
RESPECT AND SOCIAL INCLUSION

AGE FRIENDLY THEMES
COMBATING AGEISM



NPAS OBJECTIVES

1. Promote activities which will help to combat ageism and to debunk age related stereotypes;
 2. Combat ageism through awareness campaigns and by encouraging the media to provide an age balanced image of society;
 3. Ensure that older people's needs are considered in the development of any policies that might actually affect them;
 4. Promote a better understanding of the importance of intergenerational solidarity and ensuring that policy developments enhance solidarity between generations;
 5. Encourage the development of intergenerational initiatives at local, regional and national level; and,
 6. Create a better awareness of the needs and preferences of people as they age during policy and service development by adopting more comprehensive and inclusive approaches consultation.
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INTRODUCTION

The National Positive Ageing Strategy (NPAS) of Ireland (2013) identifies four national goals and two cross-cutting objectives. The goals aim to; support the greater participation of older people in all aspects of community life; maintain, improve and manage their health and wellbeing; enable them to age with security and dignity in their homes and communities and to use research to better inform policy responses. The cross-cutting objectives seek to combat ageism and improve information provision.

The Healthy and Positive Ageing Initiative was established in 2014 with the aim of increasing knowledge around the factors contributing to the health and wellbeing of older people. The Initiative seeks to provide partners in wider government and society with a framework to help prioritise actions and to translate the goals of the NPAS and *Healthy Ireland* in order to stimulate local action by stakeholders in Age Friendly Counties.

The work of the Initiative helps to achieve Goal 4 of the National Positive Ageing Strategy and it is also aligned with the goals and actions of *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025*.

The Initiative is jointly funded by the Department of Health, the HSE, and The Atlantic Philanthropies. It is operational in three main areas of activity:

- National Indicators of Positive Ageing, leading to the 2016 publication of the first biennial report on the health and wellbeing of older people in Ireland.
- Local indicators - using data from a survey of older people collected locally.
- Research - additional research to fill data gaps relating to indicators or to the design or configuration of future services and supports for older people.

Despite the recent focus on positive ageing there is evidence that negative images, attitudes, and perceptions of age and ageing still persist¹. Older people can be stereotyped in a number of ways often based on assumptions about their competencies, beliefs, and abilities across different areas². When these assumptions are based on one of the negative stereotypes about older people, ageism can result. Research has found that stereotypes about older people have been identified across different cultures as being a combination of warmth and incompetence³.

During consultations with thousands of people across the world for the development of the WHO Age-friendly Cities Guide (2007)⁴, many older adults reported experiencing conflicting types of attitudes and behaviours from others. Although, many older adults feel they are respected and included, others feel that they are not well recognised within their communities.

Negative stereotypes regarding older people can result in beliefs and expectations that can lead to older people being treated less positively than other age-groups. More significantly negative stereotypes can result in self-fulfilling prophecies and self-limiting behaviours for older people themselves that can result in less satisfactory cognitive performance, physical inactivity, and reduce feelings of well-being.

Ageist attitudes and assumptions, which can often be unconscious, can limit older people's opportunities to play their part in organisations or activities, can reduce their quality of life¹, lead to poorer quality of healthcare and health outcomes⁵, lower self-esteem⁶ and have a negative impact on a range of social and economic opportunities, including community participation.

This summary looks at the evidence from previous research and from the HaPAI survey around ageism and its links to community engagement.

REFERENCES

1. Angus J, Reeve P. Ageism: A threat to "aging well" in the 21st century. *J Appl Gerontol*. 2006.
2. Fiske ST, Cuddy AJC, Glick P, Xu J. A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *J Pers Soc Psychol*. 2002;82(6):878-902. doi:10.1037//0022-3514.82.6.878
3. Cuddy AJC, Fiske ST, Glick P. Warmth and Competence as Universal Dimensions of Social Perception: The Stereotype Content Model and the BIAS Map. *Adv Exp Soc Psychol*. 2008;40:61-149. doi:10.1016/S0065-2601(07)00002-0
4. WHO Global Age-Friendly Cities: A Guide.; 2007. doi:http://whqlibdoc.who.int/publications/2007/9789241547307_eng.pdf?ua=1
5. Nelson T. Ageism: Stereotyping and Prejudice against Older Persons. (Nelson, ed.). Cambridge, MA; 2004.
6. Levy B, Hausdorff J, Hencke R. Reducing cardiovascular stress with positive self-stereotypes of aging. *The Journals of*. 2000.
7. Palmore E. Ageism: Negative and Positive.; 1999. https://books.google.com/
8. Levy BR, Banaji MR. Implicit Ageism. In: Ageism: Stereotyping and Prejudice Against Older Persons. ; 2002:49-75.
9. Ng T, Feldman D. Evaluating six common stereotypes about older workers with meta-analytical data. *Pers Psychol*. 2012.
10. Hess T. Memory and aging in context. *Psychol Bull*. 2005.
11. MOORE S, STATHAM E. Can Intergenerational Practice Offer a Way of Limiting Anti-Social Behaviour and Fear of Crime? *Howard J Crim Justice*. 2006;45(5):468-484. doi:10.1111/j.1468-2311.2006.00438.x
12. The State of Intergenerational Relations Today. 2008. www.ilcuk.org.uk. Accessed May 15, 2018.
13. Hernandez CR, Gonzalez MZ. Effects of intergenerational interaction on aging. *Educ Gerontol*. 2008;34(4):292-305. doi:10.1080/03601270701883908
14. Litman T. Social Inclusion as a transport planning issue in Canada. In: European Transport Conference. Strassbourg; 2003:30.
15. Commins P. Poverty and social exclusion in rural areas: characteristics, processes and research issues. *Sociol Ruralis*. 2004.
16. Moffatt S, Glasgow N. How useful is the concept of social exclusion when applied to rural older people in the United Kingdom and the United States? *Reg Stud*. 2009.

NPAS CROSS-CUTTING GOAL - COMBATING AGEISM

WHAT IS AGEISM?

Ageism has been defined as “any prejudice against or in favour of an age group”⁷ or an alteration in feeling, belief or behaviour in response to an individual’s or group’s perceived chronological age.”⁸ Age discrimination is an unjustifiable difference in treatment based solely on age and can result in the exclusion of older people from employment or the purchase of goods and services. Stereotypes are defined as the mental representations people have about different social groups. Age stereotypes are therefore “beliefs and opinions about the characteristics, attributes, and behaviors” [of older people].

PREVIOUS RESEARCH

A study by Ng & Feldman⁹ looked at age stereotypes regarding older workers, based on the results of over 400 studies. A number of common stereotypes were examined, such as that older workers are less motivated, more resistant to change or less healthy and energetic. The research found that all but one were not supported by the evidence. The only stereotype that was supported by the evidence was that older workers were less willing to participate in activities aimed at developing their careers. Other stereotypes, common among all age groups including older people themselves, associate memory-loss with older people¹⁰ and while there is some evidence regarding declining memory with aging (especially short-term memory), the popular belief is more pessimistic than is actually the case.

SURVEY QUESTIONS - EXPERIENCE OF AGEISM

We asked a series of questions about whether respondents had experienced negative attitudes or behaviour towards them as an older person from the following sources or settings:

1. Their family;
 2. People in their community;
 3. Young people;
 4. Health professionals providing services;
 5. Those providing services in the financial sector;
 6. Social care providers;
 7. Other older people;
 8. In places like shops, pubs; and,
 9. Using leisure facilities such as gyms or clubs.
- Response categories: Yes or No.

SURVEY QUESTIONS - PERCEPTIONS OF AGEISM

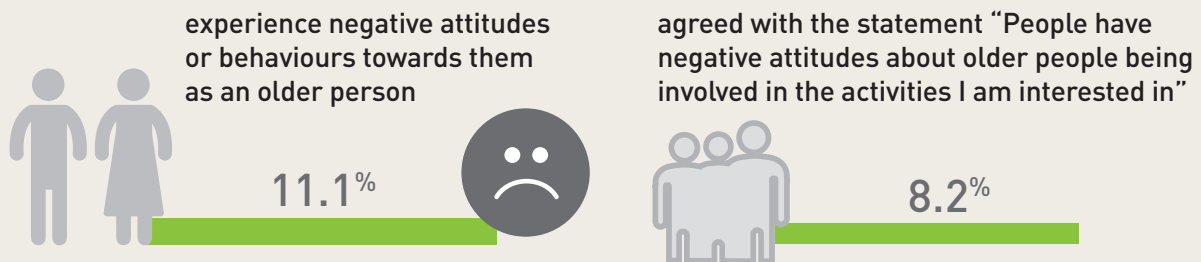
We asked whether people would agree or disagree with the following statement about their local area in relation to involvement in different types of activity in the community?

People have negative attitudes about older people being involved in the activities.

Response categories: Agree/Disagree/Don't know.

KEY FINDINGS

PERCEPTION OF NEGATIVE ATTITUDES TOWARDS OLDER PEOPLE IN THE COMMUNITY



- The HaPAI survey also found that almost one-in-five adults (19.9%) who were out of work reported experiencing ageism, compared with 10.4% of adults who were retired. Perceptions of ageism were also higher among those who were out of work (12.7%)
- Experience of ageism was also more prevalent among those who were materially deprived (32.8%) compared with those who were not (9.2%). Those who were materially deprived also reported more perceptions of ageism (22.0%).
- Almost one in five people who had less than good health had experienced ageism (18.4%) compared to those who had very good health (7.7%). Experience of ageism was also higher among those who had an illness that limits their everyday activity (18.4%) compared with those who had no limiting illness (8.0%).

INTERGENERATIONAL CONTACT - PREVIOUS RESEARCH

There is evidence that when a group is segregated in society, the social distance created can provide a fertile ground for the growth of negative stereotyping. In recent years a number of factors have contributed to an increasing social distance between generations. There has been a growing emphasis on self-sufficiency which contributes to intergenerational distance and as families become more geographically dispersed, intergenerational contact within the family has reduced. Since age segregation contributes to a lack of understanding people tend to fall back on stereotypes, which in turn reduce the possibility of contact between the generations¹¹.

Research from the UK found that a majority of respondents (age 16 to 65+) agreed with the statement that older people and younger people live in separate worlds (67% compared to 20%). However, the age cohort of 65+ agreed significantly more than respondents between the ages of 25-34 and 45-54¹². Evidence from the HaPAI survey (2016) suggests that the level of intergenerational distance is not as great. Almost half (46%) of adults aged 55+ say that they have a friend under the age of 30 (HaPAI Survey, 2016), and this is higher (60%) among those aged 70+.

TACKLING AGEISM THROUGH INTERGENERATIONAL PROGRAMMES

Research carried out with older participants, who were slightly depressed and had negative views of ageing, found that participation in an intergenerational programme produced significant changes in the wellbeing and state of mind of the older people, particularly among those who interacted with the young people. Those in the control group who did not interact showed a significant disimprovement in their state of mind. In fact both young and older age-groups who interacted with each other reduced their stereotypes while those older people with no interaction with the young people increased their stereotyping attitudes¹³.

ASSOCIATION BETWEEN EXPERIENCE OR PERCEPTION OF AGEISM AND COMMUNITY ENGAGEMENT

HaPAI researchers analysed the relationship between perceptions of ageism or experiences of discrimination and community engagement.

- Nearly 1 in 9 participants experienced discrimination
- One in 12 participants agree with the statement "People have negative attitudes about older people being involved in the activities I am interested in"

These adults were less likely to take part in community activities weekly and more likely to not participate in community activities at all. The study found that perceptions of ageism are a stronger predictor of community participation than actual experiences of ageism in that those who perceived ageism were less likely to participate. This finding adds weight to existing research on self-internalised negative stereotypes.

SOCIAL INCLUSION

Social inclusion has been described as an individual's capacity to participate sufficiently within mainstream society and reflects the quality and quantity of their social ties¹⁴. In contrast, social exclusion describes the separation of persons and groups from conventional society^{15,16} through various processes across the life course and into old age. In a recent review, Walsh, Scharf & Keating¹⁷ refined Levitas et al.'s¹⁸ definition of social exclusion in later life. They state that it involves...

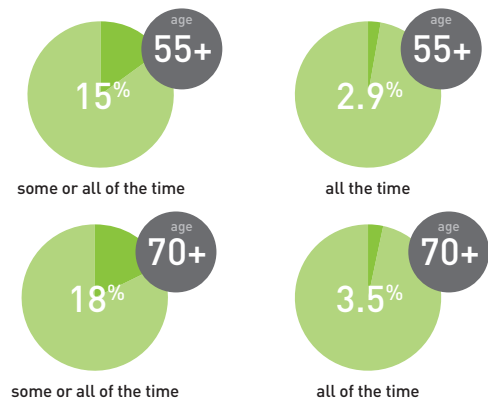
"...the interchange between multi-level processes and outcomes leading to diminished access to the activities, resources and relationships, and rights and choices available to the majority of people across the interconnected domains of: neighbourhood and community; services, amenities and mobility; material and financial resources; social relations; cultural aspects; and civic participation"(p.16).

As such, social exclusion not only encompasses economic disadvantage and disabling environments but also negative societal attitudes and norms surrounding ageing which have the propensity to exclude individuals and groups over time.

SOCIAL ISOLATION

In the HaPAI survey we asked respondents how often they feel isolated: all the time, some of the time, or rarely/never. In total, 17% of the over 55s report feeling isolated some or all of the time. A small percentage of these adults (2.9%) report feeling isolated all the time. Similar proportions of men and women reported feeling isolated some or all of the time. A higher proportion of those aged 70+ reported feeling isolated. Among those aged 70+, 20% feel isolated (14% some of the time, and 3.5% all of the time).

FEELING ISOLATED



ADDRESSING LONELINESS

WHAT IS LONELINESS AND HOW IS IT MEASURED?

Loneliness has been described as a subjective feeling, caused by being without some definite, needed relationships¹⁹. It has been defined as a deficit between a person's actual and desired quality and quantity of social engagement while social isolation is the absence of sufficient opportunities for integration with individuals and groups in the social environment (Victor, Scambler and Bond 2005). Related to this, social isolation is an objective state, characterised by the absence of contact with other people and a lack of integration with other members of society²⁰. While social isolation and loneliness are closely related, they are distinct concepts, measured in different ways, and are not interchangeable.

This study used a measure of social loneliness developed by researchers at the University of California Los Angeles (UCLA) which focuses on: feeling out of tune with other people, feeling isolated from others, feeling left out and lacking companionship²¹.

PREVIOUS RESEARCH

A number of myths have developed around loneliness and its prevalence among older people. Using data from cross-sectional surveys carried out in a number of different countries, Dykstra (2009) found that loneliness is not a problem specifically for older people.²² It has also been assumed that loneliness has increased over the past decades. Again the evidence does not support this assumption, in fact loneliness levels have decreased slightly. Data from the 7th round of the European Social Survey in 2014 which asked how often people had felt lonely in the past week found that the percentage who feel lonely 'most or all of the time' is relatively consistent across adult life;

- 6.15% of those aged 30-39
 - 2.2% of those aged 40-44
 - 7.1% of those aged 45-49
 - 1.4% of those aged 50-54
 - 4.3% of those aged 55-59
 - 6.0% of those aged 60-64
 - 7.4% of those aged 65-69
 - 5% of those aged 70-87
- The highest percentages of those who say they say that they feel lonely 'some', 'most' or 'all of the time' were as follows;
- 32.4% in the 20-24 age group
 - 35.2% in the 30-34 age group
 - 34.8% in the 45-49 age group
 - 33.2% in the 70-87 age group²³

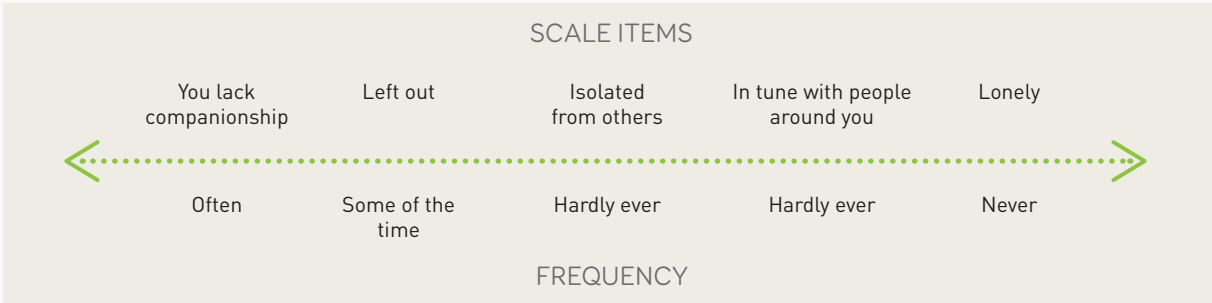
IMPORTANCE OF REDUCING LONELINESS

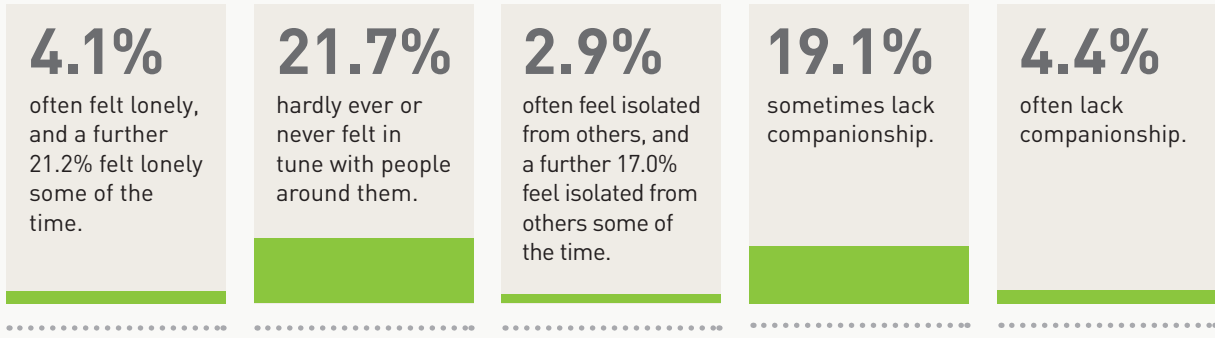
However, for a small number of people loneliness is a serious problem. There are important outcomes stemming from chronic loneliness that are relevant for an ageing population. Previous research in Ireland conducted by Golden²⁴ and colleagues showed that loneliness was associated with 61% of the risk of depression in the older population studied. This is a particularly important finding given the fact that 16% of adults aged 50+ in Ireland have moderate, and 8.9% have severe, levels of depression symptoms²⁵.

Reducing and preventing loneliness is also important for physical health. O'Lunaigh highlighted several of the key physical health consequences of loneliness among older adults from international studies, including increased systolic blood pressure, immune stress responses, poorer sleep quality and cognitive decline²⁶. In 2015 researchers in the US found that the mortality risks associated with social isolation, loneliness and living alone were comparable to that of obesity²⁷. With more and more adults living alone in later life²⁸ it is now the case that loneliness is being discussed as a matter for public health policy and intervention.

LONELINESS - SURVEY QUESTIONS

Loneliness was measured using the 5-item UCLA loneliness scale.





FACTORS ASSOCIATED WITH LONELINESS

Loneliness was significant higher among women, older adults (aged 75+ years and older) widow(er)s, those looking after home/family, and those lived alone. Loneliness was also higher among those in poorer health and who had a chronic illness that limits everyday activity.

REDUCING LONELINESS

Loneliness tends to be linked to social factors such as being unmarried and spending a lot of time alone, and to health-related factors such as poor mental health or poor current health status. Research shows that 'active interventions' which support older people in developing meaningful social relationships and roles and engaging in local community activities have more positive effects than other interventions. In addition a number of the characteristics of an age-friendly environment can contribute to a reduction of loneliness.

IMPROVE ACCESS TO SOCIAL SERVICES

Overall 9.5% of older adults have great difficulty accessing social services including shops, pubs, restaurants, and venues where they can meet friends. These adults are more likely to experience loneliness.

COMBAT AGEISM

Overall 11.1% of adults had experienced negative attitudes and behaviours towards them as an older person, and 8.2% felt that people in their community had negative attitudes towards older people taking part in community activities. These adults were more likely to experience loneliness.

ENGAGE OLDER PEOPLE IN THE DEVELOPMENT AND PROVISION OF SOCIAL ACTIVITIES

One-quarter (45%) of older adults felt that the social activities that were available in their local area did not interest them and this was an often cited barrier to participation. These adults were more likely to feel lonely.

IMPROVE TRANSPORT TO AND FROM SOCIAL AND COMMUNITY ACTIVITIES

Improving transport connections as well and improving provision is likely to reduce the experience of loneliness for the 10.7% of adults who could not get to venues where social activities are taking place.

"I'm too old for classes"

"Sure what could I do at my age, I'm too old aren't I?"

"Too long in the tooth now"

"I have seen some people are rude to the elderly people."



The HaPAI survey is a random-sample survey of community-dwelling people aged 55 and older, living in 21 local authority areas: Dublin City; South Dublin; Dublin Fingal; Dún Laoghaire-Rathdown; Galway City; Galway County; Clare; Limerick City; Limerick County; Kildare; Kilkenny; Laois; Louth; Meath; Wexford; Wicklow; Cavan; Cork City; Cork County; Mayo; and Tipperary.

The questionnaire was developed from a survey framework which mapped the WHO Age Friendly domains to the objectives of the NPAS. Several data and literature sources were reviewed (national/international surveys, research literature, and the WHO Age Friendly Indicators – A Guide) to identify survey questions that were; reliable, valid, have an explicit evidence base, support national and international comparison, are sensitive to change over time, and align directly with the NPAS and Age Friendly Ireland Programme goals.

Older people in two different public consultation sites were invited to comment on the draft questionnaire. In the first session 150 participants attended and gave feedback. Their comments and the gaps identified were addressed prior to the second consultation which involved a group of 30 participants who completed the survey individually. Overall, feedback focused on the overall clarity and accessibility of each question and substantive survey gaps.

Fourteen survey areas were included: outdoor spaces and buildings; transport; housing; safety; social participation; education and lifelong learning;

respect and social inclusion; civic participation and employment; communication and information; health status and health behaviours; carers; health services; psychological wellbeing, and personal safety (elder abuse). Questions on socio-economic status and geographic location were also included to support further analysis of the survey data.

Data was collected between 2015 and 2016 and a multi-stage random-route sampling strategy was used to generate a sample of this population. A random sample of 50 District Electoral Divisions (DED) in each local authority, were the primary sampling units (PSUs). Within each DED a starting address was selected and interviewers then called to every fifth house in order to complete the 10 interviews required in each of the 50 areas. Where two or more older people lived at an address, the interviewer applied the 'next birthday' rule to select one participant.

Each participant completed a Computer-Assisted Personal Interview (CAPI) in their own home with a trained interviewer from Amárach Research. A total of 10,540 interviews were completed. The overall response rate was 56%, and this ranged from 51% to 63% across the areas. Survey response rates typically vary for different groups within a given population and this can lead to biased estimates when reporting results. Therefore, sample weights based on the Census (2011) were applied to the survey data to adjust for differences in participation rates by age, gender, education, and marital status and ensure that the survey results are representative of this population.

17. Walsh K, Scharf T, Keating N. Social exclusion of older persons: a scoping review and conceptual framework. *Eur J Ageing*. 2017;14(1):81-98. doi:10.1007/s10433-016-0398-8
18. Levitas R, Pantazis C, Fahmy E, Gordon D, Lloyd E. The multi-dimensional analysis of social exclusion. 2007.
19. Weiss RS. *Loneliness: The experience of emotional and social isolation*. Cambridge, MA, US MIT Press.
20. Wenger GC, Burholt V. Changes in Levels of Social Isolation and Loneliness among Older People in a Rural Area: A Twenty-Year Longitudinal Study. *Can J Aging / La Rev Can du Vieil*. 2004;23(02):115-127. doi:10.1353/cja.2004.0028
21. Russell DW. UCLA Loneliness Scale (Version 3): Reliability, Validity, and Factor Structure. *J Pers Assess*. 1996;66(1):20-40. doi:10.1207/s15327752jpa6601_2
22. Dykstra PA. Older adult loneliness: myths and realities. *Eur J Ageing*. 2009;6(2):91-100. doi:10.1007/s10433-009-0110-3
23. Eurofound. *European Quality of Life Survey*. 2016.
24. Golden J, Conroy RM, Bruce I, et al. Loneliness, social support networks, mood and wellbeing in community-dwelling elderly. doi:10.1002/gps.2181
25. Nolan A, O'Regan C, Dooley C, et al. *The Over 50s in a Changing Ireland: Economic Circumstances, Health and Well-Being*. Dublin; 2014.
26. Luanaigh CÓ, Lawlor BA. Loneliness and the health of older people. *Int J Geriatr Psychiatry*. 2008;23(12):1213-1221. doi:10.1002/gps.2054
27. Holt-Lunstad J, Smith T, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect Psychol Sci*. 2015;10(2):227-237.
28. Euromonitor International. *The rising importance of single person households globally: Proportion of single person households worldwide*.