that their responses would remain anonymous and confidential.

(d) Control group

In research, a randomly assigned group of individuals who are not provided with the intervention under evaluation represents the counterfactual of what would have happened to participants without the intervention. In this research, the lack of a control group prevents us from drawing definite conclusions about the workshop as the cause of the significant differences observed between the pre-workshop and post-workshop surveys.

This limitation was partially addressed by having the same group of participants complete surveys before and after the workshop, thereby serving as their own control. As ageism is deeply ingrained and normalised, it is unlikely that substantial shifts in attitudes would occur spontaneously over a 2–3-month period. Additionally, participants' own accounts of the changes that occurred because of the workshop offered rich and detailed insights and served to further support and validate the quantitative survey results.

CHAPTER

4

Pre-workshop beliefs about ageing and older adults

CHAPTER

4

CONTENTS

Key findings

- Prior to attending the workshop, participants generally rejected ageist views and endorsed favourable views of older adults. Nevertheless, many still appeared to be influenced by implicit stereotypes of older adults as vulnerable and in need of protection. This may be related to their expectations of physical and cognitive decline in older age.
- The pre-workshop survey found that respondents most strongly disagreed with statements reflecting overt avoidance of older adults. They most strongly endorsed statements that acknowledged positive attributes and contributions of older individuals.
- While respondents commonly rejected overtly hostile and paternalistic attitudes towards older adults, more subtle forms of benevolent ageism generated mixed responses.
- Most found the notion that physical health challenges are a normal part of ageing to be at least somewhat true. Responses to the statements connecting cognitive decline with ageing generally fell within the range of 'somewhat true' and 'somewhat false', suggesting ambivalence among respondents.

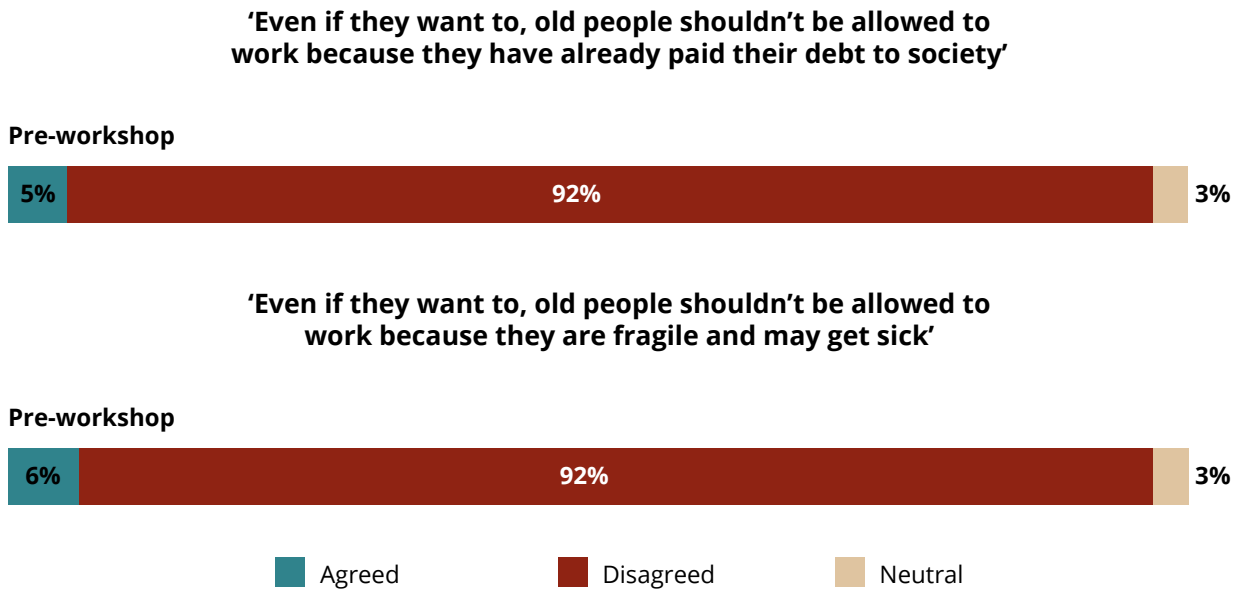
The results from the pre-workshop survey indicate that even prior to the workshop, respondents overall held favourable views of older adults, and tended to reject ageist views.

Responses to individual items were examined to gain a more detailed understanding of respondents' attitudes and expectations prior to the workshop. This was done by categorising responses into those who agreed (ie, answered 'strongly agree' or 'somewhat agree') or disagreed (ie, answered 'strongly disagree' or 'somewhat disagree') for each question.

4.1 Ambivalent Ageism Scale

On the Ambivalent Ageism Scale (AAS), which measures benevolent and hostile ageism against older adults, responses were mostly clustered between 'disagree' and 'somewhat disagree', indicating a tendency to reject ageist views.

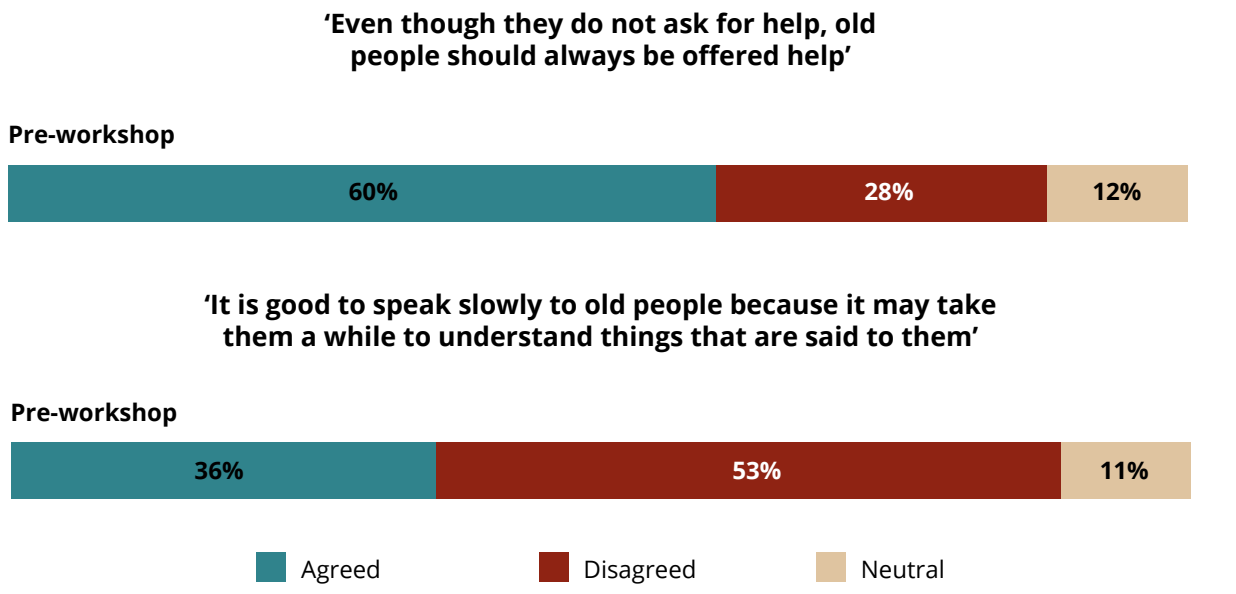
Figure 5. AAS statements most frequently disagreed with before the workshop[80]



The totals in some charts may not equal 100% due to rounding.

Respondents found the statements expressing overtly paternalistic attitudes, such as those suggesting older adults should be prevented from working, to be particularly unacceptable. More than 50% of respondents reported strong disagreement with these statements and more than 90% at least somewhat disagreed.

Figure 6. AAS statements most frequently agreed with before the workshop



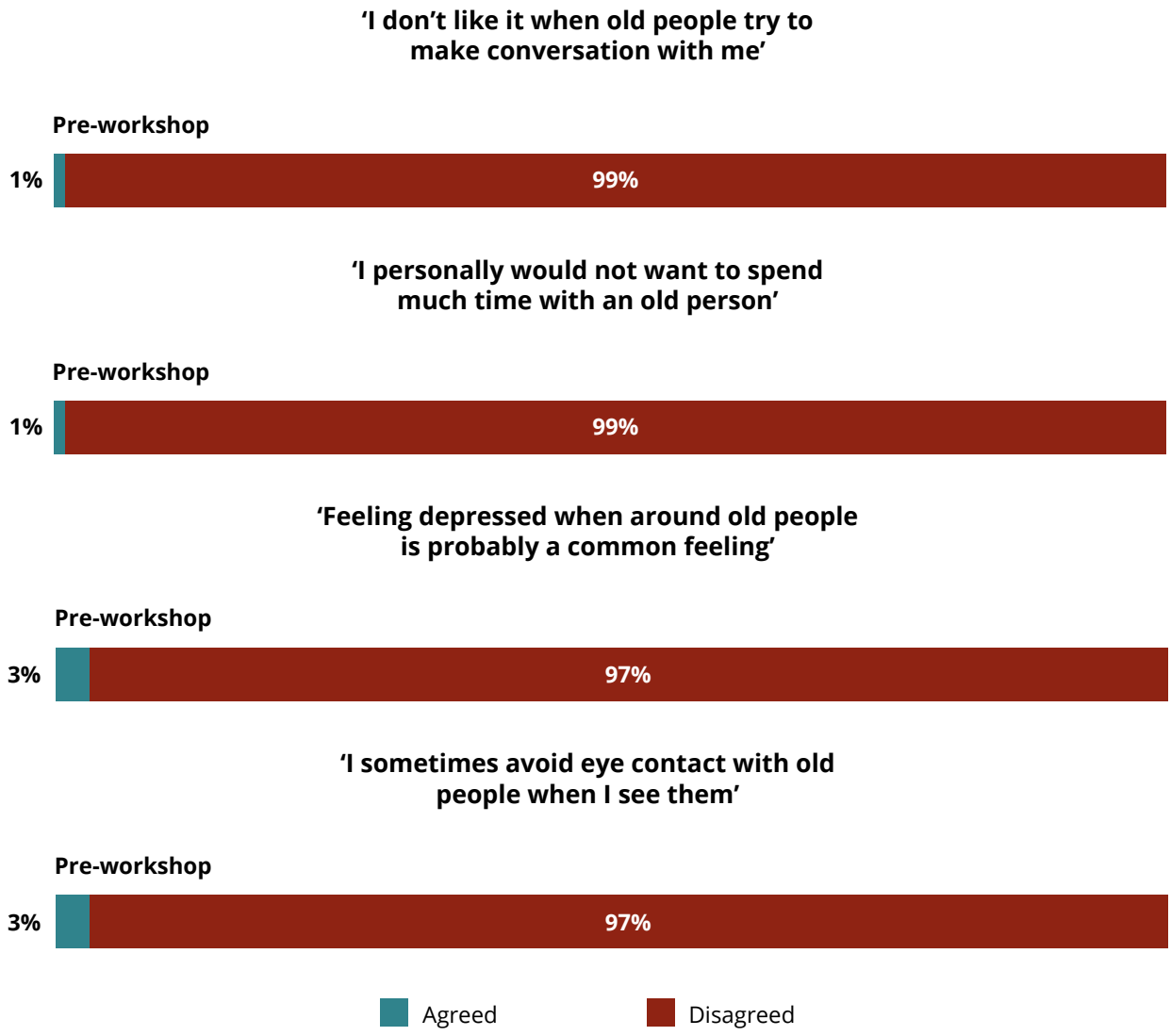
In contrast, statements that reflected more subtle forms of benevolent ageism generated mixed responses. Around 60% of respondents at least somewhat agreed that older adults should always be offered help, regardless of whether they express a desire or need for it. Likewise, over a third (36%) agreed that it was good to speak slowly to older adults as it may take them a while to understand things that are said to them.

These results suggest that respondents are influenced by the stereotypes of older adults as having reduced capacity and competence. These are likely to be implicit, given respondents' general inclination to reject explicitly ageist statements. Though they may be well-intentioned, constantly offering assistance and adopting a slower rate of speech can lead to patronising interactions and undermine the dignity and autonomy of older adults.[81]

4.2 Fraboni Scale of Ageism

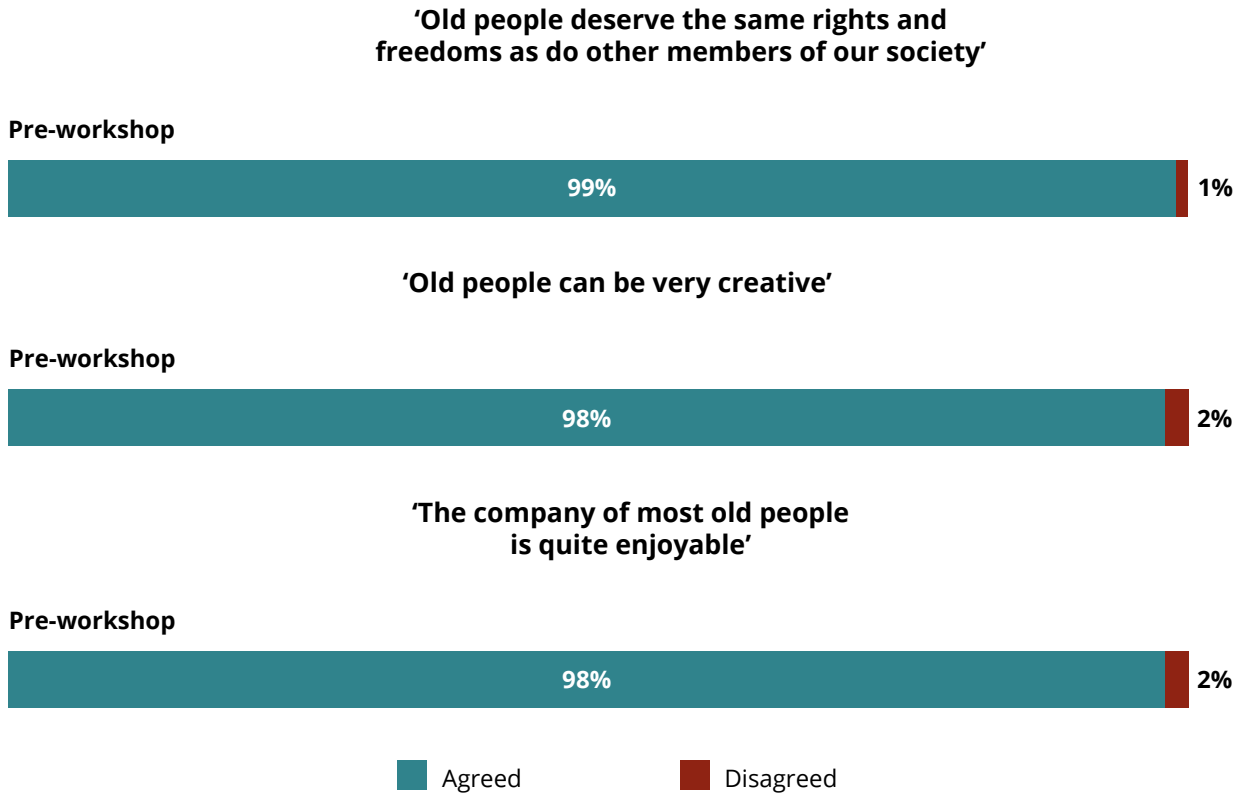
On the Fraboni Scale of Ageism (FSA), which measures prejudice against, avoidance of, and discriminatory attitudes towards older adults, respondents' scores generally fell towards the lower end of the score range. This indicates that most respondents tended to reject ageist views prior to participating in the workshop.

Figure 7. FSA statements most frequently disagreed with before the workshop



Respondents most frequently disagreed with the statements reflecting a reluctance to engage with older adults. Almost everyone disagreed with, 'I don't like it when old people try to make conversations with me' (99%) and 'I personally would not want to spend much time with an old person' (99%).

Figure 8. FSA statements most frequently agreed with before the workshop



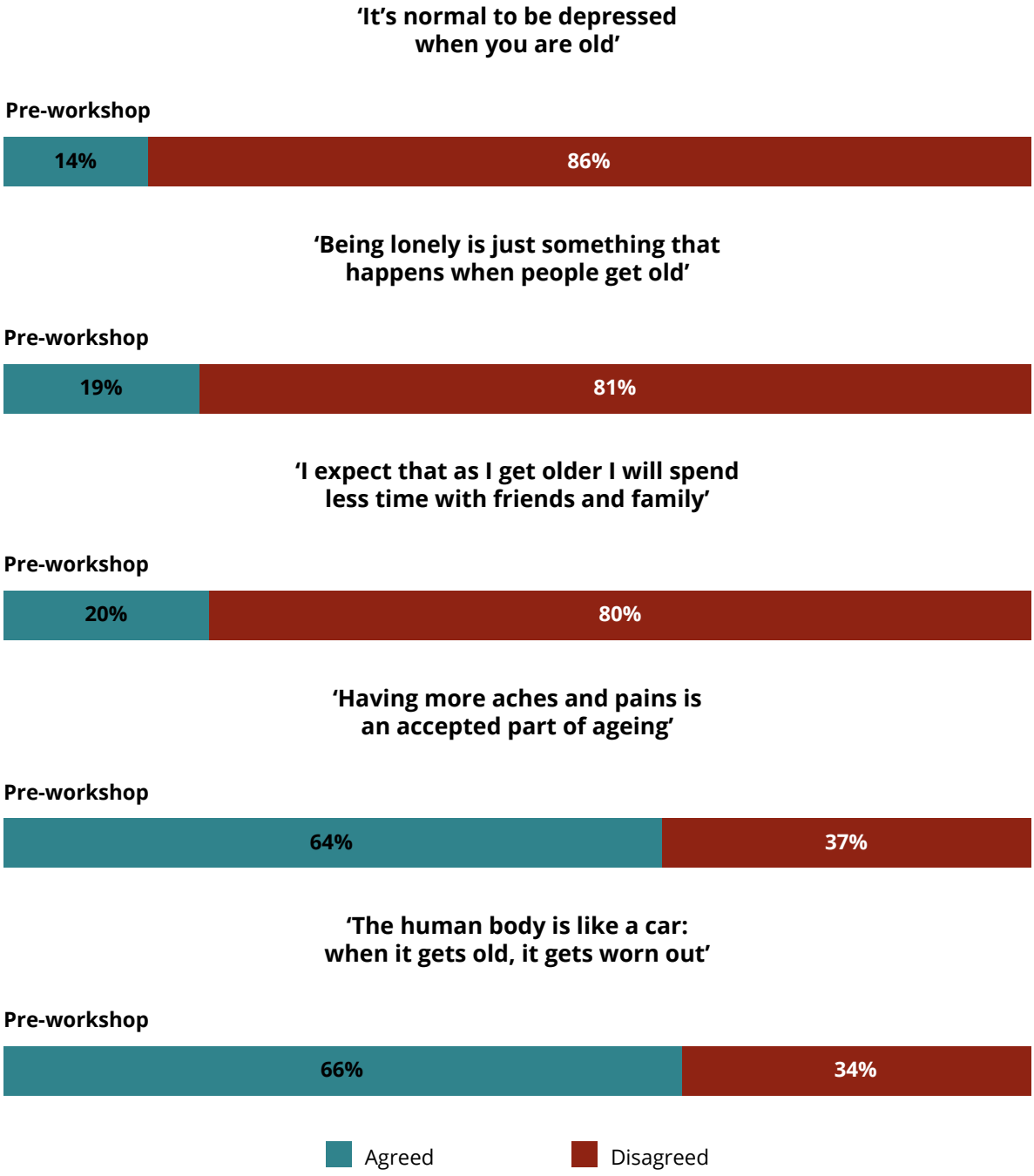
Respondents most frequently agreed with the statements that recognised older adults as equal members of society, capable of being very creative, and providing enjoyable company. Respondents in the pre-workshop survey almost universally endorsed statements such as, 'Old people deserve the same rights and freedoms as do other members of our society' (99%) and 'Old people can be very creative' (98%).

4.3 12-Item Expectations Regarding Ageing Scale

Unlike the AAS and FSA, the 12-Item Expectations Regarding Ageing Scale (ERA-12) is not specifically a measure of ageism. Instead, it is designed to measure respondents' beliefs about how well they expect to maintain high physical and cognitive function, and social and emotional wellbeing in later life.

The ERA-12 is rated on a 4-point scale ranging from 'definitely true' to 'definitely false'. To explore responses to individual items, responses were coded as either 'agreed' (ie, answered 'definitely true' or 'somewhat true') or disagreed (ie, answered 'definitely false' or 'somewhat false').

Figure 9. ERA-12 statements most frequently disagreed / agreed with before the workshop

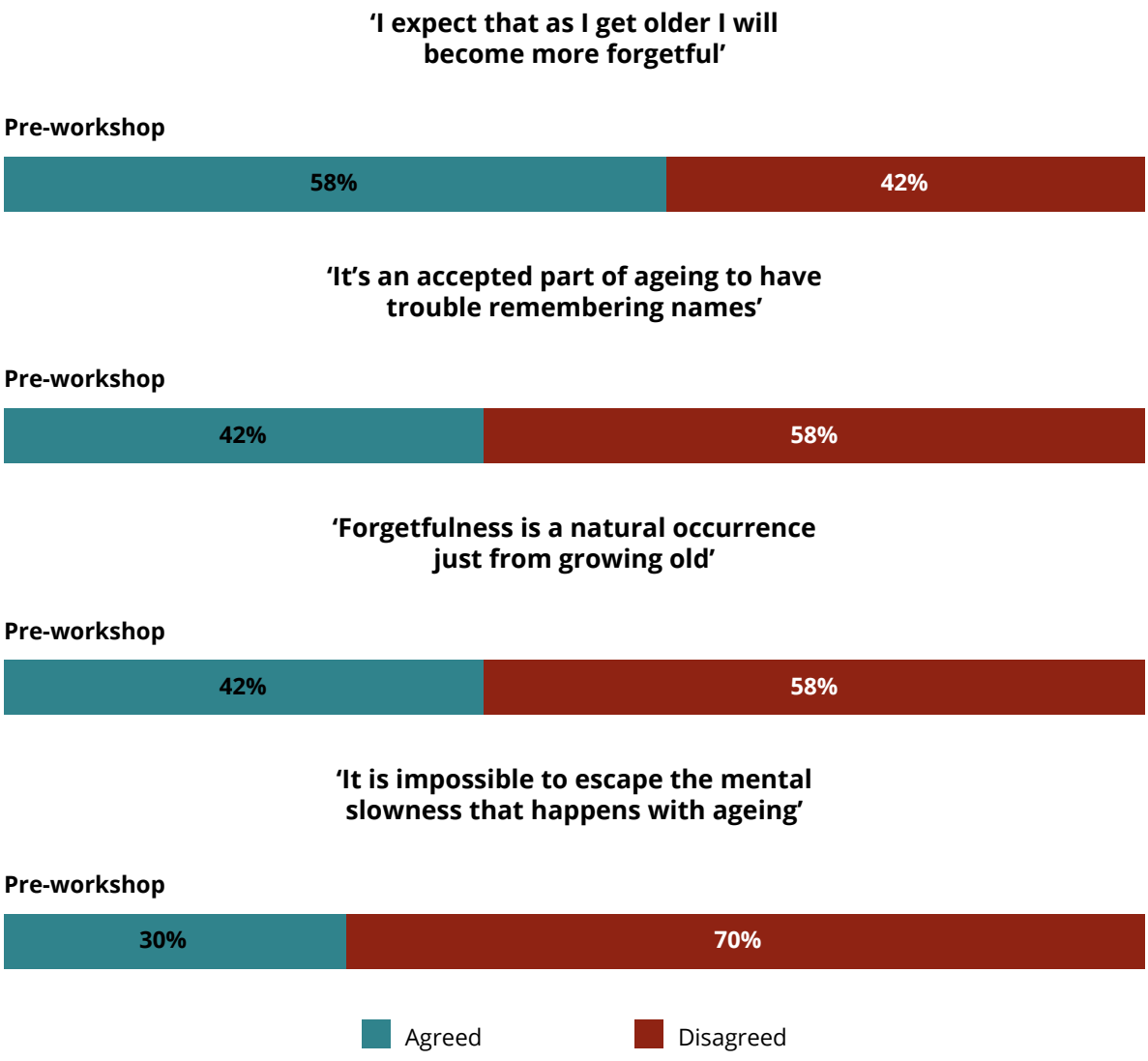


Most respondents held the view that mental health does not necessarily decline in older age. The statements connecting ageing with social and emotional changes, such as loneliness, social isolation and depression, were regarded by most respondents to be at least somewhat false.

In contrast, they tended to agree with the statements suggesting that physical health challenges are an expected part of ageing. 64% believed that having more aches and pains is a normal part of ageing and 66% agreed with the statement likening the human body to a car that gets worn out as it gets older. The only exception was the expectation that as people aged, they need to lower their expectations of how healthy they can be. Most respondents (73%) found this idea to be at least somewhat false.

All ageing adults experience changes in their physical health to varying degrees, but unrealistically high or low expectations among care providers could be detrimental to the quality of care provided. For example, the belief that some physical problems are just a part of the ageing process could lead to carers selectively attending to certain symptoms, while dismissing others. On the other hand, when care providers hold unrealistically positive expectations of physical health in older age, it may contribute to feelings of inadequacy among older adults and even lead to blame being placed on older individuals for any perceived or actual declines in physical function.[82]

Figure 10. Pre-workshop responses to ERA-12 statements related to cognitive function



Respondents' opinions were more varied about expectations of cognitive decline in older age. Responses to the statements associating forgetfulness with older age ranged from 'somewhat true' to 'somewhat false', indicating ambivalence regarding whether memory declines are to be expected with advancing age. The one exception was the statement, 'It is impossible to escape the mental slowness that happens with ageing', which around 70% of respondents considered to be at least somewhat false.

Ageing is a complex process that includes a wide spectrum of individual variations and trajectories. Research indicates that people's attitudes and expectations regarding ageing can greatly influence the way they perceive and interact with older adults.[83] While stereotypes about physical and cognitive decline in later life may be true for some older adults, they may not necessarily hold true for all older individuals. Assumptions of decline in physical and cognitive function with ageing may lead to stereotyping of all older adults, which can influence our attitudes and behaviours towards them.

Comparison of findings with other studies

The Commission found relatively low ageism scores among its cohort of aged care and community workers prior to the workshop. These results are comparable to the average scores reported in several other studies that also involved research participants who volunteered to take part. For example:

- An ageism study in the United States found similarly low scores on the AAS among its majority female sample of older (aged 60–80) and younger (aged 18–30) adults.[84]
- An Australian study found scores towards the lower end of the score range of the FSA among its participants, before they completed an intergenerational program.[85]
- A study in the United States found relatively favourable views of ageing among a sample of primary healthcare professionals, with total scores on the ERA-12 comparable to those from the respondents of this research.[86]

The pre-workshop survey results indicate that while respondents generally rejected ageist views and perceived older adults positively, they were also influenced by implicit stereotypes that portrayed older adults as vulnerable and in need of help. This is likely related to their expectations of age-related declines in physical and cognitive function.

Group discussions held after the workshops gave participants an opportunity to reflect on their perceptions of older adults and ageing prior to participating in the age awareness workshop. These findings are discussed in detail in the following section.

CHAPTER

15

Impact of the age awareness workshop

CHAPTER

5

CONTENTS

Key findings

- Workshop participants shared various life experiences, such as childhood observations, education, work and relationships, which have contributed to shaping their perceptions of ageing and older adults.
- Whether consciously or unconsciously, our behaviour is often guided by the assumptions and beliefs we hold. For those working in aged care and community settings, their interactions with clients may be influenced by their beliefs about ageing and older adults.
- Although respondents' scores on validated measures of ageism were relatively low prior to the workshop, significant further reductions in ageist views were observed immediately following the workshop. These decreases were maintained at follow-up two to three months later.
- After attending the workshop, respondents were less likely to accept age-related declines in physical health, mental health and cognitive function as the norm.
- Although the workshop resulted in improving ageist attitudes and ageing expectations among both CALD and non-CALD respondents, those from CALD backgrounds were more likely to endorse ageist views and have lower expectations of ageing throughout the study. Due to the relatively small number of CALD respondents, further research is recommended to explore these differences.
- No significant differences in outcomes were found between participants who attended an online session and those who attended in person.
- Qualitative data from open-ended survey questions and post-workshop discussions revealed that the workshop led to positive changes not only in participants' attitudes, but also their behaviour.
- Participants identified diverse groups of people who they believed would benefit from taking part in the workshop.

5.1 Participant reflections post-workshop

(a) Perceptions of ageing and older adults

Following the workshops, participants were invited to attend an online discussion session. Those who took part reflected on the perceptions of older adults and ageing they held prior to the age awareness workshop.

Some participants spoke about having respect for older adults' experience and history, while others described being influenced by negative stereotypes of frailty and decline, as well as positive stereotypes of older people as warm and endearing.

> Older people's stories, experiences, their history … it's something that is not shared enough or celebrated enough. Older people are a big untapped source of knowledge.
>
> **—Participant, age 52–60**

Recalling an activity that was done at the start of the workshop, which involved writing down five words that came to mind when they heard the term 'old person', participants reflected:

> I think initially my words were deficit-based, you know, frail, less energy, mobility issues.
>
> **—Participant, age 40–51**

> **I realised that all of my words were kind of endearing things like, 'cups of tea' and 'chats', and not really focused on competence and ability of people, but more like how lovely they are, which is such a stereotype as well.**
>
> **—Participant, age 40–51**

(b) Factors influencing perceptions of ageing and older adults

The existing research suggests perceptions regarding ageing and older adults are formed and shaped by a complex interplay of personal and social factors such as education, training, work environments, prior relationships with older adults and media representations of ageing and older age.[87] Consistent with the literature, participants of this research also shared various life experiences which had contributed to shaping their perceptions of ageing and older adults.

> Growing up, I had really good relationships with my grandparents and some older neighbours, and watching the way my parents interacted with them and how they treated older people … My relationships really influenced [my attitudes towards older people], and then possibly working with colleagues who really promoted those positive beliefs about ageing and working in teams that have promoted positive beliefs have really influenced me.
>
> **—Participant, mixed age group**

> The older people in my family had very chronic medical conditions … That did sort of make me concerned that that's what I would be like when I got older or that's what a lot of older people would be like [because] all I had exposure to were people in their 70s and 80s, who were really frail and unwell. Through my studies, I sort of realised that keeping active physically and mentally into older age is really important to maintain independence and can really promote health and reduce the risk of other medical conditions.
>
> **—Participant, age 23**

> I've worked with older people for a very long time … My whole career has been based on working with and caring for older people. As I've also aged and matured myself and become closer [in age] to the group that I care for and work with, my perspectives on ageing have certainly changed over time … both with my work experience and also with my personal life experience.
>
> **—Participant, mixed age group**

The perceptions of some participants working in aged care had been influenced by the nature of their work, which tended to limit their interactions with older adults to those who are experiencing physical and cognitive impairments.

> **I have 140 clients. 5 days a week, 40 hours a week I'm working in aged care … so I think probably at the moment [my views] are coloured by the demographics that I'm working with and that is how I see getting older.**
>
> **—Participant, age 61+**

> When you work within the nursing space you see the unhealthy side of ageing or more of the bad things that people go through, and you don't see so much of the good stories … I've probably got some negative attitudes about ageing not for any other reason than I see so much of the downsides of it, not the positives.
>
> **—Participant, mixed age group**

Other participants acknowledged their work exposed them to a subsection of the older population who are experiencing more physical and cognitive challenges, but stated this did not significantly alter their perceptions and expectations of ageing.

> On one hand [working with dementia patients] skews me to not see the whole population out there that's ageing, I see maybe a section [who have dementia] and because my own mum had dementia and so that was obviously an influence too … but … I don't particularly worry about getting dementia or being in that situation. I feel like if it happens, hopefully I'll manage it somehow. You certainly know about all the things that can go wrong as you age, but because I'm in this environment and I work in a hospital, I work with geriatricians, you also learn about the sorts of things that might counter some of those issues. Perhaps you get the balance that way … I don't think I fear getting older.
>
> **—Participant, age 61+**

> I don't think working in aged care has necessarily changed my thoughts around ageing and older people.
>
> **—Participant, age 52–60**

For others, their work or volunteer role in aged care and community settings enabled them to recognise and dismantle the biases and stereotypical ideas they had of older adults. These participants spoke about getting to know their clients as individuals beyond the stereotypes, which in turn, changed their views of older adults and ageing.

> [Working in aged care] You do sort of have those preconceived ideas, but once you realise how amazing these people are and that they shouldn't be written off and they shouldn't be stereotyped, it evolves really quickly.
>
> **—Participant, age 40–51**

> I would have to say I'm guilty of a lack of knowledge prior to having worked in this role with seniors. I would even put myself down as arrogant … I don't like the person I used to be with my attitudes towards seniors … My outlook has completely changed.
>
> **—Participant, mixed age group**

Working in aged care has very much helped me to break down those preconceived notions and ideas that I had about ageing … I suppose before I started working [in aged care], I was quite ageist.

—Participant, age 61+

I definitely had the assumption that being old meant everything just gets worse, you become frail, you have no autonomy but after working with older people and speaking to them day in and day out … These people are like the strongest people ever. They push themselves but they [also] know their limits.

—Participant, age 25

Older participants shared their personal experiences of ageing and how they became increasingly aware of ageism around them, and directed at them. It appeared that for these participants, their attitudes and views of older adults and older age had evolved through their own experiences of ageing and ageism.

As I'm ageing … I can't do the things that I used to do when I was a 20-year-old, but it doesn't mean that I'm still not able to achieve goals that I set for myself … They might take just a little bit longer but it's not impossible.

—Participant, age 61+

This idea that at 72 you're elderly and you're incompetent and you're doddery … I'm 72 and that's what I find so frustrating. People say to me, 'You don't look 72'. Well, this is what 72 looks like. Get over it.

—Participant, age 72

Now that I'm starting to age … you sort of start to feel more aware of other people's perceptions of you. When I tell people my age, they would say, 'Oh I never would've guessed that' and to me, that's displaying ageism.

—Participant, age 61+

On a daily basis now, I face ageism in the workplace. When it first started happening to me, it really did come as quite a shock.

—Participant, age 61+

For these participants, their experiences of being stereotyped as an older person reinforced the importance of recognising the great variances that exist among older adults and treating each person as an individual, rather than making assumptions about people based on their age.

I've met people who are in their 90s who are still very fit and others who are 60 and very fragile. [Older age] is a very broad spectrum.

It's about looking at everyone as an individual.

The way [the media] labels an older woman as a grandmother … What's that got to do with anything? You can be a grandmother at 34!

You can't think of all 90-year-olds as frail and tired and not able to do much for themselves because there are certainly 90-year-olds who are still living on their own.

—Participants, age 61+

(c) Impact of age stereotypes on interactions with older adults

Attitudes and beliefs about ageing and older age can influence how we perceive and interact with older adults – whether consciously or unconsciously. For example, research has found that in healthcare settings, clinicians' age-based assumptions and stereotypes about older patients can result in them being denied access to treatments and procedures, and excluded from clinical trials.[88] Such bias is often unintentional and occurs without conscious awareness by the person who holds the view.

For those working in aged care and community settings, stereotypical beliefs about ageing and older adults can influence their interactions with the older clients they support. Reflecting on their past interactions with older clients, participants discussed instances where their attitudes and behaviours had been influenced by stereotypical beliefs about older age and older adults – for example, providing assistance without being asked, communicating differently, taking control, and offering or not offering certain activities or programs.

When we talk about older people, [the words] 'weak' and 'frail' come to mind … Sometimes we might offer more help than what they want or need. We might not respect their capabilities … yeah, we do sometimes offer help before people ask for it.

—Participant, age <40

Sometimes when I meet older people, they look really frail and they don't move very well. So you tend to think maybe the mind is [also] not well when it really hasn't changed … so you can be sort of talking down to them when you don't really need to.

—Participant, age 40–51

I probably try to take more control and fix the issues that I see. I would say [to a client], 'We need to do A, B, and C …' because that is my solution to their problem.

—Participant, age 46

We were making choices about our service delivery based on assumptions about our client population, over 80% [of whom] are over 65 [years of age]. One example is that the clinic can send out text reminders of appointments and our team didn't, because the assumption was that the majority of our clients wouldn't use a mobile phone or know how to respond to a text message to confirm … because of their age.

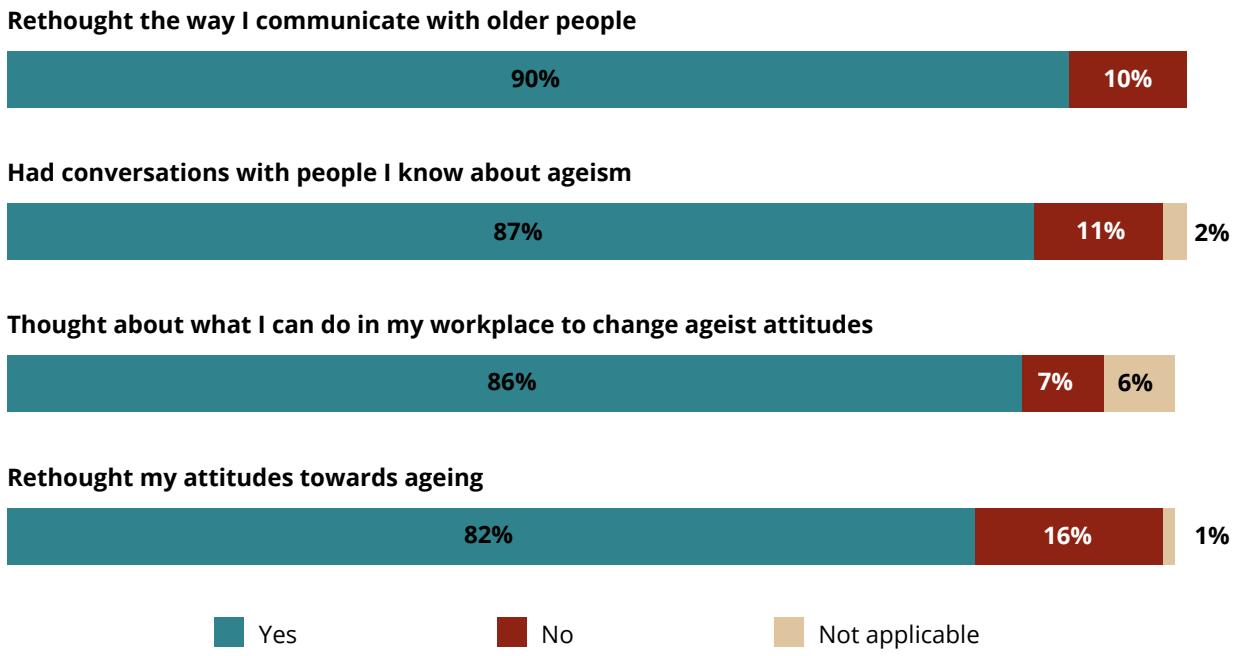
—Participant, mixed age group

5.2 Changing perspectives on ageing and older adults

Comparisons of scores from pre-workshop and post-workshop surveys found statistically significant reductions in ageist views and improvements in attitudes regarding ageing among respondents upon completion of the workshop. Across all measures of ageism and ageing expectations, these changes were found to be maintained at follow-up, 2–3 months later.[89]

In the follow-up survey, respondents were asked a series of questions about how their attitudes and behaviours had changed following the session.

Figure 11. Changes following the workshop

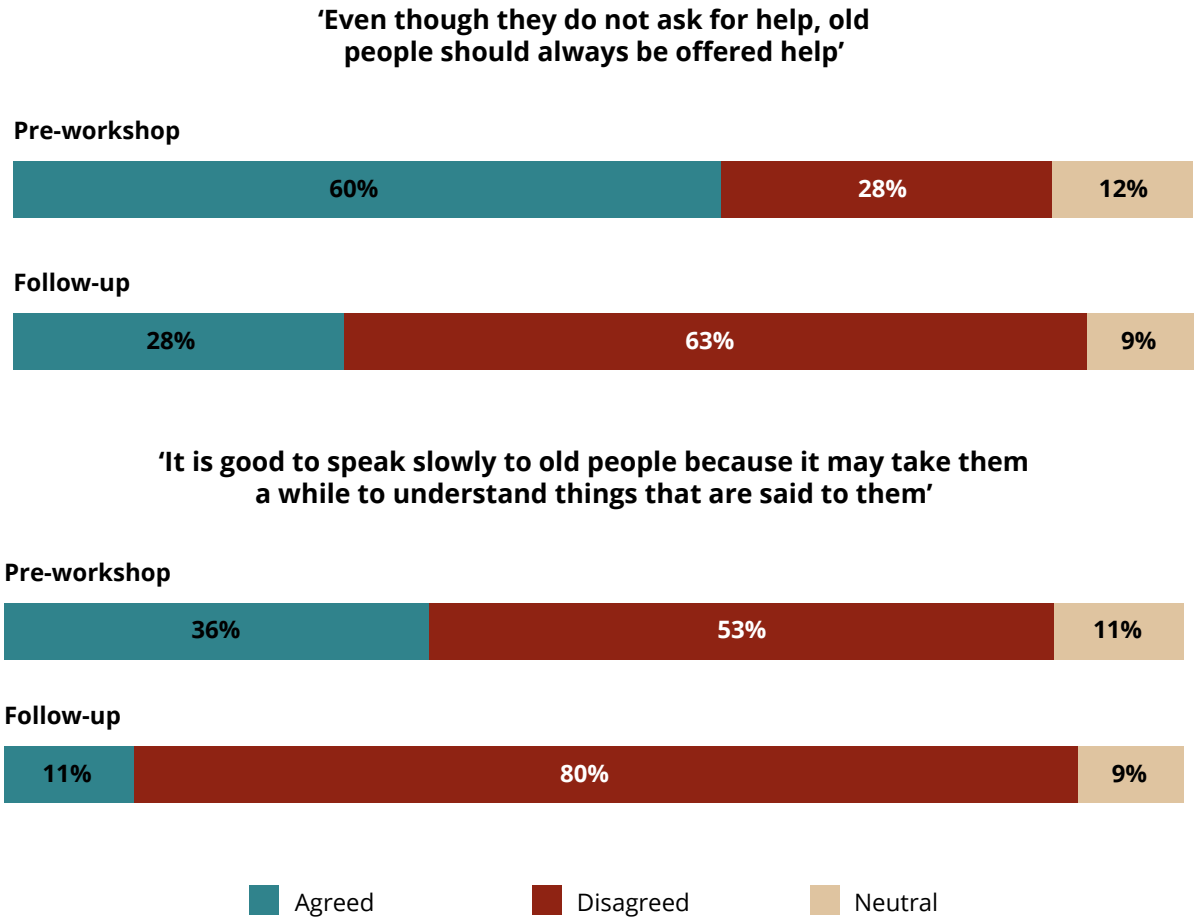


For the vast majority of respondents, the workshop had triggered positive changes in their thoughts and behaviour. For example, 90% of respondents reported rethinking the way they communicate with older adults after participating in the workshop, and 87% had spoken about ageism with people they know.

(a) Ambivalent Ageism Scale

An examination of responses to individual items found that the greatest shifts in perception between pre-workshop and follow-up surveys occurred with the items related to benevolent ageism. This finding provides an indication of the specific areas where the workshop appears to have had greater impact.

Figure 12. AAS items with the most notable changes in perception

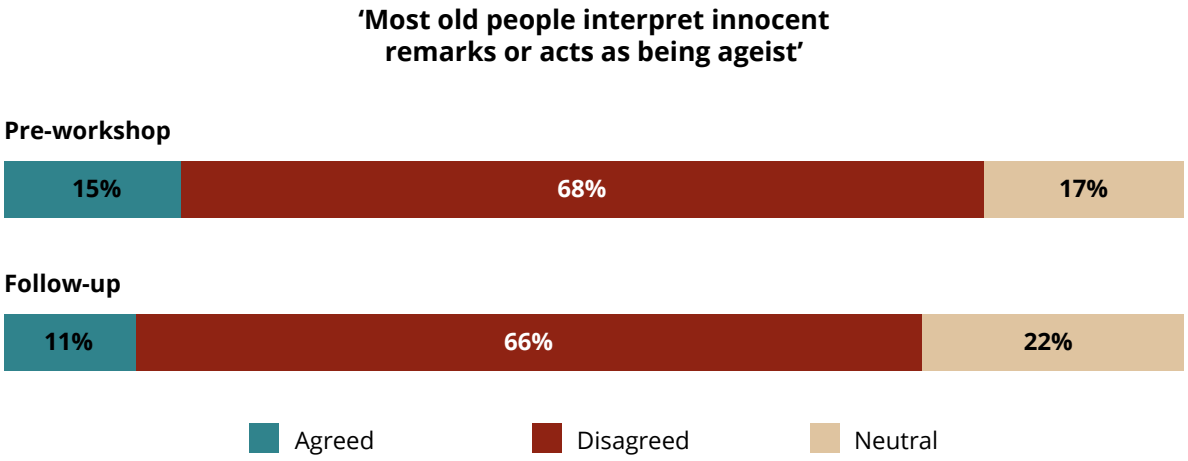


In the pre-workshop survey, almost 60% of the respondents at least somewhat agreed that, 'Even though they do not ask for help, old people should always be offered help'. At follow-up conducted 2–3 months after the workshop, a much smaller proportion of respondents (28%) agreed with this statement.

Similarly, more than one in three respondents (36%) in the pre-workshop survey agreed with the statement, 'It is good to speak slowly to old people because it may take them a while to understand things that are said to them'. At follow-up, only around 11% endorsed this statement.

These results showing more substantial reductions in benevolent perceptions of older adults than hostile attitudes, may be reflective of the content of the workshop. The workshop was constructed so that the content, such as learning about the subtle ways ageism is expressed in society and debunking common stereotypes about older adults, revolved more around the implicit and often benevolent forms of ageism, than explicit, more hostile expressions.

Figure 13. AAS item with the highest percentage of neutral responses



It is worth noting that while only a small number of respondents (11%) at follow-up agreed that, 'Most old people interpret innocent remarks or acts as being ageist', 22% selected 'neutral', indicating that more than one in five respondents neither agreed nor disagreed with this sentiment. Compared to the pre-workshop survey, this represents a slight reduction in the proportion of respondents who agreed with this statement (15% to 11%), but also a small increase in those who neither agreed nor disagreed (17% to 22%).

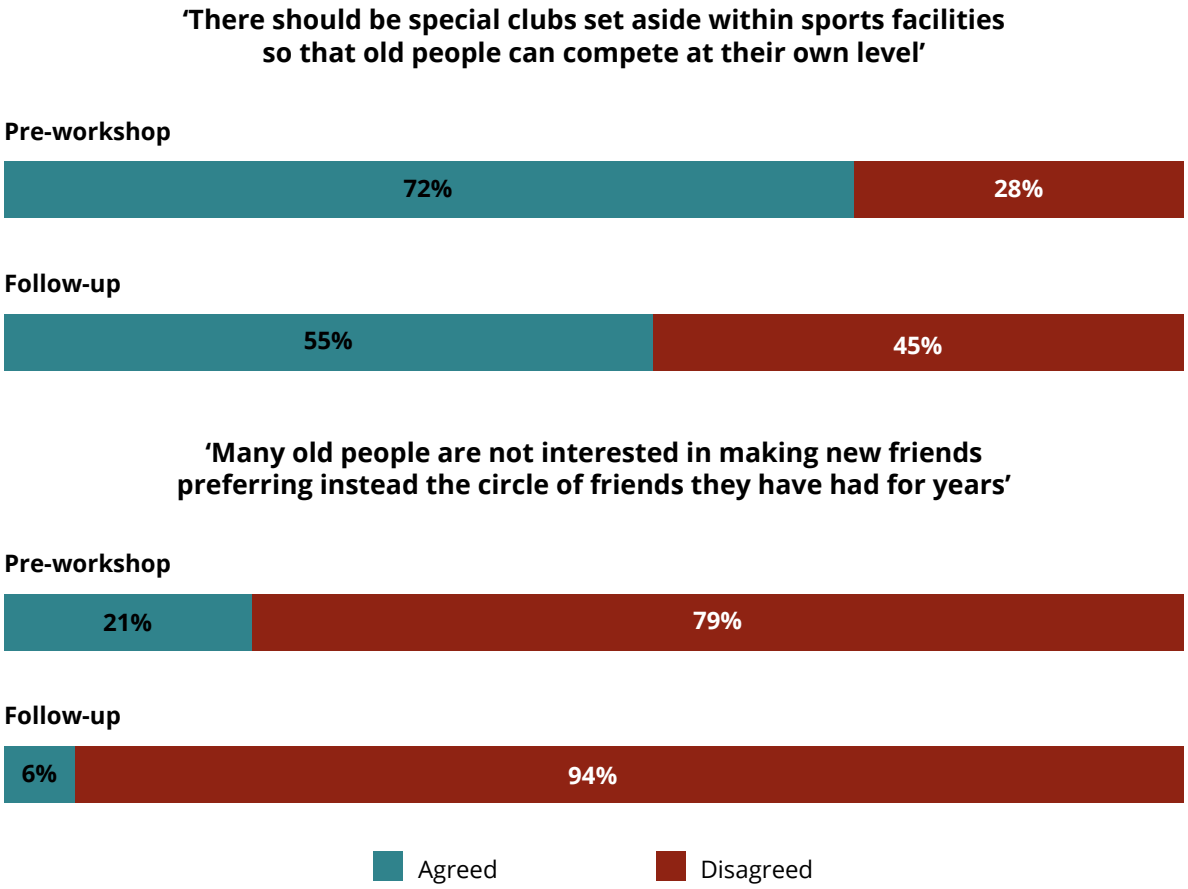
Unlike the ERA-12 or FSA, which forced respondents to either agree or disagree with the statements presented, the AAS included 'neutral' as a response option. The availability of a neutral option may have provided some respondents with a way to avoid answering a question they found difficult or uncomfortable, or for which they held ambivalent attitudes.

(b) Fraboni Scale of Ageism

Before the workshop, respondents generally scored relatively low on the FSA, which translates to low levels of antagonistic, discriminatory, and avoidant attitudes towards older adults. Despite the initial low scores, significant further reductions were observed upon completion of the workshop and sustained at follow-up.[90]

Figure 14 presents the statements that showed the most notable changes between pre-workshop and follow-up surveys.

Figure 14. FSA items with the most notable changes in perception



In the pre-workshop survey, most respondents (72%) agreed or strongly agreed there should be special clubs set aside for older adults within sports facilities. At follow-up, a smaller percentage of respondents (55%) supported this idea. Although this statement is intended to assess discriminatory attitudes against older adults, it likely also captures benevolent attitudes – particularly relating to overprotective and paternalistic treatment of older adults.

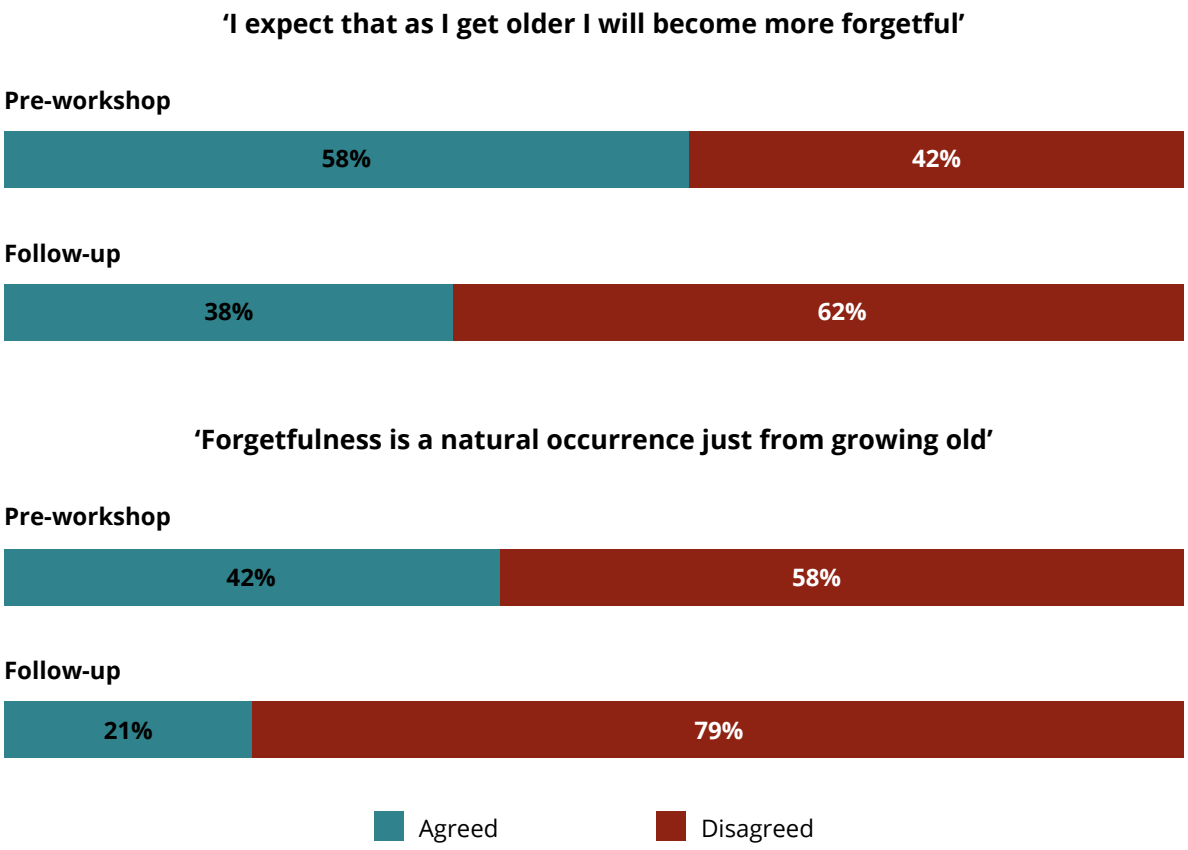
Another statement that showed considerable change was, 'Many old people are not interested in making new friends preferring instead the circle of friends they have had for years', which measures prejudice against older adults. Prior to the workshop, about one in five respondents (21%) agreed or strongly agreed with this statement, whereas only 6% of the respondents accepted this view at follow-up.

These results indicate a reduction in discriminatory attitudes and prejudice against older adults following the workshop.

(c) 12-Item Expectations Regarding Ageing Scale

Comparisons of the average scores from pre-workshop and post-workshop surveys found that respondents' attitudes regarding ageing became more positive upon completion of the workshop and remained as positive at follow-up, 2–3 months later.

Figure 15. ERA-12 items with the most notable changes in perception



The statements related to cognitive function in older age, which initially generated more ambivalent responses, showed the most substantial changes between pre-workshop and follow-up surveys.

In the pre-workshop survey, around 42% of the respondents agreed that forgetfulness was a natural consequence of getting older, whereas at follow-up, a substantially smaller proportion (21%) believed this to be true.

Similarly, more than half of the respondents (58%) in the pre-workshop survey thought the statement, 'I expect that as I get older I will become more forgetful', was at least somewhat true. The agreement rate was considerably lower in the follow-up survey, with around 38% agreeing with this statement.

In the workshop, some common misconceptions related to ageing and cognitive abilities were debunked using scientific and population data. It is likely that these discussions contributed to the shift in respondents' attitudes and expectations regarding cognitive function in later life.

(d) Workers from culturally and linguistically diverse backgrounds

It was observed that respondents who reported speaking a language other than English at home had higher average scores on the AAS and FSA and lower average scores on the ERA-12 than those who only spoke English.[91] These results indicate that among the participants of this research, those from culturally and linguistically diverse (CALD) backgrounds held more ageist views and lower expectations regarding ageing than did workers from non-CALD backgrounds.

Although the workshop resulted in improvements in ageist attitudes and ageing expectations in both CALD and non-CALD respondents, the differences between these two groups persisted across the study.[92]

On the AAS, the group differences appear to have been driven primarily by scores on the benevolent ageism subscale, rather than the hostile ageism subscale. Across all surveys, workers from CALD backgrounds had a higher tendency to agree with the statements displaying benevolent ageism, such as:

- 'Older people need to be protected from the harsh realities of society'
- 'It is good to speak slowly to old people because it may take them a while to understand things that are said to them'.

Although workers from CALD backgrounds displayed slightly lower expectations of ageing across surveys, the scores of both CALD and non-CALD groups on the ERA-12 fell within similar ranges, particularly in the two surveys following the workshop.[93] The differences were somewhat more pronounced on the cognitive function subscale. Respondents from CALD backgrounds were more likely to agree with the statements indicating that trouble remembering and decreased cognitive processing speed are natural consequences of ageing.

On the FSA, respondents from CALD backgrounds tended to have a higher level of agreement with statements demonstrating prejudice and discriminatory attitudes, such as:

- 'Most old people should not be trusted to take care of infants'
- 'Most old people should not be allowed to renew their driver's licence'.

However, it should be noted that a high majority of respondents from CALD backgrounds still disagreed with the above statements across all surveys (83% and 81%, respectively).

Given the relatively small sample size, particularly of respondents from CALD backgrounds in the follow-up survey,[94] it is important to approach these findings with caution.

Further research is recommended to explore whether cultural and linguistic diversity influences how scales, such as the FSA and AAS, are interpreted, and what impact this has on individuals' response styles.

(e) Workshop mode of delivery

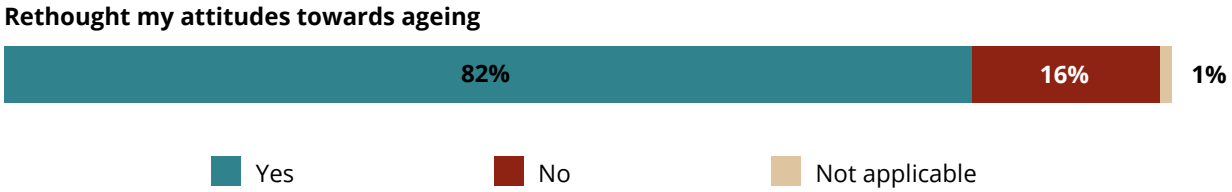
The online and face-to-face workshops had similar results in prompting positive changes among respondents. Across all measures of ageism and ageing expectations, both online and face-to-face sessions resulted in significant reductions in ageist views and improvements in ageing attitudes.[95] These findings suggest that online interventions may be a convenient and low-cost alternative to face-to-face interventions.

Overall, the quantitative data from the surveys demonstrates sustained, significant improvements in attitudes and expectations regarding ageing and older adults following the workshop.

Additionally, qualitative data from open-ended survey questions[96] and post-workshop discussions provided more detailed insights about the specific domains where the workshop had a significant impact or influence. These are discussed in the following sections.

5.3 Awareness

Figure 16. Proportion of respondents in the follow-up survey who rethought their attitudes towards ageing



For many, the workshop increased their awareness of age biases and ageism, which prompted a self-reflection of their own attitudes and beliefs about ageing and older adults.

I am much more aware of ageism now than previously.

I am more aware of my attitude towards ageing.

I have a much better understanding of ageism and how it is not just for seniors, but across all ages.

Personally, I have been much more attuned to my unconscious biases and assumptions around ageing.

I have mostly conducted a critical self-reflection to understand what I have been doing with participants of the program, and reflect on if I am acting ageist towards them and how best to ensure I am not.

—Survey responses

[The workshop] made me think about myself, as well as how I think about others.

—Participant, mixed age group

[The workshop] made me think about age bias a lot more … We often make assumptions [that] because somebody is an older person that they don't know [something].

—Participant, age 52–60

[The workshop] made me more aware of the preconceived ideas that I had. There were some personal biases that I had that I had to look at and realise that they were wrong. My attitude was quite limited, and I needed to open up my perceptions.

—Participant, age 61+

[The workshop] made me stop and assess myself.

—Participant, age 61+

This included recognising their own age biases and internalised ageism, which sometimes occurred automatically.

> **I do it without even thinking … [I would] think 'He's amazing for his age'. It's subliminal, like we're not even aware of it. A lot of these things are coming from the unconscious and we don't even realise the impact they're having.**
>
> **—Participant, mixed age group**

My attitudes towards myself changed [after the workshop]. Having conversations with other people who were quite comfortable about being older, whereas I have a challenge with that with myself … I sort of went home and thought, yeah, I do have a lot to offer and I can still do things. My knees might ache and my back might be sore sometimes, but don't focus on that part. Focus on all the positives and on what I can do and what I can achieve and all the stuff I've still got to offer. It was quite insightful for my own personal journey.

—Participant, mixed age group

For some participants working in aged care, the workshop helped them to recognise the age-based assumptions they were making about clients and encouraged them to focus on the person instead.

> **[The workshop] challenged some of the assumptions and how we think about the people that we are working with … I was making assumptions based on the person's age rather than considering who they are and what they might be capable of.**
>
> **—Participant, age 61+**

Instead of seeing that this person is a burden in life, I [now] look back to the longevity of this person. They have lived a long life, they add value to this society. It is not them [who] is the burden.

—Participant, age 61+

Case study: A new perspective on ageing

Shruti, aged care worker

Since participating in the workshop, Shruti's perceptions of older age have shifted significantly. Previously she thought that older age meant limited mobility and other health challenges that come with ageing, and living in an aged care facility.

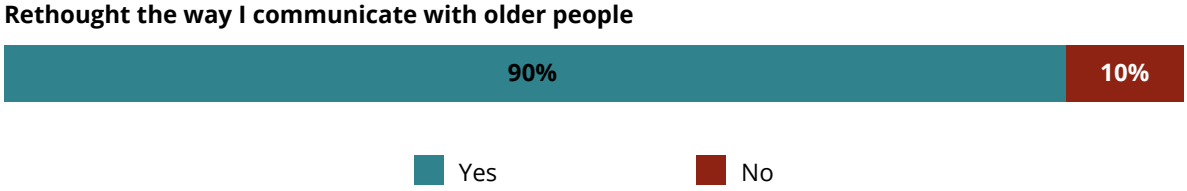
She now recognises that there are many more possibilities, which she has spoken about with colleagues and friends. She tries to get others to see that a lot of people remain healthy and active in older age.

She has also become more aware of the media promoting the idea of older adults as frail and older age as something to be resisted, while being younger is attractive and what you want to maintain. She is trying to remind herself that this is not true.

> [Before the workshop] My perception was that maybe the majority of older people lived in residential age care. [I now realise] that's not correct, the majority of older people live independently in the community. I've talked to my colleagues about how getting older isn't as bad as we think – that reality is different from what we think. We might have a more filled life. I'm more optimistic about my own ageing now.

5.4 Language

Figure 17. Proportion of respondents in the follow-up survey who rethought the way they communicate with older people



Language was a key theme in the qualitative data from open-ended survey questions and post-workshop discussions.

In the follow-up survey, respondents shared becoming more aware of ageist language – both their own and that of others around them. They commented on making changes to the language they use to refer to, and communicate with, older adults, including avoiding 'elderspeak' – a style of speech characterised by the use of simplified language, terms of endearment (eg, calling someone 'Love' or 'Sweetie'), elevated pitch, and slower pace.[97]

> I have changed how I talk about older people and have instigated change in the workplace by leading with example.
>
> The language I use has changed when speaking to patients who are older.
>
> I am more mindful and aware of the language I use and the way I speak with older people.

I have become very aware of how I address every person I meet. I address every person by their preferred name and have stopped using [terms of] endearment.

[I'm] changing the way I talk about age – where I previously thought it was a positive thing to say, 'You're so independent for your age' to clients over 90.

I have changed the language I use when talking about and talking to older clients.

> **Elderspeak – this is something I see and hear all the time. [It's] time to make a change and influence others to stop and focus on respect.**

[I will] review our policy, procedure, and induction process to make sure we clearly identify 'elderspeak' as unacceptable.

I have become more aware of 'elderspeak' when I see it.

I have spoken about the things I learned with my colleagues, including 'elderspeak'.

—Survey responses

Similarly, in the post-workshop focus groups, many participants discussed changing the way they communicate with older adults since the age awareness workshop. This included changing their language, style of speech, and how they address their clients.

> **I reflected on how I speak. Saying things louder and slower can be insulting.**
>
> **—Participant, mixed age group**

I was more mindful with my language … and the impact it may have.

—Participant, age <40

For me, even just using different language, it's been really helpful. [The workshop] made me check myself and think about what's coming out of my mouth.

—Participant, age 52–60

I think about, 'How would you like somebody to be remarking on your ability because of what their perception [of your age] is?'

—Participant, age 52–60

The fact that I never thought about asking [my older clients how they prefer to be addressed] is kind of upsetting now. You should always ask anyone what they would like to be called.

—Participant, age 25

I've double-checked the social media posts from [my workplace] to make sure the language is appropriate … I make sure we're double-checking the language before they're [posted] on the website.

—Participant, age 40–51

Case study: For your age

Near the beginning of the workshop, participants were shown a video about the inherent ageism in the phrase 'for your age'. In the post-workshop discussions, many participants mentioned how discovering that the commonly used phrase 'for your age'[98] – something they had either used themselves or heard someone else use – made implicit assumptions about a person based on their age, was an eye-opening moment that allowed them to see how ingrained ageism is in our society.

> None of us had really thought of that comment as negative … For all of us I think it was a light bulb moment … We are really conditioned to just think that it's a compliment, but it's not.
>
> **—Participant, age 52–60**

> That one was the most powerful … [I thought] 'Wow, I didn't even realise I'm doing it [being ageist]'.
>
> **—Participant, age 40–51**

> **[I thought] 'Oh wow, that is actually an ageism thing'.**
>
> **—Participant, age 52–60**

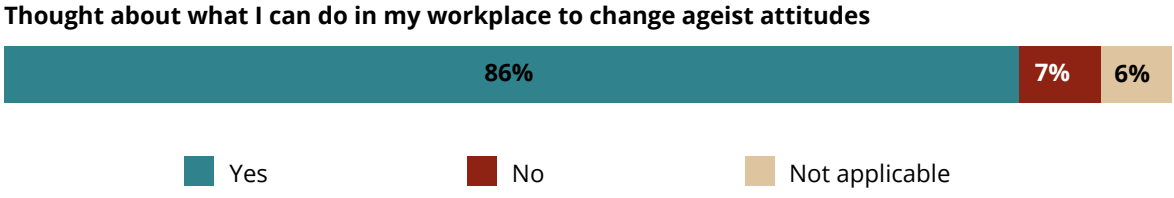
> I always thought that it was quite a nice thing to say and then you realise that well, maybe it's got other connotations that you need to think about. It made me think about how language can define your views and put people into categories.
>
> **—Participant, age 61+**

> Another revelation was around the language we use. Instead of saying, 'You look good for your age', why don't you just stop at 'You look good' … I would've never even batted an eye at that before but now [I realise] even though it's a positive comment, it's full of ageist elements.
>
> **—Participant, age 52–60**

> The video 'For her age' was an eye opener.
>
> **—Survey response**

5.5 Work approach and practices

Figure 18. Proportion of respondents in the follow-up survey who thought about how they could change ageist attitudes in their workplace



For some participants, reflecting on and recognising their own age-based assumptions led them to change existing practices or implement new ways of doing things in their workplace. These participants spoke about respecting their clients' autonomy and independence, and not making generalisations about clients' preferences and capabilities based on their age. They did this by listening rather than telling, and asking rather than doing.

> [I] have become much more reflective about my expectations for older clients and the implicit bias this is based upon. My increased awareness of this has helped me to consciously change my practice to try and negate this bias, so that I treat the client as an individual rather than a representative of the 'elderly'.
>
> It's definitely shaping the work that I do, by showing more respect and compassion, not making assumptions, and changing how I perceive the process of ageing.
>
> I don't assume older people need help by default [anymore]. I also acknowledge their capabilities and work around their needs with their consent.
>
> I have changed the way I speak to my clients and made it more about a collaboration rather than my suggestion of what help they should get.

[I have] a different perspective when working with older population – allowing and encouraging more self-management and control over their decisions.

> [I'm] more discerning of my judgement and awareness of my clients. My approach now is about what they are able to do.
>
> **—Survey responses**

> [Before] I would say, 'We need to do A, B, and C' … because that is my solution to their problem, whereas now … if there's an issue [I would say], 'What can I do to support you?', not 'This is what we're going to do'.
>
> **—Participant, age 46**

> I'm more reflective of myself … [I think to myself] 'Are we actually involving them [the clients] or are we telling them something?'
>
> **—Participant, age 43**

A number of participants shared how their team or organisation had implemented changes following the workshop.

> [As an organisation], we have increased the amount of opportunities for developing people's physical fitness and enhancing mobility through dance, yoga, etc. in our social support groups.
>
> **—Survey response**

> We use diverse images of people of various ages in our brochures, so our 65+ clients feel more included … [and that] their health conditions are not [seen to be] associated with age.
>
> **—Survey response**

> We do a case conference once a week where we talk about different clients. And one of the first things we always say is the client's age. [After the workshop] one of the things that we were trying to do as a team was to not mention how old our clients actually are when we're talking about all the other relevant factors. I still don't [mention the client's age], but I have noticed other team members have slipped back because it's just a habit and how we were doing things for so long.
>
> **—Participant, mixed age group**

The last example, referring to colleagues who subsequently returned to the previous approach, suggests a need to keep the learnings from the workshop salient and at the forefront of people's minds. Strategies may include regular reviews and reinforcement – for example, through team meetings and peer discussions; recognition and encouragement from management; and follow-up and refresher sessions to revisit and reinforce the learnings.

Case study: A reminder to keep an open mind

Kim, library outreach officer

For the most part, Kim feels like she is doing things right at work as a community outreach officer; however, the workshop did prompt her to think about trying new things and keep an open mind.

In particular, she reflected on how decisions are made in her workplace regarding the programs offered to older adults. She considered whether assumptions about older adults' preferences might be limiting the activities that are offered.

Recently, they ran a robotics program for older adults that they were not so sure would work, but proved to be a success. There was a great turnout; everyone got involved and appeared to be having fun, playing with the robots, and trying their hand at simple programming.

Kim and her colleagues initially doubted whether older adults in their community would engage with the robots, but with such a great response they are now looking to see what other things they could offer.

We didn't think they'd get engaged in that, but it was the best fun they had.

Case study: Changing work practices

Gemma, physiotherapist

Gemma works at a physiotherapy clinic with a significant number of clients aged over 65. Like many other appointment-based health services, this clinic has the option of sending people SMS reminders for their appointments.

The workshop prompted Gemma to reflect on personal assumptions and expectations about older adults, and question whether any processes and decisions in the workplace had been influenced by stereotypical thinking.

Gemma realised that the clinic did not offer SMS reminders as an option to their clients based on the assumption that the use of a mobile phone and text messaging would be low among older clients. She felt sad about taking away choices from these clients, feeling that they made 'that call' on other people's behalf, rather than asking and listening to their individual preferences.

> **Reflecting on this decision, it's pretty sad that we made that call on other people's behalf rather than actually asking them, but I'm glad we've changed it now.**

5.6 Recognising and calling out ageism

A number of participants found that the workshop provided them with the knowledge and confidence to identify ageism and in some cases, call it out. They also shared specific examples of intervening when they observed instances of ageism.

> I now have more confidence through the knowledge I gained in being able to call out ageist comments.
>
> I have felt more empowered to call out instances of ageism in the community.

I've mentioned to someone that I thought what they said was ageist. Generally, people are surprised and don't realise they are ageist but understand when you explain.

—Survey responses

> I have [called out ageism] since the workshop. It [the workshop] did improve my ability to call it out. Before, you'd hear something and you sort of think, 'That's not great', but I guess [the workshop] gave me the confidence to say, 'That's ageist and it's not healthy to say that'.
>
> **—Participant, age 28**

> [Clients] have said things to me since then [the workshop], like 'I'm doing pretty well for 75' and I've actually sort of said to them gently, 'It's how you feel, not how old you are'. It made me think about and challenge some of those views that might hold older people back.
>
> **—Participant, mixed age group**

> I reflected on the language that we use – 'Sweetie', 'Love' – and I heard this language as I walked past the front desk [at work]. We brought it up with the team so that they were made aware that this language isn't OK.
>
> **—Participant, mixed age group**

For some older participants, the workshop enabled them to identify and articulate instances of ageism they experienced in their lives.

> It's only because I've been in this [workshop] that I've been able to identify and articulate what is going on [as ageism] … [Now] I have the confidence to say, 'I am no less competent and no less understanding of what to do and how to do it, but I won't be doing it at the same pace as younger staff' and I understand I have the right to say that.

The workshop gives you a deeper understanding to stick up for yourself when someone assumes you're incompetent. Often your families are the worst, questioning whether you can do things when five years ago they wouldn't have questioned it. Having the deep knowledge gives you the confidence to call it out.

> [The workshop] deepens your understanding and encourages you to learn more and talk about [ageism] and call it out.
>
> **—Participants, age 61+**

Younger participants spoke about recognising ageist messaging around them since attending the workshop, for example, in the media, in advertisements, and in industries such as the beauty industry.

> The workshop gave me a different perspective on how we advertise our job opportunities. Like, how we think the workforce is made up of young people, while the reality is that people in their 60s and 70s are still contributing to society and they are still capable of doing so many things. I think it's time to be age-sensitive like we have been gender-sensitive for a long time. We are going to be the next [generation] to experience [ageism].
>
> **—Participant, age <40**

> [The workshop] increased my awareness of the wider societal messages we get … that older people are less capable, they are less than. I've noticed the ads … about all the negative things that happen to you when you're older … and anti-ageing cream for 40-year-olds.
>
> **—Participant, mixed age group**

> I find it particularly difficult to fight the societal expectations of women and young women, and support that there's nothing wrong with ageing and that it's a natural part of life. I think about it all the time now … about beauty ads and skincare and makeup, all of that … who is it targeting and who is it made to exploit?
>
> **—Participant, age 25**

Case study: Renewed confidence to call out ageism

Tristan, local council volunteer

Tristan, a retiree, who is now focused on reducing ageism and helping older people feel more connected, reported that the workshop boosted his confidence to actually tell people when they're being ageist.

While typically not hesitant to talk about ageism, Tristan did believe that the workshop gave him a new level of understanding and the language to identify and discuss ageism with others in his community.

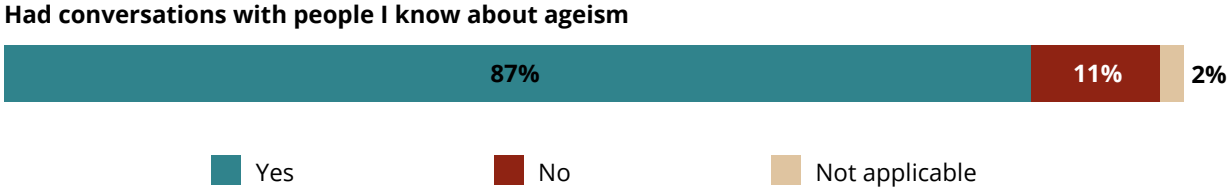
One example was at the bowls club with his friends, when he heard a friend make an ageist comment. While previously he may have let it go, he stepped in that time saying, 'Hey, do you know that what you just said was ageist?'. Then he explained why, all in a positive and constructive way, before conversation started flowing again.

What really struck Tristan was that when he was at the bowls club on a different occasion, that same person interrupted someone else to tell them that they were being ageist and explain why. He thought it was great to see that these lessons were being spread, rather than someone being 'told off' and dismissing it.

> **The workshop made me more aware, more able to identify an ageist comment and call out an ageist comment.**

5.7 Sharing the learnings

Figure 19. Proportion of respondents in the follow-up survey who had conversations about ageism with others



Many who attended the workshop reported sharing information from the session with others, such as their clients, colleagues, friends and family, which meant that the impact of the workshop extended beyond the participants.

I have had discussions about ageism with my colleagues and what that means and how it has been an accepted form of bias in the past and continues to be so – so we can work on this and educate to change.

I have presented education sessions on ageism and had more open conversations with peers since [the workshop].

I have talked with other staff about some of the things discussed, particularly the activity around language for older and younger people. This has had some mixed responses, but good to get people thinking!

I have discussed my learnings with my colleagues and friends (outside the workplace).

I have talked to my team about the things I have learnt.

I'm always referring to ageism being everyone's business.

I shared the information [from the workshop] with others.

—Survey responses

[The workshop] led us to do some sessions with our older clients and actually just talk to them about ageism and about what it means and how it's in everyday media. We looked at a slide that showed stories like Disney and how from very early on, children are taught the wicked witch is old and wrinkly, and how ageism starts so early and it's through everything – all through media and everything.

—Participant, mixed age group

I've caught my partner numerous times being quite ageist. I talked to my girls about it. They're 13 and 11. We had a conversation about the training and then they pointed out the ways they see different ages.

—Participant, age 40–51

I shared everything from [the workshop] with my team.

—Participant, mixed age group

I have shared with a couple of my colleagues. [I said], 'Look, we were thinking the reality was that most older people live in nursing homes, but actually the reality is most people live independently'.

—Participant, age <40

I said to management, 'You know what, we really need to be doing some workshops on ageism because we're working in aged care and ageism is everywhere'.

—Participant, age 61+

Case study: Helping clients to advocate for themselves

Jan, volunteer community visitor

Jan has two longstanding clients she visits and with whom she feels she has developed good relationships. One of the clients was curious about what Jan had learned and discussed during the age awareness workshop she had mentioned attending.

Jan explained that one of the topics covered in the discussions was that older adults should have a say in how they spend their time, that they should be able to do things or activities they enjoy, and have more control over their life. This reminded Jan about powers of attorney and she had a conversation with her client about when the appointments made under a power of attorney come into effect.

During that discussion, Jan made sure to ask whether the client was, in fact, doing activities that she wanted, which she was assured was the case.

Since the initial discussion, Jan has noticed that this client is much more open to directly discussing what they would like to do and advocating for themselves, rather than relying on their children as go-betweens.

Jan believes sharing this information about older adults having more agency and having the discussion about powers of attorney, helped her client gain more confidence in advocating for their own needs.

> My client remembered that I went on the training and they asked, 'Oh how was it?' and I then started to talk about it … they were really excited about the idea that older people [should] have the freedom to do what they want to do, and it reminded them to keep on talking about it.

5.8 Reinforcing and extending existing knowledge and practices

Some participants reported already having knowledge about ageism and prioritising non-discriminatory behaviour and practices prior to attending the workshop. For these participants, the workshop did not offer much in the way of new information or insights, rather served to reinforce existing beliefs and practices regarding older people.

> It's hard for me to say whether the workshop changed my behaviours or opinions because that's kind of what I do all the time anyway, so I suppose it's just more reinforced what I already do.
>
> **—Participant, age 40–51**

> I noticed [after the workshop] that I've been doing my job in a right way, so [I will] probably keep doing the same.
>
> **—Survey response**

Several participants mentioned that, while they already had the awareness, they found the workshop to be a useful reminder of the need to keep checking for age-related biases in their work and interactions.

I felt like [the workshop] was that jolt, that reset to remind you … Sometimes you're so busy doing the things that you do that you don't stop and actually think about what you're doing … It [the workshop] was about keeping those important things top of mind when you're doing things.

—Participant, age 43

It was good to get a refresher because it triggers things in your own thought processes. We all get into routines with our work, especially because we're so busy. It's just a constant pressure to churn through the workload. So yeah, it's good to have things fresh, because when you fall into those routines, that's when you start to fall back on things you hear from other people around you. You can start to use terminology and phraseology that you hear around you [that] isn't necessarily good and you might not even realise it. That session was good because I came away thinking, 'Oh I heard someone on the ward say that to that lady and I didn't say anything' or 'I nearly called someone that term of endearment'. It helped me to sort of refocus, refresh, and have things on my mind a bit more for when I'm interacting with people.

—Participant, age 40–51

It was more 'just keep monitoring yourself, checking yourself'. Fundamentally I think I treat everyone respectfully and equitably. It was just maybe a little bit of language and where it's the softer stuff that's not so overt … just to watch that stuff. There was no light bulb moment of, 'Oh, I've been really discriminatory or really patronising, or thinking someone's less capable', [because] I never have. There wasn't a big shift. It was about watching some of the softer stuff.

—Participant, 52–60 years

5.9 Groups who would benefit from the workshop

All participants stated they would recommend the workshop to others, regardless of how much they found it useful for themselves.

Participants identified diverse groups they thought would benefit from the workshop, ranging from aged care workers, healthcare providers, public servants and policymakers to high school students and anyone who works with or provides services to older adults, as well as older individuals themselves.

I think [the workshop] would be really good across the aged care sector … people in IT, in admin, in allocations, all different roles.

—Participant, age 40–51

I would love to see [the workshop] rolled out in hospitals, GP practices … make it open to the whole public health system, because how many times do they say [in the health system] to not do something because the person is too old or it's too risky and forget about the actual person.

—Participant, mixed age group

I'd like to see [the workshop] in high schools. I think they would really benefit from it and maybe a lot of them might actually volunteer to go in and spend a bit of time with older people.

—Participant, age 52–60

There is a real need for that workshop, particularly in workplaces where the customers are older people [for example] the government. In my organisation, we had a look for training and there really isn't anything out there that is suitable for everyone. This fills that need, for anyone across Australia.

—Participant, age 61+

Anyone who works with older people should do [the workshop].

—Participant, mixed age group

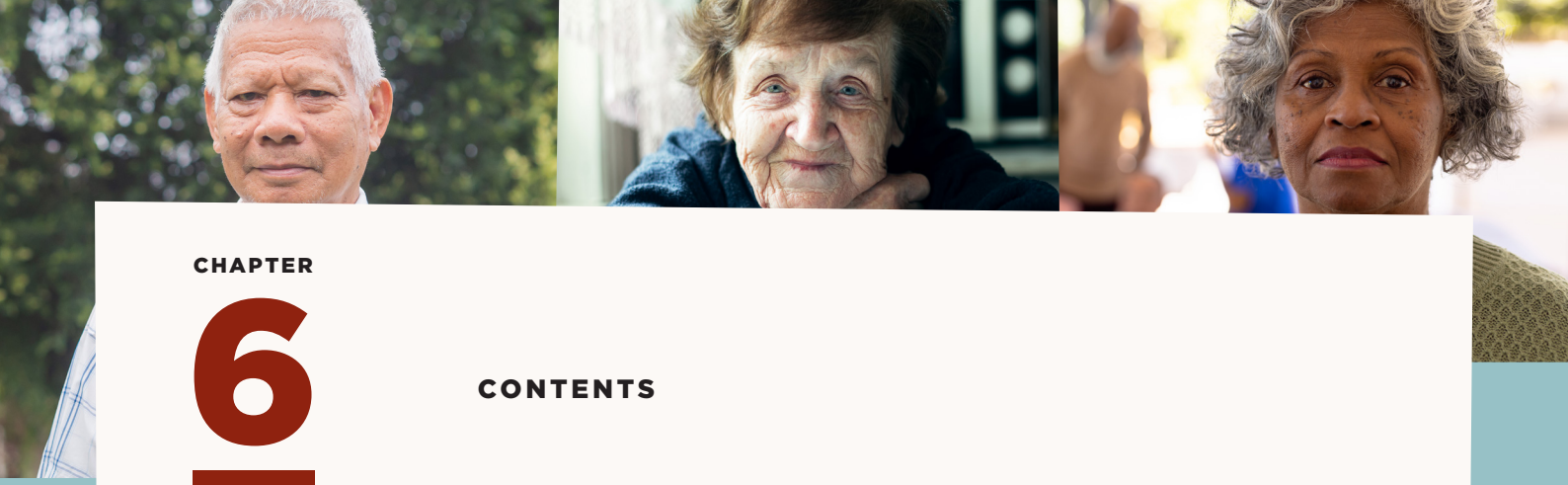
There is no set group [who should do this workshop]. People from all age groups and all professions need to learn [about ageism]. You can't just pick one particular group and teach [only those people] to be age-sensitive.

—Participant, age <40

CHAPTER

6

Conclusion



CHAPTER

6

CONTENTS

6.1 What we learned

This research set out to examine the attitudes and expectations regarding older adults and the ageing process held by workers in aged care and community settings. It also aimed to assess the effectiveness of a brief, targeted awareness session in promoting positive changes among a group of aged care and community workers.

The data builds a complex picture of positive and negative attitudes and perceptions about older adults and ageing. These beliefs appear to be shaped by personal experiences and broader social attitudes, and influence the interactions people have with older adults.

(a) Perceptions of older adults and ageing

On average, the aged care and community workers who participated in the research reported relatively low levels of ageism before the workshop. However, the Commission's findings suggest that benevolent stereotypes of older adults as warm and deserving of compassion, but less capable than younger individuals and in need of protection, persisted. These views are likely associated with participants' expectations of functional decline in physical and cognitive health in older age. The perception of older adults as warm but lacking in competence is consistent with previous studies.[99] The Commission's *What's age got to do with it?* research also found that most adults in Australia have a positive overall attitude to older adults, but considered them to have declining skills and lack competence in many areas.[100]

The Commission found significant improvements in ageist attitudes and ageing expectations immediately following the workshop, and these changes remained at follow-up 2–3 months later. Greater improvements were observed in domains of benevolent ageism and expectations regarding physical and cognitive function, where initial attitudes among respondents had been more varied. These findings suggest that the workshop was effective in shifting perceptions, particularly among those who initially held more ambivalent and subtle views.

(b) Impact of age stereotypes on interactions with older adults

Following the workshop, participants were able to reflect on their past interactions with older adults and recognise instances where they had been influenced by age-based stereotypes and prejudice. Examples included making decisions about services based on assumptions about older adults' capabilities and preferences, providing assistance without being asked, adopting a different style of speaking, and taking charge instead of providing support.

Post-workshop discussions and surveys revealed that the workshop led to positive changes in participants' interactions with older adults. Key changes included avoiding making assumptions based on age, changing the language they use (eg, not using elderspeak, avoiding making unnecessary references to a person's age), and being more collaborative in decision-making. Participants also reported recognising and treating each older person as an individual, respecting clients' autonomy and independence, and focusing on a person's capabilities rather than their limitations.

(c) Impact of age awareness workshop on attitudes and behaviour

Consistently with previous studies,[101] the Commission's findings provide support for the effectiveness of an educational intervention in reducing misconceptions and prejudice against older adults and older age. Furthermore, qualitative data from the open-ended survey responses and post-workshop discussions revealed sustained changes not only in participants' attitudes, but also in their behaviour as a result of the age awareness workshop.

Behaviour change is a gradual process that occurs over time. According to the transtheoretical model of change, individuals who have no intention to change their behaviour are said to be in the precontemplation stage.[102] These individuals are generally unaware or have limited awareness that there is a need to change anything, meaning it is important for interventions to focus on raising awareness of the issue as the first step towards behaviour change.

The Commission's findings suggest that a brief educational intervention can generate attitudinal and behavioural shifts, and serve as an effective tool for reducing ageism – though further research is required to understand long-term effects.

6.2 Ways forward

(a) Education and awareness-building

The Commission's research provides important insights which can inform policy and practice regarding reducing ageist stereotypes and assumptions, not only among workers who provide services to older adults, but also among the broader public.

While the workshop was designed to target workers in aged care and community settings, participants suggested it could be adapted and expanded to benefit a broad range of individuals, such as young people, those working in customer service, health professionals, public servants and policymakers, as well as older adults themselves. The Commission agrees with these suggestions.

Ageism is complex and often covert. Ageist sentiments tend to be subtle and go unnoticed, by both the individuals responsible and those it is directed at.[103] The Commission's findings underscore the value of education and raising awareness about ageism to inform and engage people. Furthermore, they reinforce the need for governments, businesses, and institutions to introduce, scale-up, or continue to fund initiatives that address inaccurate stereotypes, reduce prejudice, and enhance empathy.

(b) Areas for further research

The results of this research demonstrate the potential value of a brief educational intervention in improving people's attitudes and behaviours towards older adults. These results do not represent conclusive evidence, rather they provide a solid foundation upon which further research may be based, for example, among larger and more diverse samples and tested over a longer time period.

While it was beyond the scope of this research, there is a need for future studies to investigate cultural and linguistic factors that may influence attitudes towards older adults and ageing, as well as how scales measuring these constructs are interpreted. Previous studies have found cross-cultural variations and similarities in perceptions about ageing and older adults,[104] and the Commission's results also suggest there may be cultural differences, but also areas where expectations may be more aligned.

Similarly, the intersectionality of age with other social identities such as race, gender, sexuality, and disability, and the ways in which these intersecting identities shape experiences of ageing and ageism for older adults, are important areas warranting further research.

In their own words

The following are excerpts from interviews with 14 older adults, who shared with the Commission their experiences and thoughts about ageing. With their permission, direct (and translated) quotes are presented, along with a name provided by each individual, to give voice to those with lived experience.

I don't want to sound flippant, but the best [thing about ageing] is waking up every morning. All the more so, because on November the first last year, I had a stroke and I didn't wake up until November the second, and a whole 27 and a half hours went out of my life. And I came to appreciate how important time is, that each day is important. On Tuesday night I had a pub dinner with 8 or 10 people, we talked around the table and were all laughing – it was just delightful to be able to do that.

There are disappointing things. They've taken away my driver's license because I'm on a particular medication and that means I have lost my independence. I'm dependent on my partner and I've got to say things like, 'Could you take me to the pharmacy so I can get the bloody drugs that I've got to take that stopped me from driving'. That's annoying.

I'm surprised at how quickly I've aged. When I was 70, I felt I was very active, very able. Very, very busy, still working. And then I don't know where the last 10 years have gone. I was travelling frequently. And then I felt I was really unable to do so. But on the other hand, I'm glad to be growing old because it means I'm still alive. I refuse to lose my sense of humour. And to me, that's been the driving force – I can still laugh at myself.

—Ian, 80

What's good [about ageing]? I don't have to rush so much. I'm still busy but I don't have to go rushing around quite so much as when I went to work, and then came home and looked after the family. I'm on dialysis three times a week and I'm quite tired then, but the other days is doing all the normal things, washing, shopping, cooking and all that sort of stuff. And I go to ukulele. I think it's important for the elderly to get activities they like doing.

I still feel that my brain is going okay. And that's lucky because my body's given up the ghost a bit. I still feel positive. I've met old people who are very grumpy and sort of depressed, and I'm very grateful that I'm not like that. You'd think I'd be really depressed, but I just look at each day and I'm grateful for each day. And I'm very grateful to live in Australia with the medical care.

I think it's a decision. I'm not saying I'm happy all the time. Yeah, there are times when I do get depressed. And there are things that I missed out on doing. I would have loved to do the Amsterdam to Budapest river cruise – that's probably my one regret, travel. I think every person has regrets about things they haven't done, or things they have done that they wish they hadn't done.

—Mara, 80s

The good thing about my age is that I saw my daughter grow up and start working in society. I have four grandchildren to play with and look after. One of the grandchildren has a disability and I'm able to help look after him.

The bad things are … I'm now walking slowly and everything has slowed down. And sicknesses are coming up. Now I go to the doctor more often and I'm slower to do things. I had a double knee replacement 10 years ago and now it's the shoulder.

What's been surprising about being this age is maybe my driving – that I'm not driving anymore. After my cataract operation, my right eye isn't good, so I cannot drive. It's not convenient. My doctor says I'm getting glaucoma so now a specialist is looking after me. I hope one day I can drive again. My left eye is still good.

I have my religion and it's helping me a lot. I conduct an all-age fellowship every two weeks. It's great. I'm a busy grandmother and happy.

—Dorcas, 74

I was quite looking forward to retirement because I was a workaholic. And as I got older, I grew tireder. And my health was getting poorer. And so at 63 I was just happy to stop, which meant reading more and collecting books and sleeping. I've always had an interest in politics and economics. And it's interesting to watch it all play out over time, to watch the patterns that change over time … reflection is probably the greatest joy really.

The worst thing is the deteriorating body because most of the struggles of old age have to do with my decreasing capacity to physically do much. My time is mostly taken up with washing and ironing and scrubbing and cleaning, one has to shop and one has to cook and all that. Maintaining myself has pretty much taken up my time. I'm not reading the way I used to and I'm not going to as many galleries. And so there's a certain resignation about it.

I guess the surprising thing is speed at which time passes as you get older and frail, and sleep more. Suddenly I'm 13 years older than when I retired. I imagined I'd be an old man at 76. And I'm surprised I am. Now I collect doctors, the way I used to collect books. Maybe if I moved to a nursing home, I'd have more time to read.

—Ray, 76

I'm thankful for the supports and the social welfare that are available for older people. I also find that people are generally respectful towards older people.

I'm thankful for Medicare. As you get older, you do have more health needs but there are things that Medicare doesn't cover. Many older people don't have the ability or the resources to pay for treatments that are not covered by Medicare. This is worrying.

Some older migrants, especially the ones who haven't been in Australia for very long, miss out on necessary supports and services. There are also people who have been living in Australia for a long time but don't qualify for government-funded services because of visa rules.

Unlike younger people who are able to work to generate an income, many older people aren't able to work and need to rely on government support. I think there should be special consideration given to older migrants who have been in Australia for a long time, but their visa status prevents them from accessing social services.

—Anna, 80

At my age, you try to understand as best as you can, the things that happen to you in life and in the world around you ... to try and make sense of everything.

The bad things about ageing are the pain and the loneliness, sometimes. And the services that aren't there to help you. Everyone likes to talk, talk, talk, but when it comes to the crunch time, there isn't much action, and you need to fight to get things. But as you get older, you don't always have the energy to fight for everything.

I wish the government would take more notice of older people. It's because of older people that we are where we are today. All the hard work and contribution we made – during the war, after the war, and the reconstruction.

We never had anything given to us on a silver platter. We have always worked very hard, and we still do. I hope the government takes notice of this.

—Maggie, 80

I think in lots of ways, ageing is bloody awesome. I feel so blessed to be getting old. I have more freedom, I'm not as worried about how I look. People complain and say, 'Oh, we're ignored' or 'We're not noticed in shops', but I quite like the anonymity.

The downside? I put on weight easier. And you think about how you're going to die. And losing friends is really hard. Like my best friend for the last 30 years, she died of small cell carcinoma three years ago. There's a lot of grieving, looking back and thinking, I made bad decisions there and there. I think there is a pervading sadness, that you're no longer going to be having children and babies in your arms. You've got the grief of events, because as you get older, there's more and more life events that you're having to incorporate.

I thought I'd still be in a relationship, I thought I'd still be married, that surprises me. And how I feel losing my older siblings, them dying. And my older sister's 78, and what's the average life of a female 81, 82 at the most, and you know, you do the mathematics.

—Jan, 70s

The good thing about this age is that the things that you have to do – like earning money, raising children – all of those responsibilities are no longer there. Also no one nags me anymore and I no longer need to care what other people think.

The worst thing about being older is your health. I get aches and pains, my eyesight isn't as good as it used to be, and my knee hurts. I also feel a bit slower. When I was younger I felt quite clever and I was really motivated to achieve things, but I don't have that motivation anymore and my thinking feels slower. There's also a lingering feeling of sadness that you have when you're old. It's hard to say what the sadness is about, but it's there.

I think this is what's good and also what's bad about being older – when you're young, you have a lot of confidence and motivation to do things but in old age, it's good that you no longer have the pressure or the responsibility to do so many things, but it's also a negative that you don't.

—Clara, 71

I went through a period of being quite distressed and disturbed last year. Because I couldn't run anymore, I couldn't walk so far, and I was breathing heavily. But I gave myself a very severe talking to and I said, 'I've got to stop this, I'm just getting old', and I'm now just accepting the fact that this is what happens when you get to be 80. I'm 80 and still here.

I do quite a lot of volunteer work. And that keeps me occupied and using my brain quite a bit. Another highlight is helping to coordinate a high tea once a month for about 10 to 27 of us who meet at various homes. It's quite delightful – we sit and chat and share and talk about all sorts of things from politics to aged care.

The negative? I thought my super would be sufficient to let me live like I did before retirement. It didn't work like that at all and I'm dependent on my husband's income for us to exist at all. I can't do things like give gifts to my grandkids, like I expected I would. I just send them a card or an email. I've not taken a real holiday since I retired. I still have a bucket list of things to do in Australia and overseas, but I can't afford it.

The surprise for me, my parents died when they were 60, and their parents did the same. So I was surprised to turn 80 and I had quite a celebration. My best surprise is that I am still here. Because that's a turn up for my family.

—Ross, 80

For me, the best thing [about ageing] is I don't have to care what anybody thinks. If somebody's getting up my nose, I actually name it. Yeah. I feel confident enough in myself. If I see racism or sexism or ageism, I'll call it. So, I guess, you know, the activist has come out in me. Also, I can look back and I feel I have contributed to the community. And I'm still able to contribute in various ways. That gives me satisfaction.

The worst? Not being able to party all night. Not that I really want to anymore. And I've been really fortunate, but I wonder what is going to happen for my nieces and my great-nieces and nephews. What sort of a world are we leaving them? And will they have the same range of opportunities that we had? That concerns me a lot.

Probably the most surprising thing is that I was too much of a spendthrift. I wish I had been less profligate. But also, I didn't expect to live this long. I was coming up from the early 80s through the HIV epidemic, everybody around me was dropping. And so that surprised me, that between drugs, sex and rock and roll, that I've made it this far.

—Roy, 70s

At first after retiring, I had a lot of free time and felt useless. I started to feel depressed. Then I found out about a local Vietnamese senior group from my friend. I joined the group and now volunteer for the organisation.

The best thing about my age is that I can apply my skills as a computer engineer to help my community. I teach people how to use Google Maps so when we go out we can use it to find places in the city and Google Translate because some members don't speak English very well. I show them how to use social media, like Facebook, TikTok, YouTube, and Google search so they can go online and find information about whatever they like.

Not so good things about getting older are memory and health. Sometimes I run around looking for my hat, but when I look in the mirror, it's on my head! Before, when I read something, it stayed in my mind for a long time. But now, it's easy to forget. I have to ask Alexa to remind me.

The most surprising thing for me is that I am healthy and I travel a lot with my community group ... that I still can enjoy life after retirement.

—Michael, 63

I'm pleased that I've reached 82. Because my mother died at 76. And she was nine years in a nursing home. Also the pressure of bringing up the family is eased and I have my friends, that's important.

Not so good is knowing that you're getting closer to the time when you're not going to be here. You can't buy time. It's gone. So you've got to live for today. I don't have any regrets. I just feel that you've got to make yourself happy every day. You've got to tell yourself, I'm happy today. If things aren't done, well, there's tomorrow.

Surprising was when my partner was confined to the nursing home. I've found it a bit more difficult to take over the men's things in marriage. I've always dealt with the finances, I think it's really important for women to make the decisions of what to buy, what not to buy. But now I have to deal with all the car things, like getting it registered, getting a green slip. And my hubby was handy with his hands, he could go and fix the toaster or tinker with the car, but that's for me to do now.

—Esther, 82

Age Pension provides basic assistance for older people to make sure no one has to live in poverty. Supports like Home Care Packages are very helpful, too. It means getting assistance with domestic chores and transport to attend appointments.

The worst thing about ageing is the illnesses. Have you heard of geriatric syndromes? They're age-related medical conditions. I take a lot of tablets, but nothing can treat the side effects of these medications.

The most surprising thing about being my age is that nothing surprises you anymore. Generations come and generations go, but life remains the same.

I try to walk about 100 metres every day, around the neighbourhood with my walking stick … but I spend most of my days in bed. I keep forgetting too. I forget the names of my friends, I forget the names of suburbs … suburbs I've lived in. I'm forgetting my vocabulary, words in languages that I speak.

—Kyong Jae (Keith), 91

I'm retired, but not retiring. I have a choice of how to spend my time. I've made a big effort to get off all committees and organising things, I've had that. With ageing, I have slightly less energy and I need to use it carefully and purposefully. iPads are an absolute boon for us oldies, you can take them anywhere, because there's Wi-Fi – that's one of the best aspects of ageing for me, access to digital resources. And if I'm having a day in bed, I can pull out the iPad and read everything.

The worst? I suppose it's been health problems with one thing and another. I never guessed I'd have had so much bloody surgery. I don't feel quite so positive and I do have periods of depression and uncertainty. A lot of that's to do with my physical health, but also a bit about uncertainty, I have a certain amount of financial uncertainty.

The surprise is that I'm still alive because I don't come from a family with longevity. When I had my 60th birthday, I got up and told everyone, 'Half my family would have been dead and the other half nearly dead at this age' … and that was 18 years ago…

The other thing that still surprises me is that Australia is very backward when it comes to age – services are hard to get into, My Aged Care is a total mess, I just weep for people who are in residential aged care and their families, and for the staff, and also for the deplorable training and education.

—Lavender (Kate Lavender), 78

Appendix

CONTENTS

The Commission worked with a research partner, IPSOS Public Affairs Pty Limited, who provided statistical expertise and analysis.

Survey scores

Table 2. AAS, ERA-12, and FSA scores and standard deviations (SD) across surveys

Measure	Pre-workshop (SD)	Post-workshop (SD)	Follow-up (SD)	Score range
Ambivalent Ageism Scale (AAS) total	2.7 (1.0)	2.2 (0.9)	2.1 (0.9)	1–7
Benevolent ageism subscale	2.7 (1.0)	2.1 (1.0)	2.0 (1.0)	1–7
Hostile ageism subscale	2.6 (1.4)	2.4 (1.3)	2.3 (1.3)	1–7
12-Item Expectations Regarding Ageing (ERA-12) total (normed)	62.9 (17.7)	71.3 (16.8)	71.6 (17.0)	0–100
Physical health subscale	53.8 (20.5)	61.2 (19.8)	62.1 (20.5)	0–100
Mental health subscale	75.3 (21.0)	83.2 (18.3)	83.4 (17.5)	0–100
Cognitive function subscale	59.6 (23.4)	69.5 (22.7)	69.4 (24.5)	0–100
Fraboni Scale of Ageism (FSA) total	47.4 (10.0)	44.9 (9.7)	43.2 (9.5)	29–116
Antilocution subscale	16.6 (4.7)	15.5 (4.5)	14.6 (4.2)	10–40
Discrimination subscale	15.3 (3.1)	14.6 (3.0)	14.1 (2.9)	9–36
Avoidance subscale	15.5 (3.7)	14.8 (3.7)	14.5 (3.8)	10–40
Total number of respondents	271	247	149	

Significance tests

Presented below are the estimated differences between surveys for each scale, based on a linear mixed effects model with a random intercept for respondent and predictor for post-workshop scores and follow-up scores. These results do not control for other variables.

Table 3. Estimated differences between surveys

Average scores	Pre- vs Post-workshop difference (SE) p-value	Post-workshop vs Follow-up difference (SE) p-value
AAS		
AAS overall	-0.481 (0.05) ⌄ $p < .001$	-0.00659 (0.06) $p = .906$
Benevolent ageism subscale	-0.624 (0.05) ⌄ $p < .001$	-0.015 (0.06) $p = .806$
Hostile ageism subscale	-0.156 (0.10) $p = .12$	0.0346 (0.12) $p = .767$
FSA		
FSA overall	-2.83 (0.47) ⌄ $p < .001$	1.06 (0.53) $p = .044$
Antilocution subscale	-1.17 (0.24) ⌄ $p < .001$	0.576 (0.27) $p = .034$
Discrimination subscale	-0.804 (0.17) ⌄ $p < .001$	0.291 (0.2) $p = .146$
Avoidance subscale	-0.802 (0.21) ⌄ $p < .001$	0.237 (0.24) $p = .994$
ERA-12		
ERA-12 overall	8.29 (0.96) ⌃ $p < .001$	0.533 (1.1) $p = .627$
Physical health subscale	6.86 (1.22) ⌃ $p < .001$	0.049 (1.4) $p = .972$
Mental health subscale	7.53 (1.18) ⌃ $p < .001$	0.372 (1.36) $p = .784$
Cognitive function subscale	10.5 (1.48) ⌃ $p < .001$	0.906 (1.7) $p = .594$

⌃/⌄ Demonstrates the figure is significantly higher/lower than the previous survey. These results do not account for other factors.

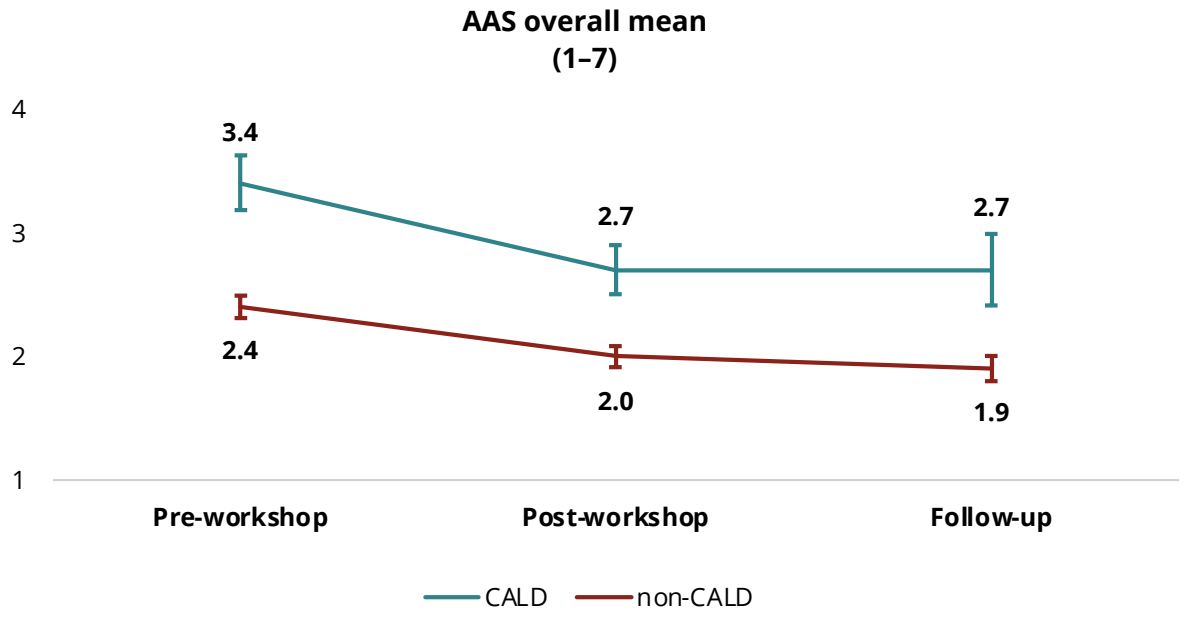
CALD and non-CALD respondents

Results presented control for levels of age, gender, location, type of work, years working with older adults, and participation in post-workshop discussions.

Table 4. Difference in scores by language spoken at home

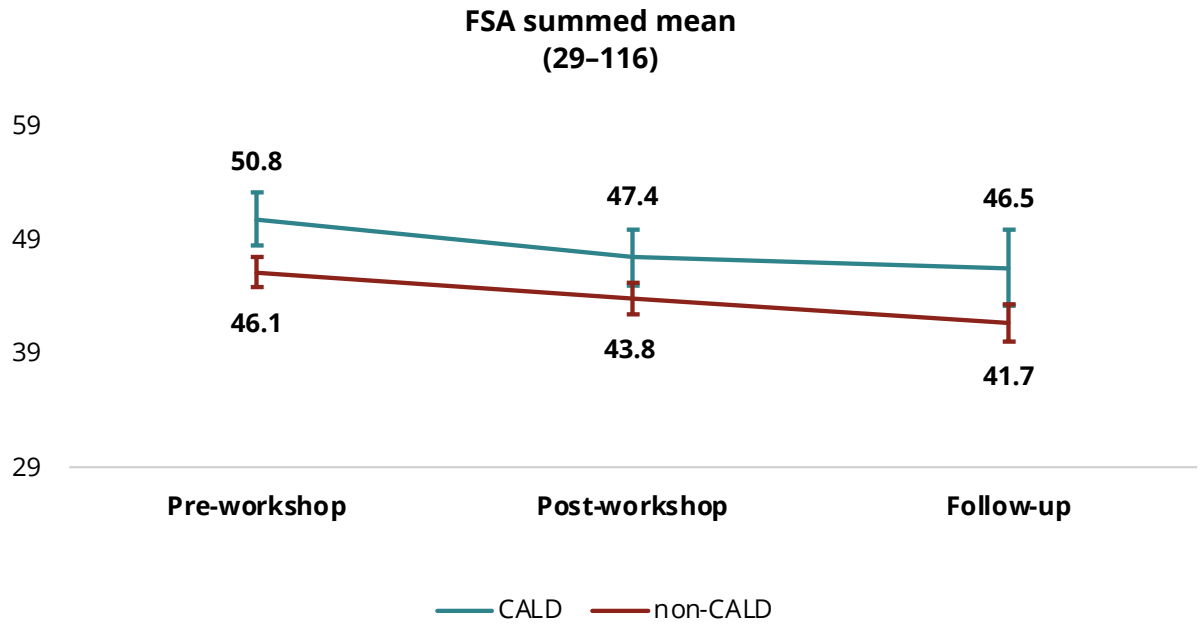
Measure	Difference	SE	p-value
AAS			
CALD vs non-CALD respondents	-0.81	0.11	<.0001
FSA			
CALD vs non-CALD respondents	-3.82	1.29	0.003
ERA-12			
CALD vs non-CALD respondents	5.43	2.20	0.01

Figure 20. AAS average scores across surveys by CALD status



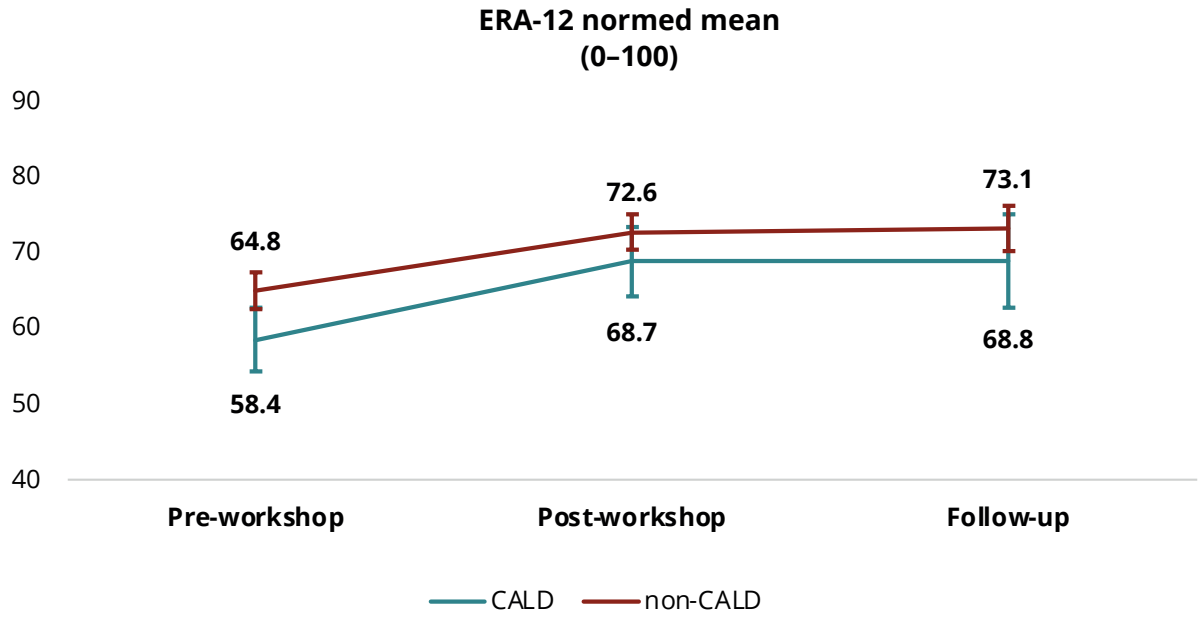
Results represent overall means on the AAS scale. Bands represent 95% confidence intervals.

Figure 21. FSA average total scores across surveys by CALD status



Results represent mean summed scores on the FSA scale. Bands represent 95% confidence intervals.

Figure 22. ERA-12 average total scores across surveys by CALD status



Results represent mean normed scores on the ERA-12 scale. Bands represent 95% confidence intervals.

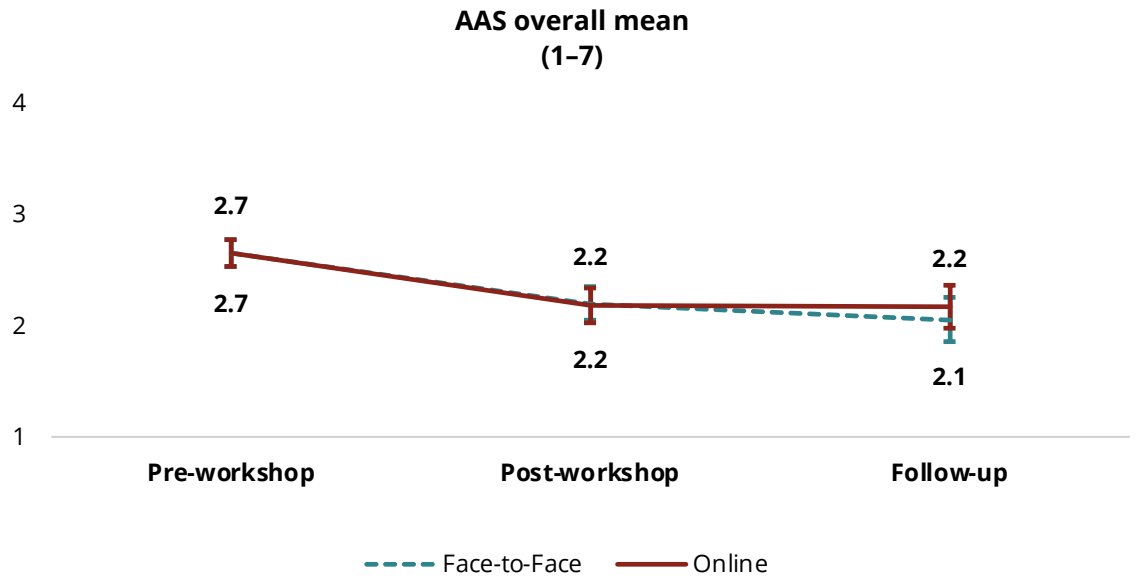
Workshop mode of delivery

Results presented control for levels of age, gender, location, language spoken at home, type of work, years working with older adults, and participation in post-workshop discussions.

Table 5. Difference in scores by delivery mode

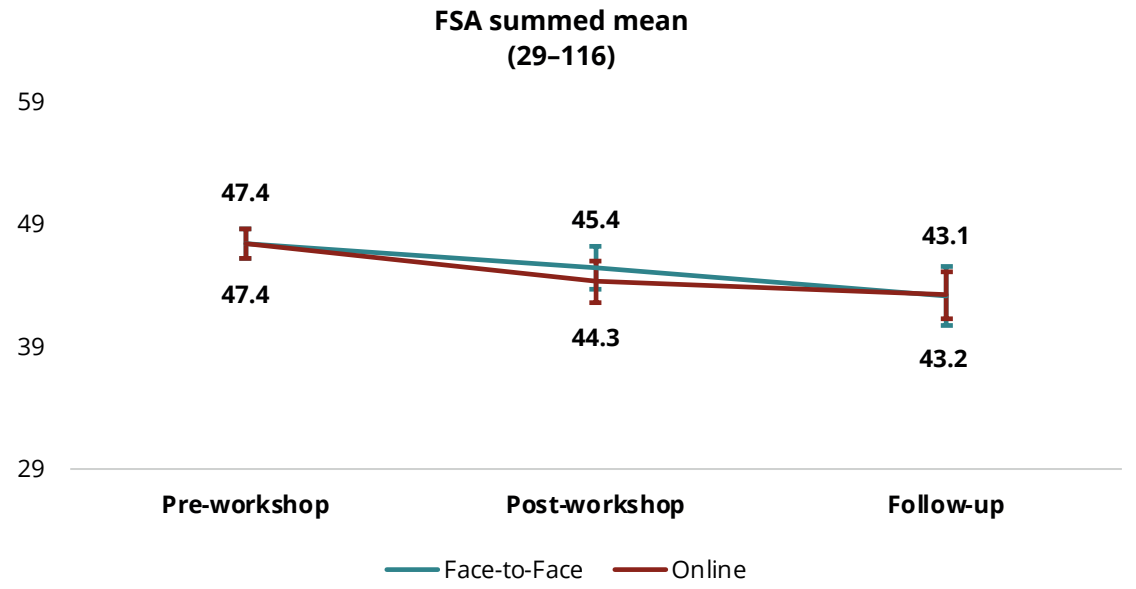
Delivery mode	Difference	(SE)	p-value
AAS			
Online (post-workshop vs pre-workshop)	-0.43	0.07	<.0001
Face-to-face (post-workshop vs pre-workshop)	-0.48	0.06	<.0001
Online vs face-to-face	0.05	0.08	0.54
FSA			
Online (post-workshop vs pre-workshop)	-3.51	0.64	<.0001
Face-to-face (post-workshop vs pre-workshop)	-2.36	0.62	.0001
Online vs face-to-face	-1.15	0.81	0.49
ERA-12			
Online (post-workshop vs pre-workshop)	8.5	1.3	<.0001
Face-to-face (post-workshop vs pre-workshop)	7.5	1.2	<.0001
Online vs face-to-face	0.1	1.6	0.92

Figure 23. AAS average scores across surveys by workshop delivery mode



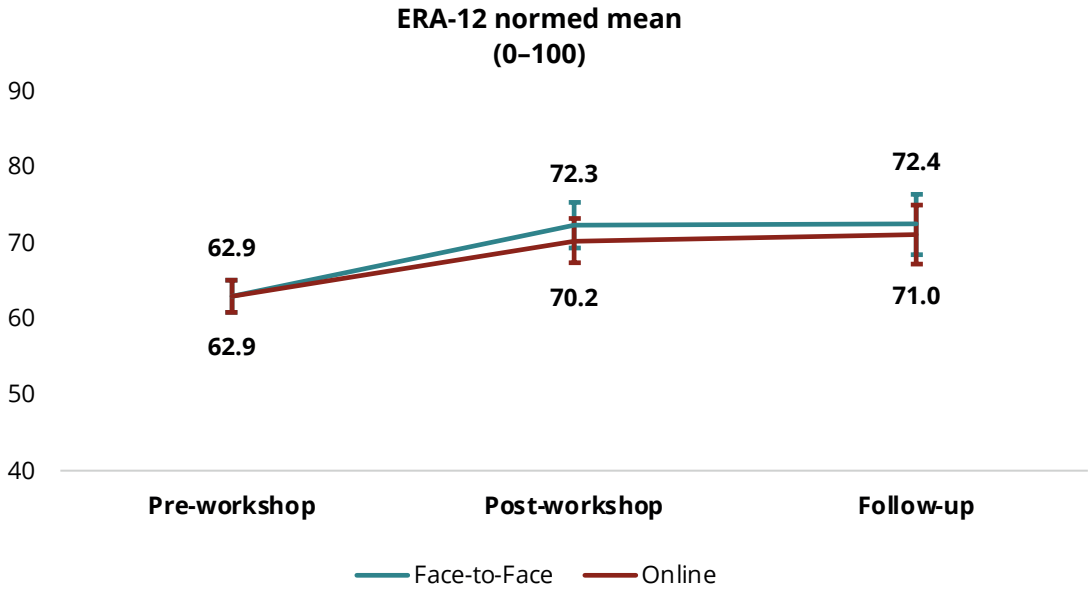
Results represent overall means on the AAS scale. Bands represent 95% confidence intervals.

Figure 24. FSA average total scores across surveys by workshop delivery mode



Results represent mean summed scores on the FSA scale. Bands represent 95% confidence intervals.

Figure 25. ERA-12 average total scores across surveys by workshop delivery mode



Results represent mean normed scores on the ERA-12 scale. Bands represent 95% confidence intervals.

Linear mixed effects models

A linear mixed effects regression model with a random intercept – a statistical method that is commonly used to analyse data collected over time from the same individuals – was used to explore the relationship between an outcome variable (eg, overall AAS scores) and one or more key predictor variables of interest (eg, training delivery mode, focus group participation). The results controlled for the effects of age, gender, location, CALD status, years working with older people, focus group participation, and the type of work, on the outcome variable.

Table 6. Linear mixed effects model results

Predictor Category	Predictor	AAS	ERA	FSA
-	(Intercept)	1.82 (0.4)	80.34 (7.9)	44.27 (4.62)
Gender	Male	0.01 (0.14)	-5.22 (2.81)	0.53 (1.66)
Age	25-34 years	0.64 (0.37)	-10.12 (7.42)	1.99 (4.33)
	35-39 years	0.69 (0.38)	0.48 (7.46)	-0.95 (4.34)
	40-49 years	0.48 (0.37)	-7.31 (7.27)	-0.23 (4.23)
	50-61 years	0.69 (0.36)	-9.37 (7.19)	0.53 (4.19)
	62-74 years	0.76 (0.37)	-10.91 (7.45)	2.55 (4.34)
	75-84 years	0.82 (0.56)	-8.98 (11.15)	3.2 (6.57)
Location	ACT	-0.54 (0.8)	-13.53 (15.88)	-11.46 (9.43)
	NSW	-0.11 (0.15)	-0.38 (3.05)	0.43 (1.79)
	QLD	-0.24 (0.11)	1.7 (2.26)	-1.23 (1.33)
	SA	-0.22 (0.16)	2.76 (3.27)	-1.23 (1.91)
	Tas	-0.09 (0.27)	-6.43 (5.46)	1.41 (3.19)
	WA	-0.47 (0.36)	0.7 (7.12)	-1.83 (4.15)
Aboriginal or Torres Strait Islander identification	Yes	-0.33 (0.43)	10.64 (8.56)	-1.93 (5.08)
Language Other than English	Yes	0.81 (0.11)**	-5.43 (2.12)	3.82 (1.24)**

Predictor Category	Predictor	AAS	ERA	FSA
Time spent working with older adults	One to two years	0.03 (0.22)	-4.89 (4.46)	1.26 (2.59)
	Three to five years	0.18 (0.21)	-2.55 (4.16)	0.35 (2.43)
	Six to ten years	-0.35 (0.2)	0.81 (4.01)	-3.31 (2.34)
	More than ten years	-0.24 (0.19)	1.9 (3.85)	-1.81 (2.25)
Delivery Mode	Online	-0.43 (0.07)**	8.5 (1.28)**	-3.51 (0.64)**
	Face-to-face	-0.48 (0.06)**	7.51 (1.23)**	-2.36 (0.61)**
Focus Group Participation	Yes	-0.09 (0.1)	1.38 (1.94)	-1.51 (0.98)
Age Care Worker	Yes	0.27 (0.12)	-9.81 (2.3)**	4.11 (1.34)**
Community Worker	Yes	0.16 (0.11)	-3.63 (2.19)	1.08 (1.28)
Random Effects	SD (Intercept)	0.644	12.883	7.954
	SD (Residual)	0.505	9.891	4.749
Model Criteria	N observations	642	642	642
	R2 Marginal	0.290	0.171	0.129
	R2 Conditional	0.730	0.692	0.771
	AIC	1490.3	5170.8	4381.7
	BIC	1610.9	5291.3	4502.2
	ICC	0.6	0.6	0.7
	RMSE	0.40	7.87	3.66

** denotes predictor is statistically significant, $p < .005$.

1 World Health Organization, *Global report on ageism* (2021) ix.
2 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 13.
3 AARP, *Global Insights on the Multigenerational Workforce* (Issue Brief, August 2020) 3.
4 Sarah Fraser et al, 'Ageism and COVID-19: What Does Our Society's Response Say about Us?' (2020) 49(5) *Age and Ageing* 692–695, 693.
5 See E-Shien Chang et al, 'Global Reach of Ageism on Older Persons' Health: A Systematic Review' (2020) 15(1) *PLOS ONE* e0220857
6 World Health Organization, *Global report on ageism* (2021) 115.
7 From workshop participants, obtained through post-workshop focus groups and open-ended survey responses.
8 Anna E Kornadt et al, 'Views on Ageing: A Lifespan Perspective' (2020) 17(4) *European Journal of Ageing* 387–401.
9 Amy JC Cuddy and Susan T Fiske, 'Doddering but dear: Process, content, and function in stereotyping of older persons' in Todd D Nelson (ed), *Ageism: Stereotyping and prejudice against older persons* (The MIT Press, 2002) 3, 3.
10 Irena Stepanikova, 'Racial-ethnic biases, time pressure, and medical decisions' (2012) 53(3) *Journal of Health and Social Behavior* 329–343.
11 Reuben Ng, 'Societal age stereotypes in the USA and UK From a media database of 1.1 billion words' (2021) 18(16) *International Journal of Environmental Research and Public Health* 8822, 7.
12 A video created by AARP, an organisation based in the United States that advocates for the rights and interests of older people, shows why we should stop qualifying compliments by adding 'for your age'. You can watch the video here: https://www.youtube.com/watch?v=bQwJNYYlkQA.
13 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 135.
14 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 43, 272.
15 World Health Organization, *Global report on ageism* (2021) xv.
16 Thomas Nicolaj Iversen, Lars Larsen and Per Erik Solem, 'A Conceptual Analysis of Ageism' (2009) 61(3) *Nordic Psychology* 4–22, 16.
17 Becca R Levy and Mahzarin R Banaji, 'Implicit ageism' in Todd D Nelson (ed), *Ageism: Stereotyping and prejudice against older persons* (The MIT Press, 2002), 49, 50.
18 Rylee A Dionigi, 'Stereotypes of aging: Their effects on the health of older adults' [2015] *Journal of Geriatrics* 954027, 1.
19 Data from the Australian Bureau of Statistics, Quarterly population estimates (ERP), by state/territory, sex and age, 2022-Q1 (Web page, accessed 10 February 2023) <https://explore.data.abs.gov.au/?tm=quarterly%20population&pg=0&fc=Measure>.
20 Australian Government, The Treasury, 2021 *Intergenerational Report: Australia over the next 40 years* (Report, June 2021) 29.
21 Anne Clancy et al, 'The meaning of dignity for older adults: A meta-synthesis' (2021) 28(6) *Nursing Ethics* 878–894, 878.
22 Rebecca Neel and Bethany Lassetter, 'The stigma of perceived irrelevance: An affordance-management theory of interpersonal invisibility' (2019) 126(5) *Psychological Review* 634–659, 635.
23 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 15.
24 World Health Organization, *Global report on ageism* (2021) 2.
25 Thomas Nicolaj Iversen, Lars Larsen and Per Erik Solem, 'A Conceptual Analysis of Ageism' (2009) 61(3) *Nordic Psychology* 4–22, 15.
26 Alina Sutter et al, 'Ageism toward older adults during the COVID-19 pandemic: Intergenerational conflict and support' (2022) 78(4) *Journal of Social Issues* 815–841, 817.
27 Michael S North and Susan T Fiske, 'A prescriptive intergenerational-tension ageism scale: Succession, identity, and consumption (SIC)' (2013) 25(3) *Psychological Assessment* 706–713, 706–707.

28 Alina Sutter et al, 'Ageism toward older adults during the COVID-19 pandemic: Intergenerational conflict and support' (2022) 78(4) *Journal of Social Issues* 815–841, 817.
29 Susan T Fiske et al, 'A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition' (2002) 82(6) *Journal of Personality and Social Psychology* 878–902, 880.
30 Eg, Amy JC Cuddy, Michael I Norton and Susan T Fiske, 'This Old Stereotype: The Pervasiveness and Persistence of the Elderly Stereotype' (2005) 61(2) *Journal of Social Issues* 267–285.
31 Lindsey A Cary, Alison L Chasteen and Jessica Remedios, 'The ambivalent ageism scale: Developing and validating a scale to measure benevolent and hostile ageism' (2016) gnw118 *The Gerontologist* e27–36, e28.
32 Mille Viktoria Døssing and Irina Catrinel Crăciun, 'From Hostile to Benevolent Ageism: Polarizing Attitudes Toward Older Adults in German COVID-19-Related Tweets' (2022) 62(8) *The Gerontologist* 1185–1195, 1186.
33 Health Consumers NSW and Older Women's Network NSW, *'What can you expect at your age?': An investigation of recent experiences of age discrimination by older adults accessing health care* (Report, 2021) 24.
34 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 41.
35 Erdman B Palmore, 'Research note: Ageism in Canada and the United States' (2004) 19(1) *Journal of Cross-Cultural Gerontology* 41, cited in Lindsey A Cary, Alison L Chasteen and Jessica Remedios, 'The ambivalent ageism scale: Developing and validating a scale to measure benevolent and hostile ageism' (2016) gnw118 *The Gerontologist* e27–36, e27.
36 Todd D Nelson, 'Ageism: Prejudice against our feared future self (2005) 61(2) *Journal of Social Issues* 207–221, 207.
37 John Macnicol, *Age discrimination: An historical and contemporary analysis* (Cambridge University, 2006) 6, cited in The Benevolent Society, *The drivers of ageism* (Full Report, 2017) 44.
38 Sagit Lev, Susanne Wurm and Liat Ayalon, 'Origins of Ageism at the Individual Level' in Liat Ayalon and Clemens Tesch-Römer (eds), *Contemporary Perspectives on Ageism* (Springer, 2018) 51, 55–60.
39 Becca R Levy, 'Eradication of ageism requires addressing the enemy within' (2001) 41 *The Gerontologist* 578–579.
40 Reuben Ng et al, 'Increasing negativity of age stereotypes across 200 years: Evidence from a database of 400 million words' (2015) 10(2) *PLOS ONE* e0117086, 4, cited in Mary F Wyman, Sharon Shiovitz-Ezra and Jürgen Bengel, 'Ageism in the health care system: Providers, patients, and systems' in Liat Ayalon and Clemens Tesch-Römer (eds), *Contemporary Perspectives on Ageism* (Springer, 2018) 193, 199.
41 Dagmar Grefe, 'Combating ageism with narrative and intergroup contact: Possibilities of intergenerational connections' (2011) 60(1) *Pastoral Psychology* 99–105, 101–102, cited in The Benevolent Society, *The drivers of ageism* (Full Report, 2017) 44–45.
42 Mary F Wyman, Sharon Shiovitz-Ezra and Jürgen Bengel, 'Ageism in the health care system: Providers, patients, and systems' in Liat Ayalon and Clemens Tesch-Römer (eds), *Contemporary Perspectives on Ageism* (Springer, 2018) 193, 199.
43 Alice Coffey et al, *Attitudes to older people and perceptions of working with older people of students of health and social care* (ELLAN – European Later Life Active Network Report, June 2015) 11 <https://research.hanze.nl/ws/portalfiles/portal/34433089/WP6_research_student_views.pdf>.
44 Dagmar Grefe, 'Combating ageism with narrative and intergroup contact: Possibilities of intergenerational connections' (2011) 60(1) *Pastoral Psychology* 99–105, 101–102, cited in The Benevolent Society, *The drivers of ageism* (Full Report, 2017) 44.
45 World Health Organization, *Global report on ageism* (2021) 49–53; E-Shien Chang et al, 'Global Reach of Ageism on Older Persons' Health: A Systematic Review' (2020) 15(1) *PLOS ONE* e0220857; Hyun Kang and Hansol Kim, 'Ageism and Psychological Well-Being Among Older Adults: A Systematic Review' (2022) 8 *Gerontology and Geriatric Medicine* 233372142210870; Becca R Levy, P Chung and M Canavan, 'Impact of explanatory style and age stereotypes on health across the lifespan' in Karen L Fingerman et al, (eds), *Handbook of life-span development* (Springer, 2011) 437, cited in Rylee A Dionigi, 'Stereotypes of aging: Their effects on the health of older adults' [2015] *Journal of Geriatrics* 954027, 3.

46 Richard P Eibach, Steven E Mock and Elizabeth A Courtney, 'Having a "senior moment": Induced aging phenomenology, subjective age, and susceptibility to ageist stereotypes' (2010) 46(4) *Journal of Experimental Social Psychology* 643–649; Andreas B Neubauer, Oliver K Schilling and Hans-Werner Wahl, 'What do we need at the end of life? Competence, but not autonomy, predicts intraindividual fluctuations in subjective well-being in very old age' (2015) *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* gbv052, cited in Michael T Vale et al, 'Ageism and behavior change during a health pandemic: A preregistered study' (2020) 11 *Frontiers in Psychology* 587911, 9.

47 Klaus Rothermund, 'Effects of Age Stereotypes on Self-Views and Adaptation' in Werner Greve, Klaus Rothermund and Dirk Wentura (eds), *The adaptive self: Personal continuity and intentional self-development* (Hogrefe & Huber Publishers, 2005) 223, 232, cited in Becca R Levy, 'Stereotype Embodiment: A Psychosocial Approach to Aging' (2009) 18(6) *Current directions in psychological science* 332–336, 345.

48 Becca R Levy, 'Stereotype Embodiment: A Psychosocial Approach to Aging' (2009) 18(6) *Current directions in psychological science* 332–336, 335.

49 Becca R Levy et al, 'Positive age beliefs protect against dementia even among elders with high-risk gene' (2018) 13(2) *PLOS ONE* e0191004; Becca R Levy and Martin D Slade, 'Role of Positive Age Beliefs in Recovery From Mild Cognitive Impairment Among Older Persons' (2023) 6(4) *JAMA Network Open* e237707; Becca R Levy, Martin D Slade and Stanislav V Kasl, 'Longitudinal benefit of positive self-perceptions of aging on functional health' (2002) 57(5) *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* P409–417; Julia S Nakamura, Joanna H Hong and Jacqui Smith, 'Associations between satisfaction with aging and health and well-being outcomes among older US adults' (2022) 5(2) *JAMA Network Open* e2147797; Becca R Levy et al, 'Longevity increased by positive self-perceptions of aging' (2002) 83(2) *Journal of Personality and Social Psychology* 261–270.

50 Royal Commission into Aged Care Quality and Safety, *Care, Dignity and Respect: Final report of the Royal Commission into Aged Care Quality and Safety* (2021) 75.

51 Sandra C Buttigieg et al, 'Researching ageism in health-care and long-term care' in Liat Ayalon and Clemens Tesch-Römer (eds), *Contemporary Perspectives on Ageism* (Springer, 2018) 493, 498.

52 Sandra C Buttigieg et al, 'Researching ageism in health-care and long-term care' in Liat Ayalon and Clemens Tesch-Römer, *Contemporary Perspectives on Ageism* (Springer, 2018) 493, 498.

53 Susan Sherwin and Meghan Winsby, 'A relational perspective on autonomy for older adults residing in nursing homes: A relational perspective on autonomy for older adults' (2011) 14(2) *Health Expectations* 182–190, 187.

54 Tova Band-Winterstein, 'Health care provision for older persons: The interplay between ageism and elder neglect' (2015) 34(3) *Journal of Applied Gerontology* NP113.

55 Tracey Gendron et al, 'Who is likely to commit to a career with older adults?' (2016) 37(2) *Gerontology & Geriatrics Education* 208–228.

56 Esther Iecovich and Michal Avivi, 'Ageism and burnout among nurses in long-term care facilities in Israel' (2017) 21(3) *Aging & Mental Health* 327–335.

57 Eg, Julie Ober Allen et al, 'Experiences of Everyday Ageism and the Health of Older US Adults' (2022) 5(6) *JAMA network open* e2217240; Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021); Johanna C Goll et al, 'Barriers to social participation among lonely older adults: the influence of social fears and identity' (2015) 10(2) *PLOS ONE* e0116664; Isla Rippon et al, 'Perceived age discrimination in older adults' (2014) 43(3) *Age and ageing* 379–386.

58 Eg, Mary F Wyman, Sharon Shiovitz-Ezra and Jürgen Bengel, 'Ageism in the health care system: Providers, patients, and systems' in Liat Ayalon and Clemens Tesch-Römer (eds), *Contemporary Perspectives on Ageism* (Springer, 2018) 193; EveryAGE Counts, *EveryAGE Counts: Ageism and Aged Care* (Submission to the Royal Commission into Aged Care Quality and Safety, August 2019) <https://agedcare.royalcommission.gov.au/system/files/2021-02/AWF.001.03798.01.pdf>.

59 Ariane S Massie and Brad A Meisner, 'Perceptions of aging and experiences of ageism as constraining factors of moderate to vigorous leisure-time physical activity in later life' (2019) 42(1) *Loisir et Société / Society and Leisure* 24–42, 32–33.

60 Johanna C Goll et al, 'Barriers to social participation among lonely older adults: the influence of social fears and identity' (2015) 10(2) *PLOS ONE* e0116664, 7.

61 Faílde Garrido et al, 'Are older adults' leisure patterns consistent with the active ageing model? The influence of the ageist stereotypes' (2022) 21(4) *Social Policy and Society* 575–596.
62 World Health Organization, *Global report on ageism* (2021) ix.
63 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 219.
64 World Health Organization, *Global report on ageism* (2021) 113–120.
65 Tracey Gendron et al, 'The efficacy of a video-based intervention to reduce ageism among long-term services and supports staff' (2021) 42(3) *Gerontology & Geriatrics Education* 316–330.
66 David Burnes et al, 'Interventions to reduce ageism against older adults: A systematic review and meta-analysis' (2019) 109(8) *American Journal of Public Health* e1–e9.
67 Sibila Marques et al, 'Determinants of ageism against older adults: A systematic review' (2020) 17(7) *International Journal of Environmental Research and Public Health* 2560.
68 David Burnes et al, 'Interventions to reduce ageism against older adults: A systematic review and meta-analysis' (2019) 109(8) *American Journal of Public Health* e1–e9.
69 World Health Organization, *Global report on ageism* (2021) 115.
70 Participants were offered a $25 digital gift card for completing each of the post-workshop and follow-up surveys. Individuals who participated in the post-workshop discussions were offered an $80 gift card for their time.
71 Lenora Marcellus, 'Are we missing anything? Pursuing research on attrition' (2004) 36(3) *The Canadian journal of nursing research / Revue Canadienne de recherche en sciences infirmieres* 82–98, 84.
72 One participant who was unable to join a scheduled focus group session due to experiencing technical issues provided their reflections via email.
73 Lindsey A Cary, Alison L Chasteen and Jessica Remedios, 'The ambivalent ageism scale: Developing and validating a scale to measure benevolent and hostile ageism' (2016) gnw118 *The Gerontologist* e27–36.
74 Maryann Fraboni, Robert Saltstone and Susan Hughes, 'The Fraboni Scale of Ageism (FSA): An attempt at a more precise measure of ageism' (1990) 9(1) *Canadian Journal on Aging* 56.
75 Item 13, 'I would prefer not to go to an open house at a senior's club, if invited' was revised to 'I would prefer not to go to an open day at a senior's club, if invited' to facilitate understanding for an Australian audience.
76 Catherine A Sarkisian et al, 'Development of the 12-item Expectations Regarding Aging Survey' (2005) 45(2) *The Gerontologist* 240–248.
77 Mary C Whatley and Alan D Castel, 'Improving Expectations Regarding Aging in Younger Adults: A Classroom Study' (2020) 46(12) *Educational gerontology* 785–795, 789.
78 David Nunan, Jeffrey Aronson and Clare Bankhead, 'Catalogue of bias: Attrition bias' (2018) 23(1) *BMJ Evidence-Based Medicine* 21–22.
79 Pamela Grimm, 'Social desirability bias' in Jagdish Sheth and Naresh Malhotra (eds), *Wiley International Encyclopedia of Marketing* (John Wiley & Sons, 2010) wiem02057.
80 While the Commission's preferred term is 'older' person/people/adults, no modifications were made to the wording of the validated instruments used, as this may affect the validity and reliability of these tools.
81 Lindsey A Cary, Alison L Chasteen and Jessica Remedios, 'The ambivalent ageism scale: Developing and validating a scale to measure benevolent and hostile ageism' (2016) gnw118 *The Gerontologist* e27–36, e28.
82 Melinda M Davis et al, 'Primary care clinician expectations regarding aging' (2011) 51(6) *The Gerontologist* 856–866, 863.
83 Melinda M Davis et al, 'Primary care clinician expectations regarding aging' (2011) 51(6) *The Gerontologist* 856–866, 857.
84 Michael T Vale et al, 'Ageism and behavior change during a health pandemic: A preregistered study' (2020) 11 *Frontiers in Psychology* 587911.
85 Bianca Brijnath et al, *Primary prevention of family violence among older people living in Victoria* (Respect Victoria Report, June 2021) 42–43.
86 Melinda M Davis et al, 'Primary care clinician expectations regarding aging' (2011) 51(6) *The Gerontologist* 856–866.

87 Eg, Alice Coffey et al, *Attitudes to older people and perceptions of working with older people of students of health and social care* (ELLAN – European Later Life Active Network Report, 2015) <https://research.hanze.nl/ws/portalfiles/portal/34433089/WP6_research_student_views.pdf>; Sibila Marques et al, 'Determinants of ageism against older adults: A systematic review' (2020) 17(7) *International Journal of Environmental Research and Public Health* 2560; Jordan Boeder et al, 'Medium matters: A decade of media consumption predicts positive and negative dimensions of self-perceptions of aging' (2021) 76(7) *The Journals of Gerontology: Series B* 1360.
88 E-Shien Chang et al, 'Global Reach of Ageism on Older Persons' Health: A Systematic Review' (2020) 15(1) *PLOS ONE* e0220857.
89 The results of the statistical analysis are included in the Appendix on page 90.
90 The results of the statistical analysis are included in the Appendix on page 90.
91 The differences were significant, even after controlling for other variables. The results are included in the Appendix on page 90.
92 Results of the statistical analysis are included in the Appendix on page 90.
93 The ranges refer to 95% confidence intervals. A confidence interval provides the range of values within which we can reasonably expect the true effect to fall.
94 In the pre-workshop survey, there were 73 respondents who reported they spoke a language other than English at home. At post-workshop, there were 69 and at follow-up, 40 respondents reported speaking another language at home.
95 Results of the statistical analysis are included in the Appendix on page 90.
96 The post-workshop survey asked, 'What, if anything, do you intend to do differently after participating in the age awareness session you recently attended?' The follow-up survey, which occurred 2–3 months later, asked respondents, 'Have you done anything differently in your job or workplace since participating in the age awareness session?'
97 Susan Kemper 'Elderspeak: Speech accommodations to older adults' (1994) 1 *Aging and Cognition* 17, 17.
98 The video shown was created by AARP, an organisation based in the United States that advocates for the rights and interests of older people. You can watch the video here: https://www.youtube.com/watch?v=bQwJNYYlkQA.
99 See Susan T Fiske, Amy JC Cuddy and Peter Glick, 'Universal dimensions of social cognition: warmth and competence' (2007) 11(2) *Trends in cognitive sciences* 77–83.
100 Australian Human Rights Commission, *What's age got to do with it? A snapshot of ageism across the Australian lifespan* (2021) 93.
101 World Health Organization, *Global report on ageism* (2021) 113–120.
102 James O Prochaska and Wayne F Velicer, 'The transtheoretical model of health behavior change' (1997) 12(1) *American Journal of Health Promotion* 38–48, 39.
103 Tracey Gendron et al, 'The language of ageism: why we need to use words carefully' (2016) 56(6) *The Gerontologist* 997–1006, 997.
104 Eg, Corinna E Löckenhoff et al, 'Perceptions of aging across 26 cultures and their culture-level associates' (2009) 24(4) *Psychology and Aging* 941–954.

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