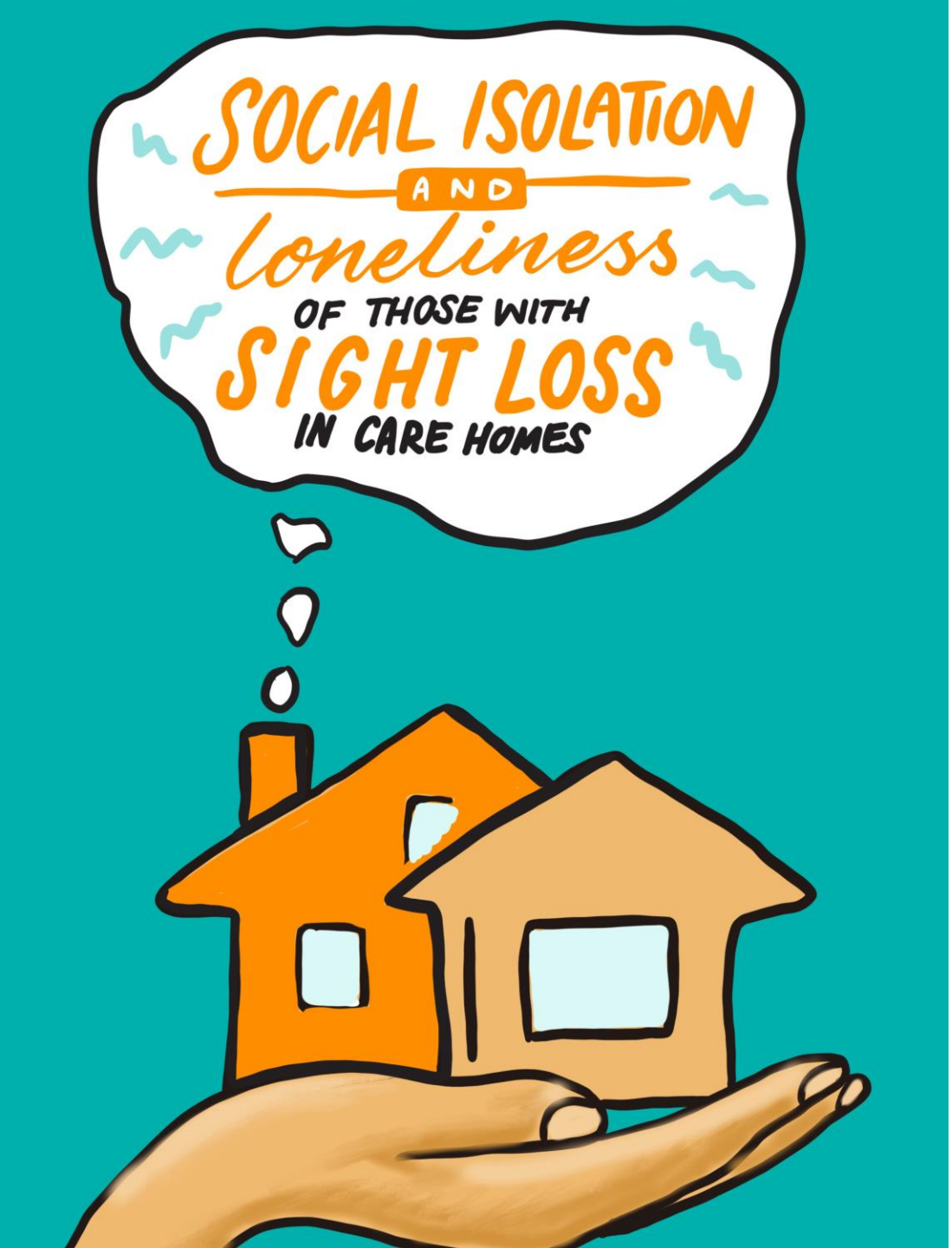

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NIHR | School for Social Care Research

Mark Wilberforce

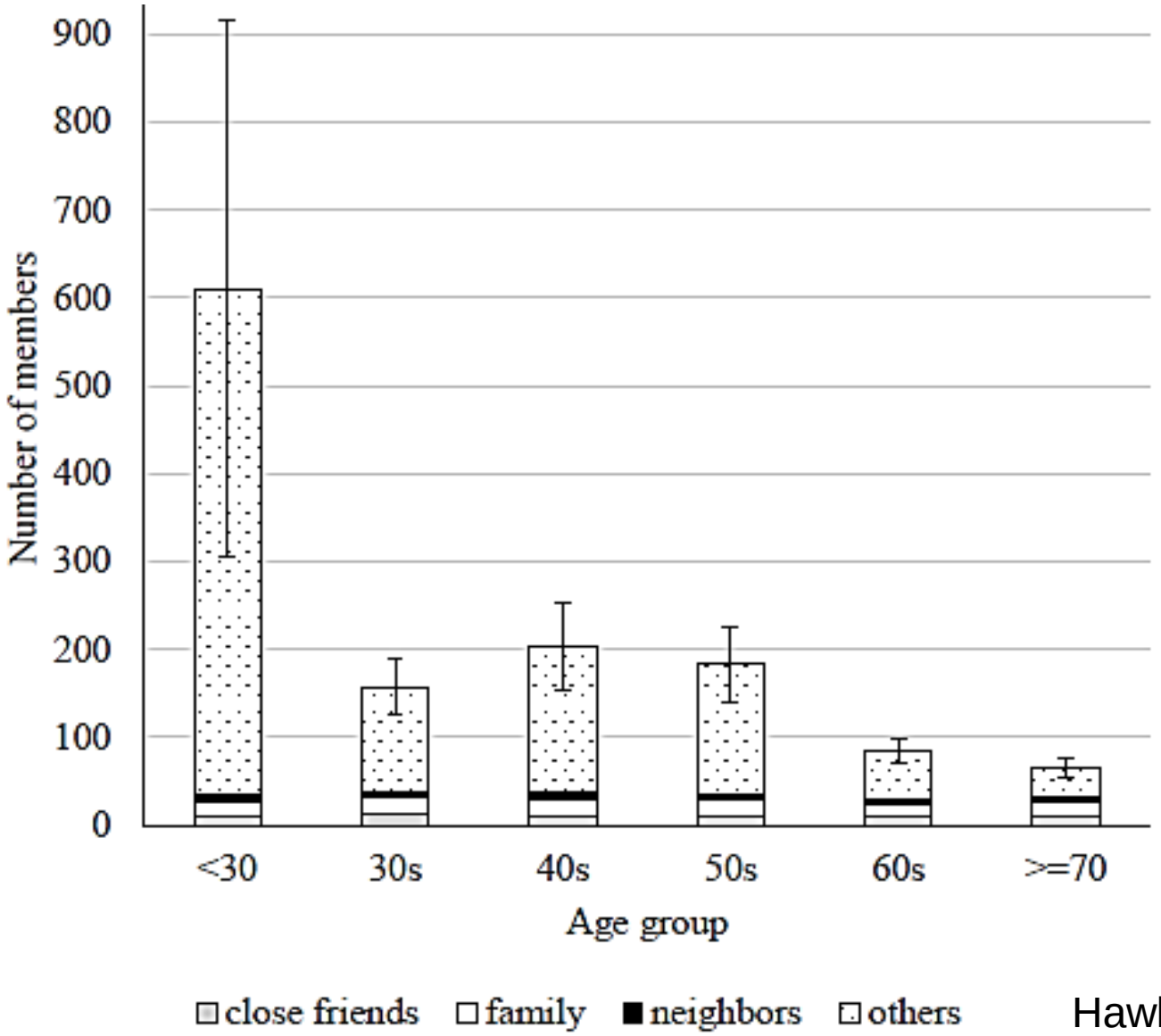
School for Social Care Research Webinar

9th June 2020

A loneliness crisis?

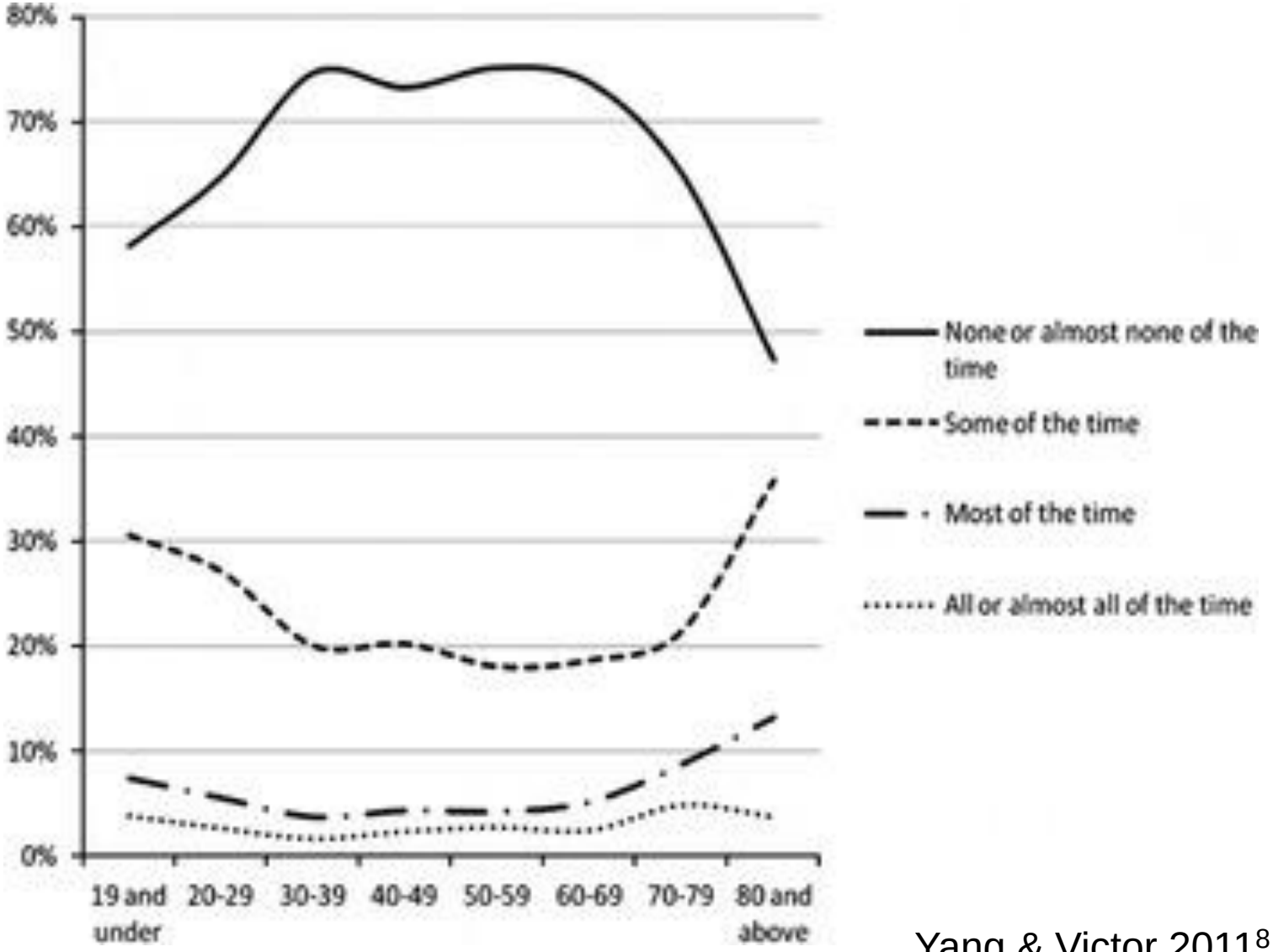
- Ageing population and societal change has caused a “loneliness crisis” facing those in later life[1]
- Significant implications for wellbeing[2]
- Important health consequences?
  - Life-limiting?[3]
  - Causal link to dementia?[4]
- Concerted local and national efforts to address loneliness[5,6]

Is loneliness a ‘problem of old age’?



Hawkley et al 2020[7]

Is loneliness a ‘problem of old age’?



Yang & Victor 2011[8]

So what exactly is loneliness?

- "You are lonely when you feel sad about not being part of companionship or society"[9].
- Two forms of loneliness commonly identified[10]:
  - **Emotional loneliness**: relating to close and intimate relationships
  - **Social loneliness**: relating to social networks and groups
- Often studied as a psychological process[11]
  - Objective state → cognitive state → emotional state.

Loneliness, care homes and sight loss

- Loneliness is itself a risk factor for care home entry[12]
- Meta-analysis of prevalence of ‘severe loneliness’ in care homes estimated at 35%[13]
  - about twice rates of community-dwelling counterparts[14]
- Sight impairments makes forming/maintaining social relationships more challenging[15-17]
- Evidence to support care home responses to loneliness amongst residents with sight loss is scarce[16,17]

INSIGHT study: Cast and crew

Parvaneh Rabiee (lead investigator),
Rachel Mann
Yvonne Birks
Mark Wilberforce

Clive Nicholson (carer of resident with sight loss)
Sinead Cregan (commisioner)
Donna Crockford (care home manager)
Karen Croucher (academic)
Sally Gordon (ENRiCH)
Lizzie Hancock (care home manager)
Simon Labbett (specialist in vision rehabilitation)

What we wanted to do.

- Increase our understanding about sight loss, isolation and loneliness in care homes
  - identify how people with sight loss characterise loneliness
  - examine the different dimensions of loneliness
  - identify encouraging care home practices
  - coproduce resources on how to recognise and address loneliness.

How we went about doing it.

Residents with sight loss interviews (n=18)

- Sampled from 11 care homes (residential, nursing, and a specialist home for people with sight loss) – research ready (ENRiCH)
- Two under 85 years old, 16 aged 85+
- 14 female, 4 men
- 3 blind, others with a range of residual sight
- Multiple other impairments

Family member interviews (n=10)

- All adult children

Care home manager interviews (n=5)

- Range of years in post

Findings in three parts

1. Perceptions and understanding of loneliness
2. Four dimensions to loneliness experience
    a. Intellectual
    b. Physical / environmental
    c. Emotional
    d. Institutional
3. Drawing out ‘encouraging practice’

1. Residents' own assessments

- General satisfaction with social wellbeing
- Evidence of normalising loneliness?
  - 'This is all I want at my age'
  - 'I am used to being on my own'
  - 'I don't feel particularly lonely. The days just pass.'
  - 'The odd time you do [feel lonely] but then you get over it'
  - 'Loneliness is difficult to avoid'
- No-one expected care homes to have the answers

2a. Intellectual

- Social connections in the home were not stimulating
- Accounts involved positioning of self…
- …but also of others
  - Age
  - Cognition
  - Intellect and interests
- Activities that don't exercise the mind
  - "institutionalised recreation", cruise ship lifestyle.

Activities: To what end?

“We also play bingo... residents that cannot see, we will always try and have either myself, my assistant or a volunteer sat with that resident, so if we're playing something like bingo, we can tell them they've got that number or so on.”

“If they were playing bowls on the floor and they, they could only vaguely see where things were, it’s just about saying, you know, “roll it a little bit to the right”, and that sort of thing”

“We do lots of sensory stuff with [people with sight loss], like a feather boa, bean bags, a twiddle muff … They seem to like them. It keeps them occupied”.

2b. Physical and environmental

- Tendency to prefer own room to communal spaces
- Embarrassment
- Background noise
- Some solutions created new problems
  - “We opened up the lounge area upstairs so that people with visual impairment, and those less mobile, and with complex health needs and dementia, have a light and open space, nice light atmosphere, and there are fewer people up there so fewer people to be aware of“

2c. Emotional

- Superficial relationships
  - with other residents
  - with care workers
- “It’s not like ordinary life”
- Not particularly a sight loss issue?

2d. Institutional

- Meaningful social contacts and activities of interest more often located outside care home
- Missing-out on ‘what’s going on’ locally
- Dependent on individual’s own social networks
  - “At the end of the day, the safety of all the residents is paramount so you can’t put 27 residents at risk because you’ve allowed a member of staff to take one individual to attend a social group”

Institutional

"They're all, kind of, in a little bubble, these people. They're all there together, but they're not together…when there's a big group of people, people tend to get lost. People with sight loss, I don't think get a lot of enjoyment out of it"

"We experience the same things here so usually all we can talk about is ourselves and our past. Living in a home kills conversation.

3. What was encouraging practice?

I. Attention to small but crucial practices
   - Removing sources of noise (e.g. corridor buzzers)
   - Cleaning carts on one side of corridor only
   - Choice of seat in communal area
   - Being ‘on top of’ hearing aids
   - Seeking informal advice with digital equipment and aids

3. What was encouraging practice?

II. Closer match of activities to interests

- Avoid one-size-fits-all activities
- Build on resident feedback and ensure involvement in planning
- (Generally found to be easier in care homes with a bonding feature)

What was encouraging practice?

III. Maximise the care home's 'social capital'

- Use of volunteers
- Student placements and work experience
- Drawing on church groups
- Ongoing relationships with friends and families

Conclusions

- Participants were accepting that some loneliness was unavoidable
- Sight loss contributes alongside other factors
- Social connection and occupation needs to be meaningful
- Activities targeted to interests of smaller groups
- Role for building community assets
- Research needs to identify effective interventions

SUPPORTING THOSE LIVING WITH SIGHT LOSS

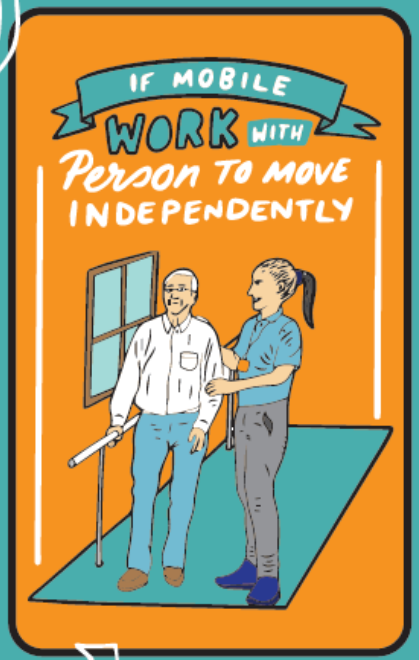
SOME MIGHT BE LONELY

IT'S ESTIMATED THAT HALF OF CARE HOME RESIDENTS EXPERIENCE SIGHT LOSS & ARE MORE LIKELY TO FEEL LONELY

BUT YOU CAN HELP!

THERE ARE EASY, SIMPLE THINGS THAT CAN BE DONE DAY TO DAY TO IMPROVE PURPOSEFUL SOCIAL CONNECTIONS FOR THOSE WITH SIGHTLOSS.

QUICK TIPS THAT HELP



FIND OUT MORE: bit.ly/sight-loss-uni-of-york

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UNIVERSITY of York
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Acknowledgements

For further information and resources see:

https://www.sscr.nihr.ac.uk/sight-loss-and-loneliness/

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