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Abstract

Background: Dementia is a topic of interest for me and with the recent launch of the National Dementia Strategy it is timely to investigate. There is increasing concern that older people are discriminated against in terms of access to services and those with dementia are among the most vulnerable of patient groups. The recent strategy calls for greater awareness of dementia among health care workers.

Aim: To examine the level of dementia knowledge and attitudes towards ageing and to test whether there is an association between them among student nurses.

Research Design: Questionnaire survey of student nurses.

Methods: A self-completion questionnaire was distributed to pre-registration student nurses. The questionnaire measured knowledge of dementia on a scale of 0 to 24 with higher scores indicating greater knowledge. Attitudes to ageing were measured with the AGED Inventory. The two variables were examined for differences on demographic and course related variables. The two score variables were then analysed to assess whether there was a relationship between the two.

Results: With regards to dementia, a mean total score of 14.2 indicated an average achievement of 60%. Public health issues such as mortality, prevalence and cost were answered poorly. The existence of negative attitudes towards older people were found among student nurses, especially with regards to adventurousness and sexuality. No direct relationship between dementia knowledge and attitudes towards ageing was found. Pearson's correlation coefficient was 0.041 (P=0.39) suggesting no evidence for a linear relationship.

Conclusions: As a result of an ageing population, the burden dementia presents is likely to increase and as a result, it is crucial that current student nurses are prepared in order to deal with this challenge once qualified. Findings from this study would suggest that this is not the case. Pre-registration nurses would therefore benefit from increased education in both dementia and challenging stereotypes.

Introduction

Chapter One – Introduction

This chapter outlines the background to this dissertation by presenting a summary of the literature review carried out for this study. The rationale for the chosen topic areas is presented and the aims and objectives of the study are outlined.

1.1 Rationale for the study

A personal interest in dementia awareness stemmed early in my nursing course from placements undertaken in a variety of healthcare settings where I was involved in the care of people with dementia. Over 500,000 people in England are living with dementia and although it can occur at any age, there is a strong increasing trend for dementia with age (Brayne et al, 2006). It is estimated that about one in twenty people over the age of 65 years have dementia (NHS, 2008). Not only is dementia highly prevalent (see table 1.1), it is also very costly to the economy. Dementia costs the United Kingdom economy £17 billion a year and it has been estimated that the cost of dementia exceeds that of cancer, heart disease and stroke combined (Department of Health (DoH), 2008). Furthermore, it has been estimated that by the year 2050, 20% of our population will be over seventy (Bowling, 2005), and with this ageing population the increase in the relative and absolute numbers of people with dementia will increase the burden on the economy.

Table 1.1: Estimated prevalence (cases per 100 population) of dementia in the UK by age and gender *

	Female	Male
65 - 69	1	1.5
70 - 74	2.4	3.1
75 - 79	6.5	5.1
80 - 84	13.3	10.2
85 - 89	22.2	16.7
90 - 94	29.6	27.7
95 and above	34.4	30

* Source: Knapp and Prince,

It is crucial therefore that dementia services are able to respond to this challenge. However, recent reports and research have highlighted the shortcomings in the current provision of dementia services within the UK (Katsuno, 2005; Kümpers et al, 2005; Lliffe et al, 2000). One reason highlighted as a source for these shortcomings is the stigma associated with dementia and stereotypical ageist views that people hold about those with dementia and generally those of old age (Katsuno, 2005). In a survey carried out by the Alzheimer's Society, it was suggested that general practitioners and medical staff working within specialist services compounded the problems faced by people with dementia (Banerjee, 2009). A possible explanation for this is that ageism and stereotypes relating to older people are important factors in the care of people with dementia.

There has also been a great deal of research over the last decade that suggests that older people have a low priority within the NHS and that they are therefore disadvantaged with regards to healthcare. In a study into mental health services by Age Concern, the researcher concluded that older people are denied access to mental health services because they are deemed too old (Lishman, 2009). Furthermore, services that do exist are chronically under funded and are not of the same working quality as those offered to younger adults. In another study by the European Health Management Association (EHMA), cases of under treatment of older adults in many areas of healthcare were identified including prevention, health promotion and mental health (EHMA, 2006).

For these reasons, I personally felt it would be interesting to study attitudes towards ageing within NHS staff, and see if this has an effect on knowledge and awareness of dementia which would consequently affect the care people with dementia receive.

1.2 Background

In 2005, the government identified dementia as a national priority after it was estimated that approximately 180,000 new cases of dementia occur in England and Wales each year (Matthews et al, 2005). The National Dementia Strategy was published by the Department of Health and introduced on 3rd February 2009. The strategy aims to transform the quality of dementia care. It does this by expressing a need for significant improvements to dementia services in three key areas (1) earlier diagnosis; (2) higher quality of care; and (3) improved awareness. It is the third of these aims that underpins the premise of this study. The objective states that public and professional awareness and understanding of dementia are to be improved and the stigma associated with it reduced. I am interested in finding whether this lack of understanding outlined is associated with ageist attitudes among student nurses.

Much research has been conducted concerning attitudes towards ageing and over the past twenty-five years, there has been increasing interest in assessing how older adults are viewed (Kite & Johnson, 1988). However, the empirical evidence is inconclusive. There is much empirical evidence that supports the existence of ageist attitudes (Kastenbaum & Durkee, 1964; McGuire et al, 2008). Kastembaum and Durkee were some of the first researchers to investigate attitudes towards ageing amongst school children and concluded that young people negatively appraise older people and tend to omit any consideration of being old in their own lives. More recent research has also supported the existence of negative attitudes (McGuire et al, 2008). McGuire et al used a sample of 247 older adults ages between 60 and 92 and questioned them about their experiences as an older adult. 84% of participants stated that they had been subjected to ageism. On the other hand, some research challenges the idea that ageist attitudes are imbedded in our society (Schonfield,

1985; Hubbard et al, 2003). Schonfield studied attitudes towards ageing and found that ageist stereotypes such as loneliness and inflexibility diminished when respondents were asked to provide statements which were representative of 80% of older people. In a more recent study, Hubbard et al followed the care of patients in critical care and concluded that unmet needs within critical care are not related in any way to the age of the patient (Hubbard, 2003). Other studies however have suggested that while attitudes towards the aged are increasingly positive, they are still stereotypical (Austin, 1985). These stereotypical views that exist against older people may well affect the level of care they receive and I felt it would be interesting to test a relationship between the two.

1.3 Aims and Objectives

The aim of the study is to examine the association between knowledge of dementia and attitudes towards ageing among a sample of student nurses.

There are three main objectives of the study which are to, (1) measure the attitudes of student nurses towards older people, (2) explore the awareness and knowledge of dementia among student nurses and (3) test whether attitudes towards ageing and knowledge of dementia are related to each other.

Literature Review

Chapter 2 – Literature Review

2.1 Introduction

This chapter outlines a review of the available policy, procedure and literature that surrounds the topics of ageism and dementia awareness. The chapter is presented in three key sections; (1) dementia and the National Dementia Strategy - a highly topical document with regards to dementia care (2) ageism and (3) the relationship between the care of people with dementia and ageist attitudes. The literature is reviewed critically in order to contextualise the study.

A literature review is described as a systematic, explicit and reproducible method for identifying, synthesising and evaluating existing completed work (Fink, 2008). Literature reviews are important as they allow the researcher to acquire understanding of the topic area and also highlight what has already been done in order to avoid repetition of research (Hart, 2003). Literature reviews are therefore an important beginning to any research. Although the following literature review is not a systematic review, it has been attempted to approach it in a systematic manner and logical order.

2.2 Dementia

Dementia is defined as a clinical syndrome characterised by a widespread loss of mental function with the following features; memory loss, language impairment, disorientation, change in personality, self neglect and behavior which is out of character (Department of Health (DoH), 2007). Dementia is not a single disorder, but a syndrome of mental life that is characterised by a decline in cognitive ability. It is most common in older people, and with a rapidly increasing ageing population, the

numbers of people with dementia is set to rise which will further increase the burden on the economy. Dementia is highly prevalent all over the world and with a high level of associated morbidity, it is an urgent health and economic issue for the developed world. As public health efforts improve and technology betters, so does life expectancy, and the number of people with dementia worldwide is expected to quadruple by 2050 to 1.2 million (Whalley and Breitner, 2002). Urgent effective intervention and prevention are therefore needed due to not only high prevalence but also due to high costs, especially within the NHS. Dementia costs the United Kingdom economy £17 billion a year and it has been estimated that the cost of dementia exceeds that of cancer, heart disease and stroke combined (DoH, 2008). In 1987, there was a total of approximately 31,000 long term dementia beds and it is estimated that the NHS provided around 79% (Norman, 1987). This figure is only an approximation as it is difficult to obtain detailed figures due to some authorities not making the distinction between people with dementia and other illnesses. However, in 2007, twenty years later, it was estimated that 244,000 people have specialist dementia beds in nursing homes, and this is only 60% of those that require them. Due to such high prevalence, it is clear that a great deal of people with dementia are nursed within the NHS. If money is spent now on improving quality of life for people with dementia, the Department of Health feel that money will be saved in the future and that the situation will improve for everyone concerned (DoH, 2009).

The work of Tom Kitwood focused on giving quality care to people with dementia. In his influential book 'Dementia Reconsidered' (Kitwood, 1997), Kitwood outlines dementia care mapping which is aimed at improving the quality of life and care of people with dementia. To do this, Kitwood sets out ten ways of ensuring a person with dementia's personhood is strengthened (see table 2.1). The book is an important milestone in dementia care and raises expectations of what can be

achieved. However, despite these recommendations for improved care of people with dementia, dementia services are still failing to provide best practice care (Sperlinger and Furst, 2004; Ferri et al, 2004). In one study 15 carers were asked about their experiences of healthcare services whilst looking after someone with dementia. The majority of carers said they would have like more advice and support and expressed concerns about a lack of day care facilities (Sperlinger and Furst, 2004).

Table 2.1: Ten ways to ensure a dementia sufferers personhood is strengthened*

Need	Explanation
1. Recognition	Person with dementia is recognised and affirmed as unique
2. Negotiation	Person with dementia is consulted about their preferences
3. Collaboration	Two or more people share a common task and work together to achieve a common aim
4. Play	The exercise of spontaneity and self-expression
5. Timilation	A word created by Kitwood to capture a form of sensuous interaction e.g. aromatherapy/massage
6. Celebration	Enjoying life experiences that are especially joyful
7. Relaxation	Time out which may involve social and physical contact
8. Validation	Refers to a high degree of empathy to understand someone's behavior
9. Holding	Containment of hidden emotions when needed
10. Facilitation	To enable someone to do something that he/she cannot manage alone

*Source: Kitwood, 1997

One factor highlighted as key in improving dementia services is early recognition and detection of dementia which enables people with dementia and their families to better understand and come to terms with the diagnosis and also to discuss future care. It also enables more timely access to treatments and drugs (Swainson et al, 2000). However, several studies into dementia care have reported high levels of unmet need, with widespread under detection of dementia, poor long term management of patients' problems, and low rates of referrals to specialist care and to other statutory agencies. This situation is not confined only to primary care in the

United Kingdom. Therefore, despite a clear need for treatment and preventative intervention, research suggests this is not happening.

With increasing need for effective intervention and prevention, dementia is a topic that is timely to investigate. At the time of writing, dementia is highly topical and there is a great deal of media attention surrounding concerns about patients being treated unfairly and not getting access to the treatment they require. When reviewing the media with regards to dementia, a host of stories are found about people who feel their relatives with dementia have been treated unfairly (BBC, 2009). Headlines such as 'dementia patients are ignored' and 'care staff sedated him' are found which usually come from relatives talking about their loved ones. The media therefore has a great impact on dementia services.

In 2000, 'Forget me not: Mental health services for older people' was published by the Audit Commission. The study focused on general practitioners and their opinions on dementia. They found that only half of GP's believe it is important to look actively for signs of dementia and to make an early diagnosis and that less than half felt that they had received sufficient training in how to diagnose dementia. The report also found that there was a lack of clear information, counseling, advocacy and support for people with dementia and an insufficient supply of specialist home care. Furthermore, poor assessments and treatment were noted, with little joint health and social care planning (Audit Commission, 2000). Unfortunately, a follow up review two years later found little improvement (Audit Commission, 2002). Following this study, the National Audit Office (NAO) published findings of its review of dementia services (NAO, 2007). The NAO was critical of the quality of care received by people with dementia and their families and also criticised general practitioners for a lack of confidence when spotting the symptoms of dementia. There are a number of key

policy documents regarding dementia services in the UK, all of which have shaped the care of people with dementia (see table 2.2).

Table 2.2: Key policy documents on UK dementia services*

Organisation	Title	Published	Summary
Department of Health	National Service Framework for Older People	Mar 2001	Sets out standards which aim to provide person centered care, remove age discrimination and to promote older peoples health. Eight standards are detailed with milestones for completion of steps.
National Audit Office	Forget me not: Mental health services for older people	Jun 2002	Sets out the state of dementia services and makes 17 key recommendations for its improvement.
NICE/SCIE	Clinical Guidelines on Dementia	Nov 2006	A guide for health and social care staff who work with people with dementia. Identifies nine key recommendations as priorities for implementation.
Alzheimers Society	Dementia UK report	Feb 2007	A report that highlights the cost and prevalence of dementia in the UK and assesses the current provision of services and treatment. Recommendations for future dementia care are made.
National Audit Office	Improving services and support for people with dementia	Jul 2007	Outlines findings from a dementia audit with regards to (1) challenges and responsibilities, (2) diagnosis and early intervention, (3) service and support and (4) scope to respond to the challenge of dementia.
Commission for Social Care Inspection	See me, not just the dementia	Jun 2008	Findings from an inspection of people with dementia in 100 care homes across England. Relationships between people with dementia and their carers were the main focus.
Department of Health	The National Dementia Strategy	Feb 2009	A landmark document that sets out initiatives designed to make the lives of people with dementia and their carers better and more fulfilled. It focuses on 3 main areas, (1) earlier diagnosis, (2) higher quality of care and (3) improved awareness.

*Source: Social Care Institute for Excellence, 2009

With both a number of research studies being carried out as well as media attention highlighting the mistreatment of people with dementia, it is possible that mistreatment may be due to the stereotyping of and stigma associated with older people. Those with dementia are likely to be particularly affected. The World Health Organisation suggests that stigma can be defined as a mark of shame, disgrace or

disapproval which results in an individual being shunned or rejected by others (Biernacki, 2007). People with dementia often suffer double stigma in that they are viewed as being both old and mentally ill (Biernacki, 2007). A report in 2001 into stigmatization by the Royal College of Psychiatrics found that doctors are known to give up on some patient's dementia and as a result published a paper entitled 'Changing Minds – every family in the land' (2006). The paper argues that medical practitioners are often the first port of call for people with dementia and therefore it is crucial that their assistance is not hampered by prejudice.

Although the last decade of research and media attention has highlighted problems in dementia care, this negativity has resulted in a growing acknowledgement of the challenge posed by dementia and the need for service improvement. The 'National Service Framework for Older People' included a chapter on mental health and older people (DoH, 2001). Within this chapter there were recommendations for early diagnosis and intervention as well as recommendations for the NHS to review health promotion, care and treatment planning, assessment and access to specialist services. However, reviewing progress, the framework had little positive impact on services for people with dementia (DoH, 2009). Another clinical guideline on management of dementia came from a joint report from the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) in 2006. These guidelines suggested that in order to manage dementia effectively, six key recommendations needed to be fulfilled. These are (1) integrated working across all areas, (2) increased assessment for diagnosis, (3) support and treatment for carers, (4) assessment of challenging behavior, (5) improvement of care for people with dementia in hospital and (6) dementia care training for all staff working with older people. It is the latter that is of direct relevance to my own study. A more recent report published in 2007 by the Alzheimer's society is key in the

management of people with dementia. The Alzheimer's Society report key findings on the number of people with dementia as well as its costs and as a result argue that earlier guidelines have not improved the care of people with dementia and have campaigned for dementia to be made a national priority. Following this recommendation, the Department of Health created the National Dementia Strategy, a strategy set to transform dementia care.

2.2.1 The National Dementia Strategy (Department of Health, 2009)

The main aim of the National Dementia Strategy is to transform the quality of dementia care. It is a key document with regards to the care of people with dementia. It focuses on creating services that meet the needs of everyone, regardless of their age, ethnic group or social status. The strategy uses a five-year plan to do this and attempts to address the needs of people with dementia, as well as carers, health and social care professionals and also anyone affected by dementia.

The strategy lists seventeen key objectives that the Department of Health want to achieve and what these objectives will mean for people with dementia and their carers. These seventeen objectives are focused around three main key areas which are, (1) earlier diagnosis, (2) higher quality of care and (3) improved awareness. The latter of which is the focus of this study. This chapter of the strategy suggests that public and professional awareness and understanding of dementia needs to be improved and the stigma associated with it addressed. Individuals should be informed of the benefits of timely diagnosis and care and the prevention of dementia needs to be promoted. Social exclusion and discrimination also needs to be minimised. It is the premise of this improved awareness section of the strategy that will be tested empirically within this study.

2.2.1.1 Improved awareness

The improved awareness section of the National Dementia Strategy focuses on two main recommendations; (1) increased public and professional awareness of dementia and (2) an informed and effective workforce for people with dementia. The first of these recommendations suggests that public and professional awareness and understanding of dementia need to improve and the stigma associated with it addressed (DoH, 2009). Within this objective, the Department of Health recognise that the stigma associated with dementia acts within professional groups to mean that the development of the skills needed to identify and care for people with dementia is accorded to low priority. The second of the recommendations suggests that all health and social care staff that are involved in the care of people with dementia are to have the necessary skills needed to provide the best quality care in their roles and in the settings where they work. This best quality care should be achieved through effective basic training and continuous development in dementia awareness. A study into levels of understanding of dementia in the workforce found that a lack of understanding can lead to care practices that can make the situation worse for both the person with dementia and their carer (Ballard et al, 2002). The aim of the improved awareness element of the strategy is therefore to develop a better understanding of dementia for both the public and professionals in order to improve the care of people with dementia.

2.2.2 The nurses role in dementia care

With an increasing older population, there is likely to be a growing amount of individuals with dementia on acute hospital wards (Fessey, 2007). As a result, patients with dementia are likely to have an increasing contact with nurses on the wards. It has been suggested that nurses are the linchpin of achieving good quality care and they can therefore rapidly improve the experiences of people with dementia

as well as their carers and loved ones (Pearce, 2005). Pearce suggests that the nurses role is the most crucial one, particularly in the early stages of dementia. This is because nurses can provide self-management training and offer one to one support and advice for those affected. In order to do this, nurses need to be fully qualified and trained with regards to dementia. In 2009, the Alzheimer's Society reported that 54% of nurses have never had any dementia training and another third stated that they had had some training but it was not sufficient to deal with the increasing importance of this area of care. Consequently, as nurses play such a key role in the care of people with dementia, it is apparent that they require more training and support in order to deal with the increasing need. Therefore training should be mandatory for all health service staff but in particular nurses who work within the geriatric setting (Ebrahim, 1999).

2.3 Ageism

With a rapidly ageing population, ageism is an increasingly important issue. Ageism is defined as prejudice and discrimination directed towards people purely on the grounds of age and usually towards the older person (Butler, 1969). Although this definition is old, it was the first recognised definition of ageism and is therefore key to this review. Ageism has more recently been defined as the association of negative traits with older people (Palmore, 2003). The perception of ageing has changed overtime. In the colonial era, old age is said to have connoted esteem and honour (Palmore, 1999). However, it is claimed that older people now tend to be on the receiving end of prejudice and discrimination (Age Concern, 2009a). Age Concern suggest that everyday older people face discrimination in access to health services, social care, financial products, benefits and insurance (Age Concern, 2009b). These suggestions were made following a study which aimed to find out how ageist Britain

was (Age Concern, 2006). The survey, which used a nationally representative sample of adults, concluded that 29% of people reported suffering age discrimination more that any other form of discrimination. Furthermore, from the age of 55 years onwards, people were nearly twice as likely to have experienced age discrimination than any other form of discrimination. The study also found that one in three people viewed the over seventies as 'incompetent and incapable' (Age Concern, 2006).
Ageism can be divided into negative stereotypes and negative attitudes. Negative stereotypes are mistaken or exaggerated beliefs about a group, in this case older people, where as negative attitudes are negative feelings about the group (Palmore, 1999). Stereotypes are usually more cognitive and attitudes more affective, although the two tend to work in parallel. Palmore (1999) outlines nine major negative stereotypes that reflect negative attitudes towards older people. These are illness, impotency, ugliness, mental decline, mental illness, uselessness, isolation, poverty and depression. However, Palmore accepts that these negative stereotypes should be taken with caution and that it must be recognised that most people believe in only some of the stereotypes, and that some people do not believe in any of them.

Ageism has been referred to as the third 'ism' of our society following racism and sexism (Butler, 1995). The word ageism was first used by Robert Butler in 1969 and since then the problem of ageism and elder mistreatment has begun to gain increased attention with studies being carried out in England (McGuire, 1993), America (Baumhover and Beall 1996) and Europe (Saveman, 1994). In addition there is now evidence of ageism and the mistreatment of older people from Greece, Hong Kong, India, Israel and South Africa (Kosberg and Garcia, 1995). However, comparatively very little research has been directed at understanding ageism with regards to the empirical and theoretical attention that has been devoted to the study of racism and sexism. Research over the past sixty years has identified the existence

of ageism in a number of countries, but it is not known with any accuracy to what extent these ageist attitudes affect care within the National Health Service. In order to do this, evidence that older people are treated poorly or on a basis of age rather than clinical need or otherwise needs to be analysed.

There have been a number of allegations surrounding ageism occurring within the NHS. Dr John Chisholm, chairman of the British Medical Association General Practitioners committee, suggests that priority in the NHS should be determined by clinical need, and age should not disbar people from the treatment they require. However, studies have shown that this is not always the case. In a study carried out by Age Concern, 77% of 200 general practitioners surveyed believed that ageism with regards to treatment occurs within the UK. The charity believes that the GP's views were representative of all of family doctors. The survey found that 16% of GP's decide in some cases not to refer elderly patients for secondary treatment because they suspect they will not be treated due to their age. Age concern also claims that there is evidence of rationing for the withdrawal of key treatments affecting older people including donepezil hydrochloride used in Alzheimer's, chiropody services and physiotherapy (Beecham, 2000). Similarly, in a study of stroke patients it was found that older patients do not get the same level of care as younger sufferers (Nursing Times, 2009). The study, which looked at 379 stroke patients, found that patients over 75 were less likely to be given the appropriate diagnostic tests and lifestyle advice compared to younger patients. Younger patients were scanned quicker, and were five times more likely to be given a brain scan to check for blockages and bleeds.

It has been suggested that ageism is not always necessarily negative and that there are both scientific and moral arguments against the complete abolition of age

discrimination (Heath, 2010). Although the most common interpretation of discrimination involves prejudice and stereotyping, the contradictory meaning is admirable and relates to the power of observing differences accurately. With this in mind, ageism can be seen as admirable as treating a patient of 90 the same as a patient of 20 is unscientific and ill advised. Prejudice only begins when we judge without first asking, listening and thinking (Heath, 2010). However, with this being recognised, studies still suggest that negative discrimination is occurring within our health system (Beecham, 2000; Nursing Times, 2009). Furthermore, older people are decreasingly accessing health care. Shah et al (2001) investigated rates of consultation for psychiatric disorder in people over the age of 65. It was reported that consultation rates were much lower than expected. In a similar cross sectional questionnaire study in 2002, Nelson et al concluded that dementia is a negative predictor of hospital and GP consultation. Only 44% of people with dementia had consulted their GP in the previous three months compared with 61% who did not have dementia. This decreasing access to health care may be a result of prejudice received from healthcare professionals.

As a result of studies like these, plans for reform have been made. In the NHS Plan for Investment and Reform (2000), a vision of the health service designed around the patient, it explicitly claims that ageism within the NHS will be eradicated. A year later the National Service Framework (NSF) for older people (DoH, 2001) was announced which for the first time set national standards of care for older people in the UK. Two principles lie at the heart of the NSF, (1) the promotion of person centred care and (2) the eradication of age discrimination in the NHS. Furthermore, in 2002, the Human Rights Act of 1998 came into force which gives details on an equal right to life saving treatment of all people (Sayers and Nesbitt, 2002). However, with all these documents in place protecting older people, studies are still

finding that they are treated on a basis of their age and not clinical need. A recent British Geriatric Society study of 200 doctors found that more than half would be worried about how the NHS would treat them in old age (British Geriatric Society, 2009). The study also found that two thirds of doctor's specialising in the care of older people agreed that they are less likely to have their symptoms fully investigated. Furthermore, seven out of ten geriatricians said older people were less likely to be considered and referred on for essential treatments. Studies like this however are few and therefore more research is needed into ageism within the NHS since the publishing of these three key documents.

2.2.1 Measuring ageism

There are a number of scales of ageism in place that aim to assess a variety of components of ageing. Scales of ageism are often criticised for only focusing on a few components of ageing (Rupp et al, 2005), for example the Awareness of Ageism scale which focuses on the extent to which individuals view the amount of respect and consideration older people are given. One scale that manages to partially overcome this criticism is the Fraboni Scale of Ageism (FSA) (Fraboni et al, 1990). The FSA was developed to measure antagonistic, discriminatory attitudes and the tendency toward avoidance, in order to represent a more complete measure of ageism. The scale is comprised of 29 items and has been found to have high levels of construct validity and high internal reliability (Neto, 2006). However, the Fraboni scale uses descriptive ageism dimensions such as 'many old people are stingy and hoard their money and possessions' and 'old people complain more than other people'. For the purpose of this study, the items were found to be too subjective and therefore not relevant for this research.

Another scale of ageism deemed more suitable for this research study is the Age Group Evaluation and Description Inventory (AGED) (Knox et al, 1995). The AGED scale was designed in order to overcome the shortcomings identified in other scales. The AGED scale is made up of 28 contrasting objective pairs, for example friendly/unfriendly and wise/foolish (see questionnaire in appendix two for a full list of the contrasting pairs). These 28 pairs are more suitable descriptive factors for the basis of this study.

2.4 The relationship between ageism and dementia

In one study carried out by the Alzheimer's Society, it was found that only 31% of general practitioners believed they had received sufficient basic and post-qualification training in order to diagnose and manage dementia. Furthermore, 78% of general practitioners said that they believed that an awareness campaign would lead to people reporting symptoms earlier and therefore agreed that dementia awareness, or a lack of it, does have an effect on the care of people with dementia (Alzheimer's Society, 2007). These figures suggest that increased knowledge and awareness of dementia does affect the care of people with dementia. However I was interested to find whether this apparent lack of dementia knowledge and awareness was due to ageism within the NHS.

There has been little research into the effects of ageist attitudes towards dementia awareness and knowledge. However, research has been carried out which shows the negative effects that ageism has on our healthcare system as a whole. For example, in 2005, Kane and Kane found that ageism causes complacency in healthcare and thus affects the quality of care given. Another study that explored aspects of stigmatisation found high levels of ageism in long term care and found that a lot of

the stigma is related to disease and illness including dementia (Dobbs, 2008). Although this research was only in care homes, and not within the hospital setting, it still shows a link between ageism and the standards of care of people with illnesses such as dementia. In another study, it was concluded that many healthcare professionals hold stereotypical and negative attitudes towards older people (Lothian and Philp, 2001). As a result of these findings it was suggested that tackling attitudes through exposure and education could help to preserve patients dignity and autonomy and thus improve the quality of care of older adults. This suggestion had been tested in Sweden and it was reported that after a year of special education, healthcare professionals came to view older people with dementia as "unique human beings" rather than "a homogenous group" (Hope, 1994). All this suggests that there is a possible link between dementia awareness and knowledge and ageist attitudes and that increased education could well improve the care of people with dementia. However these relationships have been under investigated.

2.5 Summary

From researching the literature and policy with regards to the two topics focused on in this study, ageism and dementia awareness are clearly significant problems within the NHS, and with a rapidly ageing population, problems relating to ageism and the care of people with dementia are likely to worsen in the future. Dementia is not only highly prevalent but also very costly. Furthermore, with a high level of associated morbidity, dementia has become an urgent health and economic issue for the developed world. Therefore, quality dementia services are needed to deal with the challenge posed by dementia. However, research and media attention over the past decade has highlighted suboptimal dementia care. A need for improvement has therefore been recognised and a number of papers have been introduced in order to

aid this improvement. With regards to ageism, a rapidly ageing population means that ageing is an increasingly important issue. A number of studies have proven the existence of ageist attitudes within the National Health Service as a result, plans for reform have been made. However, despite these reforms, there is evidence that older people are being treated on a basis of their age rather than clinical need. Therefore ageism remains a challenge to the NHS.

There is a great deal of research into the potential effects that ageism has on society, but little to suggest it has a detrimental effect on people with dementia. The research that has been conducted suggests that there is a lack of knowledge of dementia within the NHS, and that general practitioners are of the consensus that they are not taught enough about dementia and that care could be improved if they were. It is apparent that despite efforts to eradicate ageism within the NHS through the introduction of policies that are in place to protect older people, studies are still finding that older people are treated on a basis of their age and not clinical need. The literature suggests that ageism causes complacency in healthcare and thus affects the quality of care given. However, there is a clear gap in the research when determining a definite link between ageist views and their affect on dementia awareness. This study aims to fill that gap in the research.