
The Selwyn
Foundation
2018 Gerontology
Nurses Conference

01
Karakia

The Reverend
Marianne Hornburg
Director, Spiritual Care
The Selwyn Foundation

Gathering

We stand on this small earth which God has created. **And we look about us to rejoice in the boundless universe.**

The night with its darkness and Milky Way is over. **And we rejoice for the rest and restoration of the silent hours.**

A new day has dawned with light and warmth. **And we step forward into its gift and promise.**

A time to focus


Lonely

Prayer & blessing

02
Opening address

Hilda Johnson-Bogaerts
Director, The Selwyn Institute
The Selwyn Foundation

Thank you…

To our speakers and our sponsors

Care partnership approach

The Selwyn Foundation

03

Loneliness in later life in New Zealand

Dr Sally Keeling
Senior Lecturer, University of Otago

Setting the scene: loneliness in later life in New Zealand.

Dr Sally Keeling

Hon Snr Research Fellow,

University of Otago, Christchurch

Presentation to The Selwyn Institute

October, 2018

Setting the scene - outline

1. Clarify the concept and significance of loneliness, alongside several other broader approaches to understanding the social context of everyday life and of individual life-courses.
2. Review evidence available from social and health research from several different NZ populations: prevalence and impacts of loneliness.
3. What interventions and services might be effective in alleviating loneliness, improving quality of life and health outcomes for older people?

Life course perspective

Holistic perspective

- Biopsychosocial dimensions

- Multidisciplinary research and practice

Ageing in context: the background to loneliness

- Cultural
- Social
- Environmental
- Historical

Environmental: features of loneliness?

- Urban Living Vs Rural -sense of belonging, neighbourhood structure (De Jong Gierveld et al 2008; Keating, 2009)
- Transport (Public and Private) (Davey 2004)
- Amenities – perceived sense of community (Wiles et al 2009)
- Rest home care and/or ‘Ageing in place’

Place matters .....

Demography

- Family size in each generation
- Longevity
- Gender mix
- Life course events
- Household composition
- Housing career

Geography

- Mobility - Global, national and local
- Migration - cultural and historical patterns

Cultural variation and loneliness

- Loneliness studies from many different countries - now a global concern.
- Familial obligation versus globalization.
- Pacific languages – difficult to express loneliness (Waldegrave et al, NSC work in progress).
- Loneliness levels can be affected by the culture in which a person lives e.g. Some European countries advocate a solitary and individualistic lifestyle featuring ‘independence’ whereas others are very social, family integrated, ‘collectivist’.
- Immigration- adjusting to a new lifestyle and culture late in life (Victor et al 2002); can offer a bonus of support and connection in more than one place.

Impacts of health upon loneliness or of loneliness upon health?

- Loneliness is not a medical diagnosis. It is ‘parasitical’, present with other physical & mental health conditions - heart, cognition, depression (Hawkley and Cacioppo 2010).
- Further research required to gain greater understanding of the relationship between subjective feelings of health & loneliness.
- Loneliness may also be a contributory factor in increased alcohol intake in the elderly (Khan et al 2006).

Definitions

- Loneliness has been defined as “a subjective and negative state that occurs when the number or quality of personal relationships falls short of the level desired or expected” (De Jong Gierveld & Dykstra, 2008).
- “Loneliness is a complex set of feelings encompassing reactions to the absence of intimate & social needs” (Ernst & Cacioppo 1999).
- Social/Emotional Loneliness - the impact of different types of attachment or relationship.
- Loneliness a believed inconsistency between need and availability in social or emotional ties

Emotional and social loneliness

- BEING CONNECTED

- FEELING CONNECTED

Mosgiel network study

- Individuality and sense of personal independence is expressed in social context
- Talk about family and friends shows sense of self is embedded in relations with others
- An independent self without a viable social context – a contradiction in terms?

Major NZ ageing studies

- Canterbury Health, Ageing & Life Course Study
- Enhancing Wellbeing in an Ageing Society
- Health, Work & Retirement Study
- Living to Advanced Age
- NZ Longitudinal Study of Ageing
- Observational Study of Midlife Women
- Te Hoe Nuku Roa: Best Outcomes for Māori

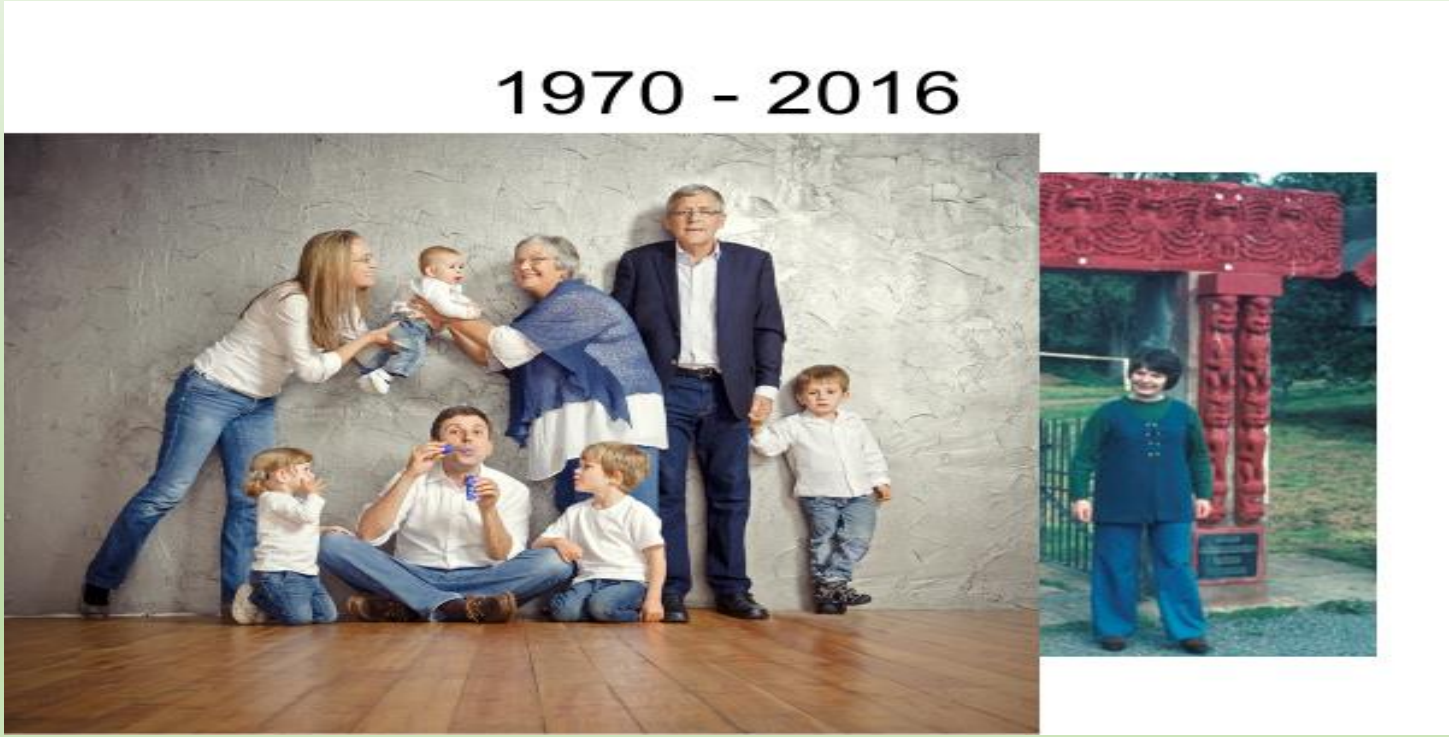
Social Network Research in Gerontology

- Key influence: the work of Prof Clare Wenger, Wales, UK. Structure and function of social networks, their capacity for support and care.

- US work from Seeman and Berkman, in MacArthur Studies. Enables understanding of that are seen as “upstream and downstream effects”, including the intrapersonal and subjective experiences. Both ‘who does what’, and the multiple psychosocial mechanisms involved in support: information, association, instrumental and emotional.

- Convoys of social support (Antonucci) – networks through time. Linked lives, as well as support networks which accumulate experience.

Linked lives – part of lifecourse perspective



Questioning framework for help, care and support, used in NZ studies (MLSA and LiLACS) based on Seeman and Berkman (1988).

- A. When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, cooking, house cleaning, telephoning, give you a ride?

- B. Can you count on anyone to provide you with emotional support? (talking over problems or helping you make a difficult decision?)

- C. Is there any one special person you know that you feel very close and intimate with – someone you share confidences and feelings with, someone you feel you can depend on?

For each question:

Yes/ No/ I don't need help/ Refused/ Don't know/ Not applicable.	In the last year, who has been most helpful with these daily tasks? Spouse/ Daughter/ Son/Sibling/ Other relative/ Your neighbours/ Co-Workers/ Church members/ Club members/ Professionals/ Any friend not included in these categories/ No-one/ Refused/ Don't know/ Not applicable.

Name of study	Waves/years	Population	Social measures	Health measures
Mosgiel Longitudinal Study of Ageing F, RC.	1988/ 1994	Community total aged 70+ in 1988; N= 891	Seeman and Berkman (1988)	Comprehensive, ADL/IADL esp nutritional, physical, ltd psychological/ QOL.
HWR P M now HART	2006/2008/2010/2012	N = 2624 (55-70 7ears)	Wenger Network Type and psychosocial measures. Aim: to identify psychosocial, economic, and resilience factors in 'health, work and retirement" transitions.	Diagnoses, and disabilities self-report.
NZLSA P (with subsample F) M now HART	2010/2012	N = 2743 (50-84)	Volunteer and caregiving activities, social participation, ethnic identity.	Depression, QOL, Loneliness, Life satisfaction, SF12.
EWAS T	Both cohorts 2007.	2 cohorts: 40-64 years (N=1858) & 65-84 years (N= 1680)	Domains of wellbeing	Self-report.
LILACS NZ F M RC	2010, 2011, 2012, 2013, 2014, 2015.	85 years for nonM; 80-90 years M Total N =	Family make-up; living situation; network type; (satisfaction with) social support received; neighbourhood, housing and environment	Nottingham Ext ADL/IADL; QOL, depression, dementia.
CHALICE M RC F (baseline + 5 years); annual P.	2012	50 year olds: 500 completed of 1000		Heart disease, hypertension, eye disease, bowel cancer, diabetes, dementia, depression, stroke.

Social isolation checklist(MSD –Office for Seniors)

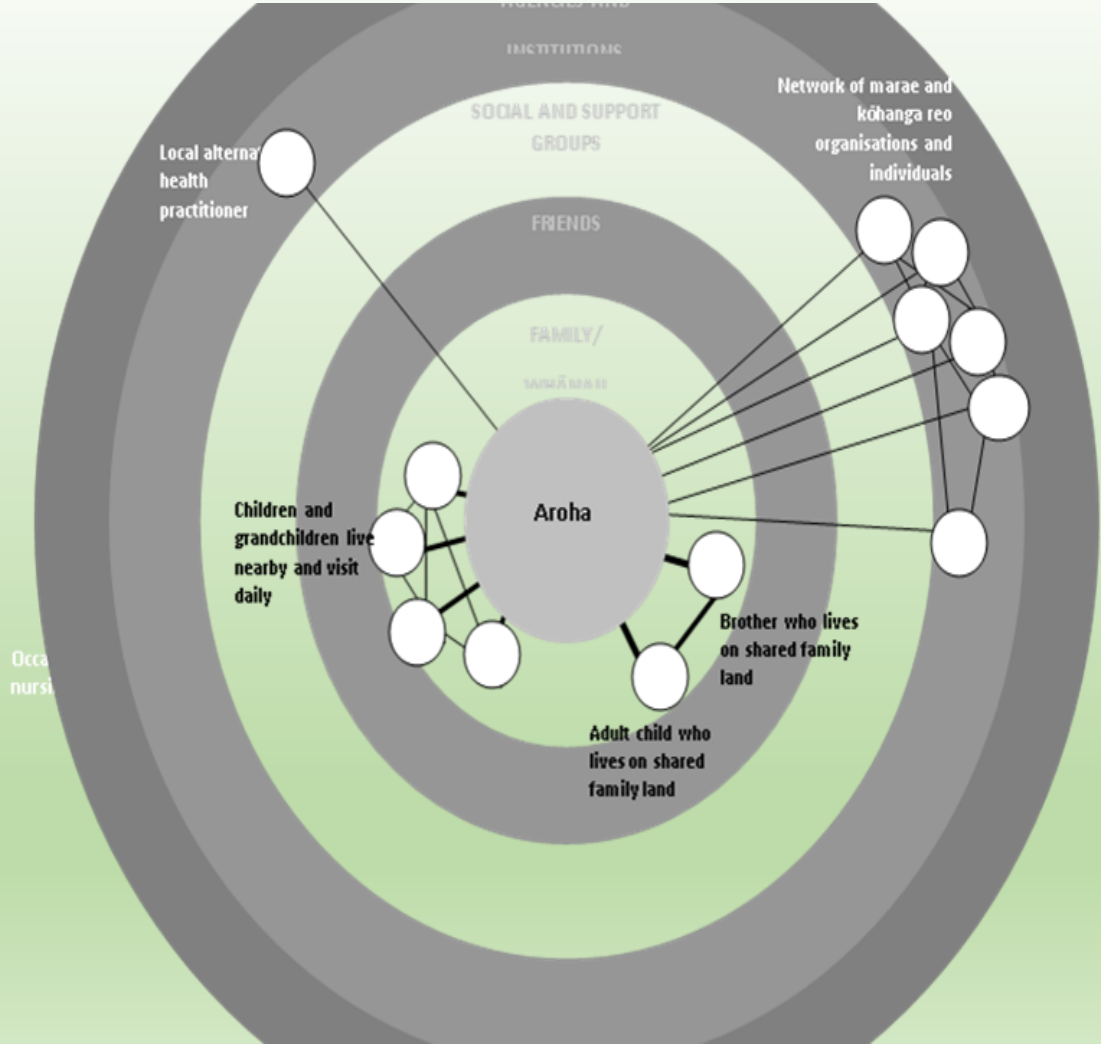
Social isolation and loneliness affects older and younger people the most.

Have you, or someone you know, experienced…….

- ✓the loss of a spouse, partner or friends (through death or relocation)
- ✓difficulty meeting new people or communicating in English
- ✓a move to a new country or to a different way of life
- ✓the loss of a vehicle or driver licence
- ✓retirement from work
- ✓poor health, frailty or sickness
- ✓depression or mental health problems.

Older person at the centre of a social network

"A place to call my own"- Ageing in Place case studies, Min of Social Development, 2009.



LILACS NZ- led by Prof N Kerse, University of Auckland

LiLACS NZ: Key Findings 2014

LILACS NZ

About LiLACS NZ

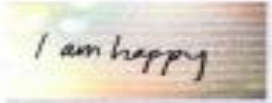
The LiLACS NZ longitudinal study was started in 2010 by the School of Population Health at the University of Auckland.

In 2010 LiLACS NZ interviewed 904 people of advanced age: Māori aged 80–90 years and non-Māori aged 85 years living in the Bay of Plenty and Lakes District Health Boards region.

The same participants have been interviewed every year—with the option of a full or partial questionnaire. The study is currently on its 5th year.

For more information: **Phone**: 0800 LILACS, **Email**: lilacs@auckland.ac.nz, **Website**: https://www.fmhs.auckland.ac.nz/en/faculty/lilacs.html

Social and Living



Over 88% of participants in 2010 had someone to provide them with emotional support

Most participants are happy in their relationships.

75% still lived with their partner/ spouse in 2013.

Less than two percent of participants lived in Residential care in 2010, this increased to 3% by 2013.

Kaiāwhina: Carers

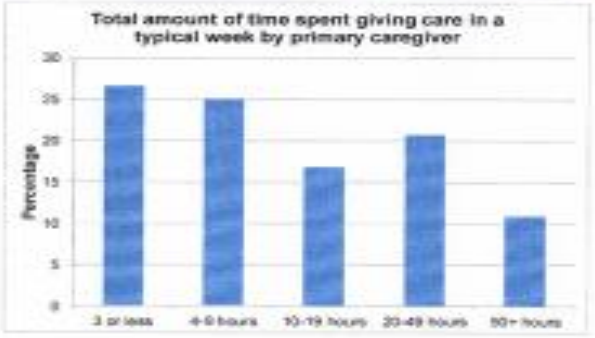
92% of participants have carers and 63% of carers were interviewed each year from Wave 3.

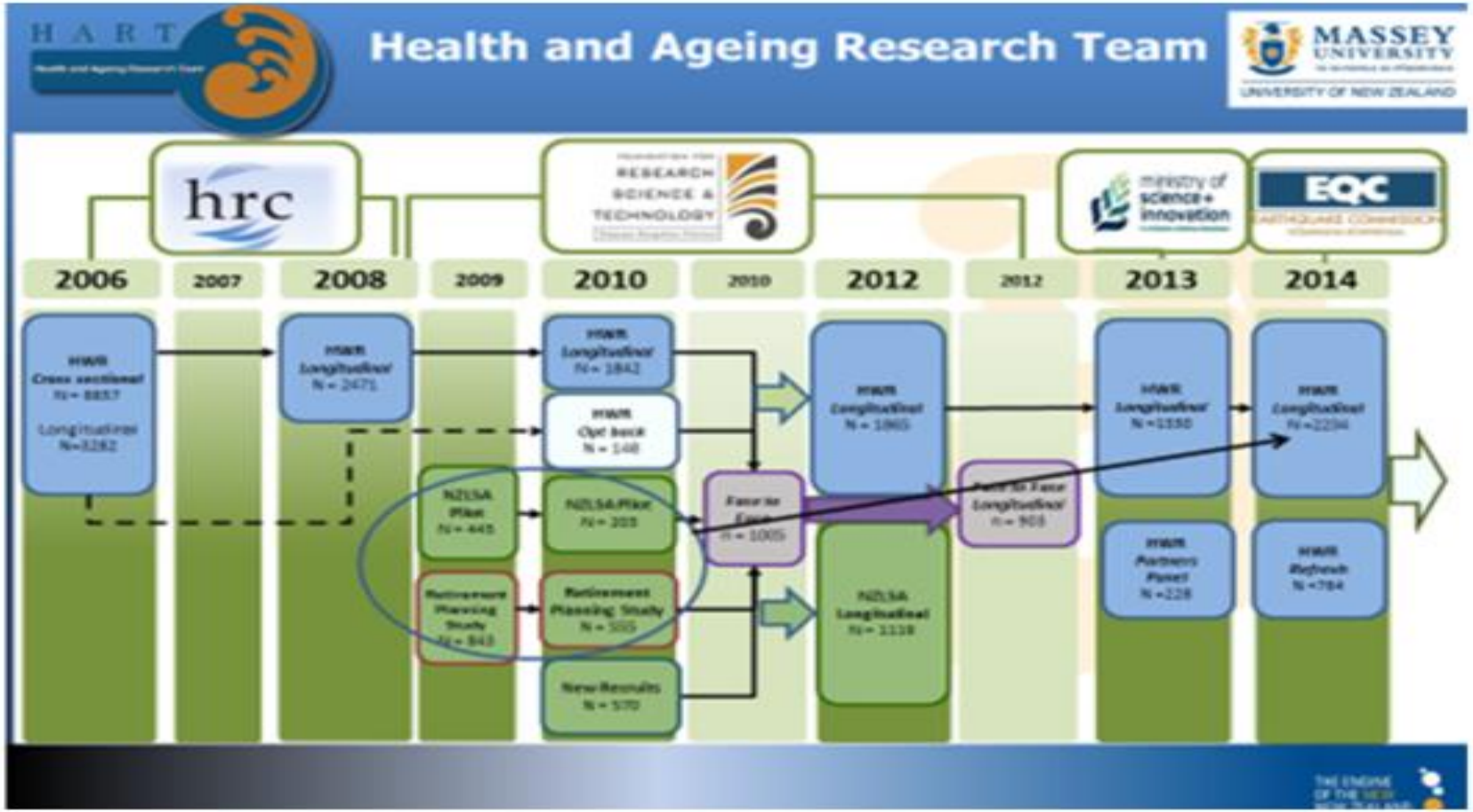
Over seventy percent of informal carers began caring for participants more than two years ago.

69% of married participants listed their spouse as their carer.

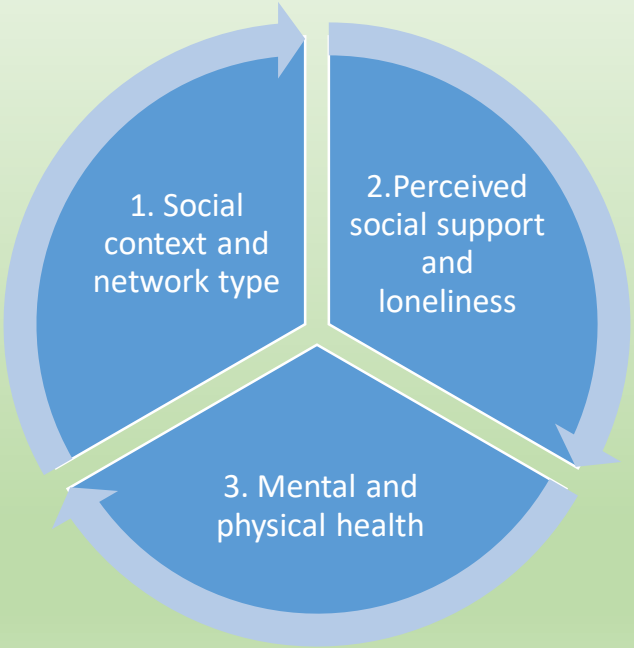
68% of widowed participants with children listed them as their carer.

One in ten carers give more than fifty hours of care per week.




HART
Health and Ageing Research Team
MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND
hrc
RESEARCH SCIENCE & TECHNOLOGY
ministry of science + innovation
EQC
2006
2007
2008
2009
2010
2010
2012
2012
2013
2014

Stephens et al, 2011: based on Massey longitudinal study



Commonly measured components

- Social situation - core socio-demographic factors; household and living situation; educational & occupational background and current status
- Family and social network – composition, structure and function; geographic location
- Supportive context – care and support given and received, satisfaction with support/unmet need
- Community and environment – emplaced life history; current participation and perceptions.

Loneliness by several other names ……

- Social network
- Social support
- Support network
- Care network
- Informal care
- Primary and secondary caregiver
- Family care

Only the lonely? A prelude to interventions

Hamish Jamieson, **Rebecca Abey-Nesbit**, Ulrich Bergler, Philip J. Schluter, Richard Scrase, Sally Keeling

Presentation to NZAG Conference, Sept 2018.

Ageing Well National Science Challenge

Harnessing science to sustain health and wellbeing into the later years of life

This project was designed to comprehensively assess the health and social needs of older people who are supported at home with community-based care.

National Science Challenges

AGEING WELL

Kia eke kairangi ki te taikaumātuatanga

Objectives

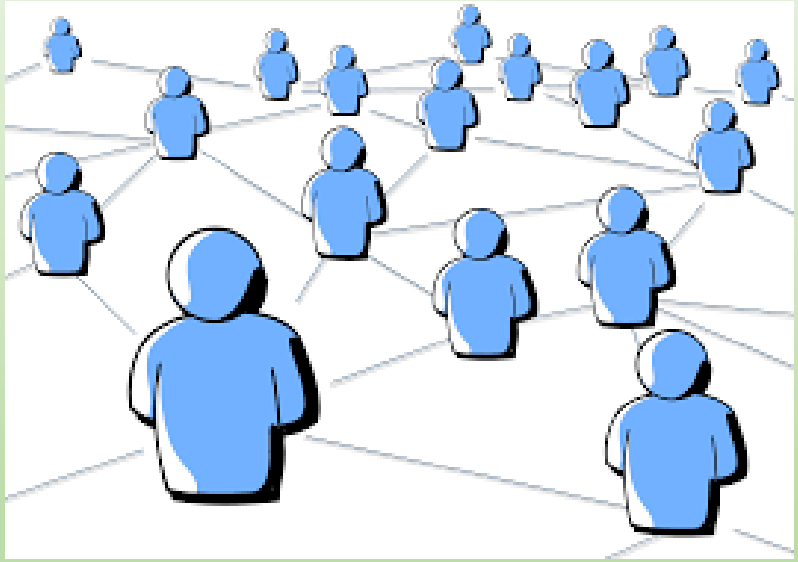
- Evaluate the influence of social factors on admission to aged residential care (ARC) facilities using the New Zealand database of interRAI Home Care assessments

- Potential to guide targeted or universal interventions

interRAI Home Care in New Zealand

- Mandated since June 2012
- Approximately 146,000 HC assessments up to 2017
- Linked to data from Ministry of Health (encrypted)
- Data is high quality
- Supports evidence based practice

Four Key Social Factors



- Living alone
- Negative social interactions
- Perceived loneliness
- Carer stress

- Emerged out of over 20 social factors available in database.

Questions arranged by Important Social Concepts …

Social Activity

- (E1i) Withdrawal from activities of interest
- (E1J)Reduced social interaction
- (F1a)Participation in activities of long-standing interest
- (F3) Change in social activities in last 90 days

Perceived Loneliness

- (F2) Lonely
- (F4) length of time alone in day

Care & Support

- (F5)Major life stresses in last 90 days
- (F1b)Visit with long standing rel/family member
- (F1c)Other interaction with long standing rel/family member
- (F1d)Conflict or anger with family or friend
- (F1e)Fearful of a family member/close acquaintance
- (F1f)Neglected, abused, mistreated
- (P2a) Informal helper unable to continue caring activities
- (P2b) Primary informal helper expresses feelings of distress, anger or
- (P2c) Family/friend feeling overwhelmed by situation
- (P3) Hours of informal care & active monitoring
- (P4) Strong supportive relationships with family
- (A13c) person /relative feels person would be better off elsewhere PTO

Paper in Aust Journal of Ageing

Profile of ethnicity, living arrangements and loneliness amongst older adults in Aotearoa New Zealand: A national cross-sectional study, Jamieson et al, 2017

National interRAI-HC assessments conducted between 1.9.12 and 31.1.16 were analysed. Focus on the associations between loneliness and both ethnic groups and living arrangements: 71 859 eligible participants, av. age 82.7 yrs: Māori (5%), Pasifika (3%), Asian (2%) and European/Other (89%).

Most were **not** lonely (79%), but those living alone were more likely to be lonely (29%) than those living with others (14%) ($P < 0.05$). Amongst those living alone, significant differences in the likelihood of being lonely emerged between ethnic groups ($P < 0.05$).

Ethnic identification and living arrangements were significantly associated with the likelihood of loneliness for those having an interRAI-HC assessment. Efforts to reduce the negative impacts of loneliness need a nuanced approach.

Living arrangements

European

Maori

Conceptualisation of Variables

	Individual's perception	Surrounding environment
Tension	Experiences tension => Negative Interaction	Carer experiences stress => Carer Stress
Isolation	Experiences isolation => Perceived Loneliness	Physical isolation => Lives Alone

Statistical Analyses

- Descriptive statistics in SPSS v23
- Competing Risk Regression Analysis in Stata IC v14.2

  with controlling for age, sex, ethnicity, cognitive impairment, Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), continence, timed walk, falls, and depression.

Basic Demographics

- Mean age 82.7 years
- 62% female
- 88.6% European Ethnicity
- 22% entered ARC
- 14% died

Social Variables

Social Variable	Total (%)
Negative Interaction	
Yes	5,462 (10.1)
Loneliness	
Yes	11,491 (21.1)
Carer Stress	
Yes	16,406 (30.2)
Living Alone	
Yes	26,597 (48.9)

Competing Risk Regression

	Unadjusted Model		Adjusted model	
	Subhazard Ratio	(95% CI)	Subhazard Ratio	(95% CI)
NO	1	Reference	1	Reference
YES				
Living Alone	0.86	(0.83, 0.89)	**1.43**	(1.37, 1.50)
Carer Stress	1.52	(1.47, 1.58)	**1.28**	(1.23, 1.34)
Negative Interaction	1.31	(1.24, 1.38)	**1.22**	(1.15, 1.30)
Loneliness	1.20	(1.15, 1.25)	**1.18**	(1.13, 1.24)

Conclusions

- Living alone, loneliness, presence of carer stress and negative social interactions are all associated with increased risk of entry to ARC
- Knowing social components can influence entry into ARC means interventions could be developed and applied in those areas

Nicky Davies-Kelly, PhD Univ of Otago, Christchurch.

Ageing and loneliness

- Sense of being a burden
- Changing health
- Planning ahead
- Outliving social network
- Driving
- Independence/Choice

Social comparison

- Stereotypes of old age
- Sympathetic to others
- Ambiguous - not wishing to comment
- Stoic
- Stigma

The way we talk about loneliness as health professionals is a key discovery.








Loneliness : social support
t

- Different types of relationship provide different forms of support (Spouse, Child, Friends, Associates) De Jong Gierveld et al 2006.
- Links between ‘informal/formal’ support and the sense of reciprocity or burden
- Helpful or harmful e.g. Home help - too much of a good thing?
- Ageing increases the likelihood of change in social networks - which can increase risk of loneliness (Alpass & Neville 2003).
- Greater awareness/preparation for change may encourage adaptation.
- Education relevant to role change and adaptation following bereavement, e.g., but also be aware of family, friends, neighbours moving out of town.
- Call for subjective research to establish greater understanding of meanings older people attach to relationships/support (Hellstrom et al 2004, Sabir et al 2009, Shiovitz-Ezra & Leitsch 2010, Tikkainen et al 2008).

Pictogram of health care system in Canterbury (Kings Fund, 2014)

Post Canterbury earthquakes

- **Loneliness measures in national older community population**: (Massey study).

Overall, emotional loneliness increased between 2010, 2012 and 2014. Also a significant difference in emotional loneliness between those exposed and not exposed to the earthquakes, with those exposed to the earthquakes less lonely in 2012, but returned to comparable levels in 2014.

- **Rockers of Ages**

The Rockers of Ages Choirs were started to provide an enjoyable activity in a non-threatening supportive environment that would lift people's spirits in areas that were badly affected by the Christchurch earthquakes and give them something positive to focus on.

Ageing as a journey into uncharted territory

- Our personal future includes places we haven’t yet been.
- What can we learn from those who have gone before us?
- Who will be with us on this journey?

Loneliness interventions

- Meaningful activity
- Honouring the sense of reciprocity
- Proactive approach to loneliness may moderate effects of deteriorating health
- Individually focused to meet the needs of the person
- Ill planned interventions can be more damaging than the loneliness itself (Manthorpe et al 2007)
- Non medicalised Loneliness is a normal human feeling not an illness – normalize loneliness work within a comfort zone before introducing new ideas (De Jong Gierveld et al 2006).
- Health promotion to maintain well being and social connectedness

Gardiner, C, Geldenhuys, G, Gott, M. Interventions to reduce social isolation and loneliness among older people: an integrative review. *Health & Social Care in the Community* 2018;26(2):147-157.

- Relatively weak evidence base
- The most effective interventions included adaptability, a community development approach, and productive engagement
- Contrary to previous review findings, our review did not find group-based activities to be more effective than one-to-one or solitary activities.

Building social connection: examples

- WeVisit. WeVisit is a social enterprise that fosters intergenerational connection for mutual benefit.
- https://youtu.be/eTRrrWfU3WE

Enliven Upper South Island

HOME SHARE brings older people with shared interests together in the comfort of a host's private home or suitable community facility.

Small groups get together for six hours at a time, to share a home cooked meal and conversation and to undertake activities decided on by the group. The service enables older people, who may be lonely and/or isolated, to socialise within their own communities.

HomeShare hosts are fully trained to support the needs of older people, in particular, those who may have special needs relating to memory loss. They also receive regular support from their local Enliven HomeShare service co-ordinator.

Age Concern Accredited Visitor Scheme

- http://www.ageconcern.org.nz/ACNZ_Public/Loneliness_and_Social_Isolation.aspx

“The majority of older people are not severely lonely, but findings from The Social Report 2016 show that 10% of New Zealanders aged 65-74, and 13% of those aged over 75 feel lonely all, most, or some of the time. This is important, not just because loneliness is painful, but because having inadequate social relationships has been shown to be as bad for health as smoking. Loneliness has also been linked to increased likelihood of entering rest home care.”

Back to the future: all of our futures

Acknowledgements

The Univ of Otago, Christchurch team working on the National Science Challenge: Dr Hamish A Jamieson (co-PI), Rebecca Abey-Nesbit, Ulrich Bergler, Associate Professor Philip J. Schluter (Univ of Canterbury), Richard Scrase, Helen Gibson.

Brigette Meehan and Jason Theobald (TAS) and interRAI NZ.

Funders: Ageing Well - National Science Challenge, & Canterbury District Health Board

Colleagues from both NZ Association of Gerontology, and British Society of Gerontology; Editorial Team and Board, *Ageing and Society.*

Personal thanks to

Dame Peggy Koopman Boyden, and Professor Sir Mason Durie.

Selected References

AGE CONCERN NZ: http://www.ageconcern.org.nz/ACNZ_Public/Loneliness_and_Social_Isolation_Research.aspx

NZ MSD: osc301-looking-out-for-one-another.pdf (accessed 31/8/18)

WeVisit & My Care: https://wevisit.co.nz/services/wevisit/

Campaign to End Loneliness, UK: https://www.campaigntoendloneliness.org/

04

Loneliness: What is a nurse's duty of care?

Kathy Glasgow
Senior Advisor - Nursing from the Office of the Chief Nurse
Ministry of Health

Loneliness - what is a nurse's duty of care

2018 Gerontology Nursing Conference

Dr Kathy Glasgow, Principal Advisor Nursing, Office of the Chief Nursing Officer, Ministry of Health

Overview

- Nursing – what is our role in dealing with loneliness – have we a ‘duty of care’?
- Key features of loneliness
- Interventions for loneliness
- Success factors for responding
- Looking ahead

Office of the Chief Nursing Officer

Advise the Minister

Hon. Dr David Clark

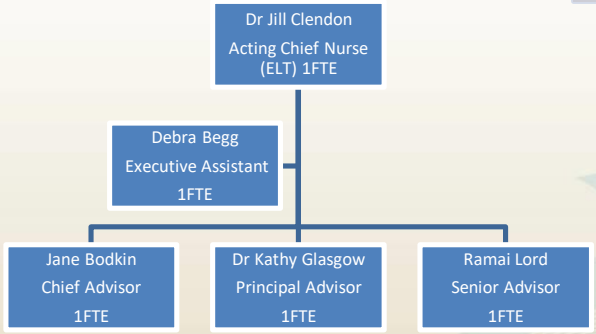
Advise the Ministry

- 1

MANATŪ HAUORA
MINISTRY OF HEALTH

Sector Leadership

- 2,648 Enrolled Nurses
- 52,399 Registered Nurses
- 242 Nurse Practitioners



Our Ministers



Minister of Health – Dr David Clark

Associate Ministers – Jenny Salesa and Julie-Anne Genter

The Health and Independence Report

- Director-General's report tabled in Parliament by the Minister of Health each year

Uses a wide range of information to paint a picture of population health

Reflects both progress and challenges and helps to inform Ministry and sector planning

What does the report tell us?

- We are living longer and spending more time in good health
- At the same time we are spending around a decade in poor health (and this is slowly increasing)

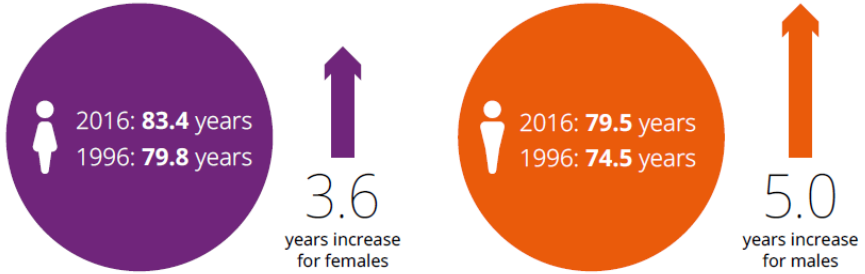
Long-term conditions are a major and growing contributor to poor health and premature death

Around a third of health of loss can potentially be avoided by tackling key modifiable risk factors

We are making progress but significant health inequities remain across a wide range of measures particularly for Māori and Pacific peoples

1 We are living longer and spending more time in good health...

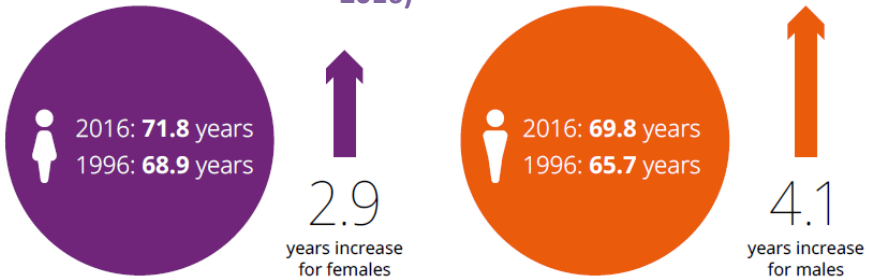
Life expectancy 1996 and 2016 (GBD 2016)



Life expectancy for Māori has increased but is around 7 years below non-Māori (Stats NZ)

...but...

Health expectancy 1996 and 2016 (GBD 2016)



We are also spending around a decade in poor health and this is slowly increasing (GBD 2016)

2 Examples of factors influencing our health

Housing

1 in 10

live in a crowded house, rates are highest for Pacific peoples

Education

1 in 3

Māori school leavers did not have NCEA level 2

Material Hardship

15%

of 0-17 years lived in households experiencing material hardship

Transport

148,000

missed out on a GP visit due to transport

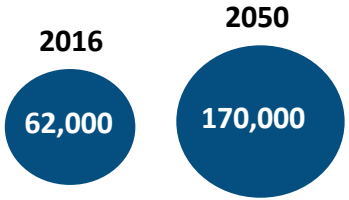
Social-economic and environmental determinants contribute to inequities in physical and mental health outcomes

Healthy ageing

Health and Independence Report 2017

The number of people aged 65 years and over is forecast roughly double over the next 30 years.

Ageing impacts on the prevalence of long-term conditions eg. **Dementia** is estimated increase significantly by the middle of the century



1 in 3 people aged 65 years and over **received 5 or more** long-term medications in 2016

Falls are the leading cause of injury for people 65yrs+ **Approx 75%** of hospital trauma admissions for older people were falls related

Loneliness is associated with poor health and wellbeing and affects **approx 1 in 5** older adults (InterRAI)

4 The report helps us as we look forward

- **Addressing inequities in health outcomes**, which are often entwined in the determinants of health, is vital if are to improve the health of all New Zealanders
- A significant amount of **poor health is avoidable** through prevention and modifiable through early detection and prompt treatment
- At same time, **adding life to years,** by supporting people living with disability, long-term and life limiting conditions, is vital as our population ages

Improving equity

Child wellbeing

Mental health

Primary health care

Signing of the Accord 30 July 2018

The Accord commits all parties to the following….

- to explore options for providing employment and training for all New Zealand nursing and midwifery graduates, taking into account the current model for doctors, and report to the Minister by the end of November 2018
- to develop any accountability mechanisms that the Parties believe are necessary (over and above those already agreed) to ensure DHBs implement the additional staffing needs identified by CCDM within the agreed timeframe (June 2021) and report to the Minister by the end of February 2019
- to develop a strategy for the retention of the existing nursing and midwifery workforce and the re-employment of those who have left the workforce, and report to the Minister by the end of May 2019.

Strengthening the HOP nursing workforce

Promoting and showcasing aged care nursing

Engaging with key stakeholders to support recruitment and retention

employers, providers, educators,

HWNZ and the Nursing Workforce Advisory group

MBIE, ImmigrationNZ

Supporting Healthy Ageing Strategy implementation

Supporting Models of Care for Home Support Services for older people

Loneliness – nurses role

What is loneliness

- Loneliness occurs when a person perceives their social relationships as insufficient or unsatisfying.
- There is little difference between the pattern of daily activities of those who are lonely and those who are not lonely and how much time they spend with others – i.e. it is **subjective.**
- Loneliness is seen as a subjective negative experience relating to dissatisfaction with the quantity or quality of relationships with others.
- Loneliness can be invisible and is underreported.

Loneliness as a social and health issue

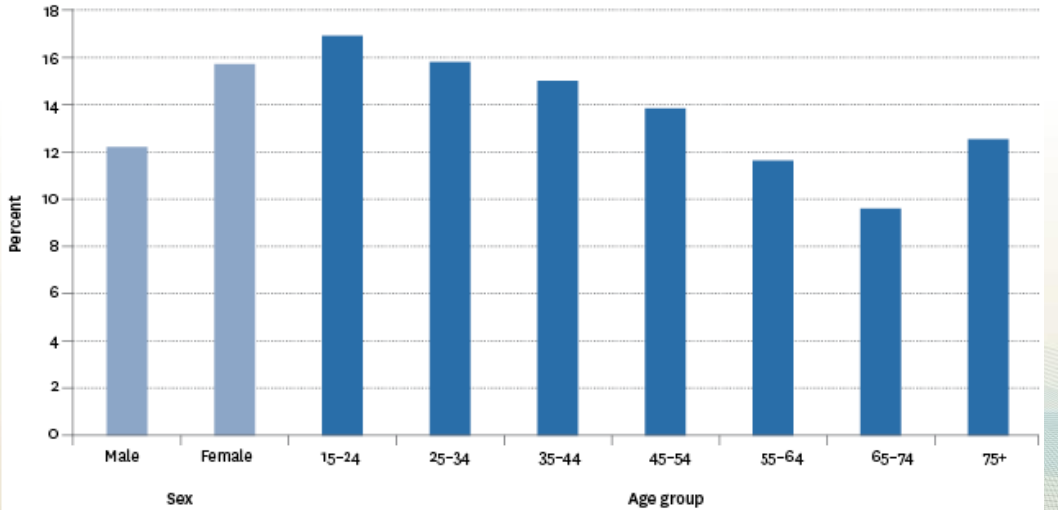
- How ready are we to cope with more lonely people?

- Loneliness as a public health issue – identifying those most at risk and offering support – UK charity Campaign to End Loneliness

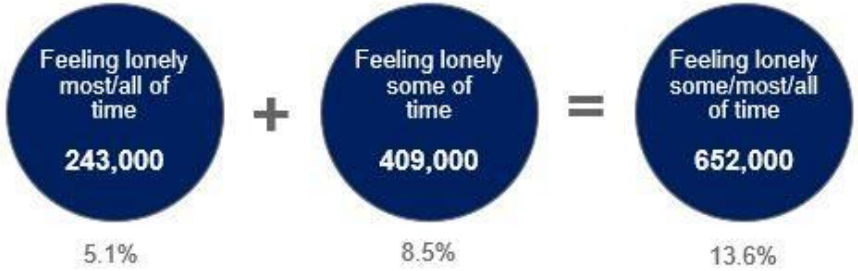
- https://www.youtube.com/watch?v=V5EsxU84ay4

- Loneliness as a area of advocacy – Loneliness NZ - seeking a less fragmented response that addresses social connectedness as the primary driver of loneliness, and targets loneliness and social wellbeing as part of prevention and early intervention in mental health issues
- www.lonely.org.nz

- NZ General Social Survey 2016: Proportion of population who felt lonely all of the time, most or some of the time, in the last four weeks, by sex and age group

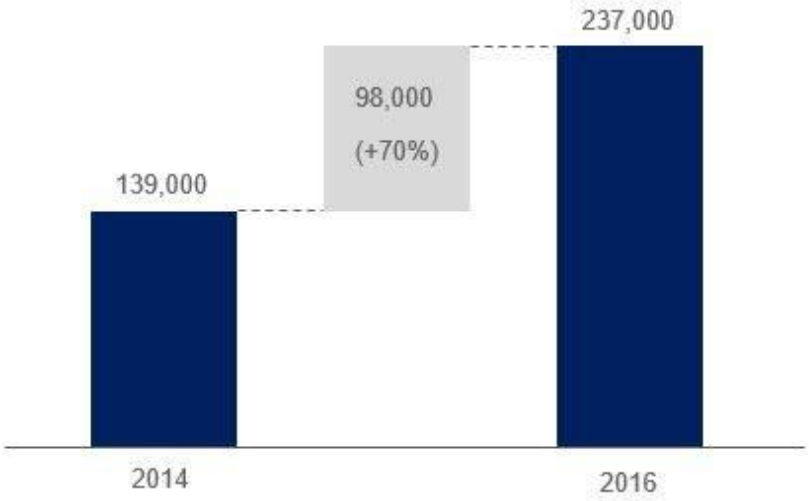


New Zealanders (aged 15+) feeling lonely some/most/all of time in last four weeks



Source: New Zealand General Social Survey 2016; New Zealand Estimated Residential Population 2017

New Zealanders (aged 15+) feeling lonely most/all of time in last four weeks



Source: New Zealand General Social Survey 2014, 2016; New Zealand Estimated Residential Population 2014, 2016

Key features of loneliness

- Those most likely to report loneliness belong to vulnerable social groups – the young, old, impoverished, chronically unwell, mentally unwell
- Negative effects of loneliness on physical and mental health - higher risk of depression, social anxiety, obsessive-compulsive disorder, cognitive decline and paranoia.
- Persistent loneliness linked to physical poor health including poor sleep, alcohol consumption, smoking, increased mortality

Types of loneliness

Hawkins-Elder, H – PhD research on Loneliness (NZ Attitudes and Values Study):

- 4 distinct ways people experience loneliness with varied impact on wellbeing: low loneliness 58%, appreciated outsiders 29%, superficially connected 7%, high loneliness 6%.
- Those experiencing high loneliness were the most introverted, emotionally unstable and poorest in wellbeing.
- 'Appreciated outsiders' were relatively higher in wellbeing than the superficially connected, despite greater introversion and neuroticism.
- So a few close meaningful relationships are better for health than many shallower connection (quality versus quantity).
- The more lonely a person is, the more likely they see themselves as in poor health, lower life satisfaction and self esteem, lowest perceived social support, greatest psychological distress

Duty of Care

- Duty of care has a particular significance in a medico-legal framework and has a different meaning from “the duty to provide care” and the “duty to give care”.
- The duty of care only arises once a health practitioner accepts the care of a patient.
- A duty of care is about ensuring our actions (or omissions) do not harm someone else.

Factsheet NZNO - Understanding Duty of care

Duty of Care 2

- Practitioners caring for a patient may also have a duty of care to third persons, such as family members or others if, through their actions or ommissions, harm (for example mental harm) occurs to the third party.
- Health practitioners do not have a legal duty to go to the aid of those injured in an accident. However, if they do go to the aid of those injured, they have a duty of care to ensure their actions do no harm. Consideration would be given to the circumstances in which care is given.
- Right 4(1) of the Code of Health and Disability Consumer's Rights. Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill. Where this right is breached, it can be assumed the nurse has breached their duty of care.

Professional accountability

- As a part of their professional responsibilities, nurses and midwives are expected to take the same amount of care to prevent harm as any other “reasonable regulated nurse or midwife” in the same situation.
- It is also important to note that nurses or midwives holding a practising certificate are expected to meet nursing and midwifery competencies at all times.
- **The same competencies apply when giving care as a nurse to a family member, friend, neighbour or person on the street**. If your next door neighbour arrives at your door seeking advice for a sick child, you are accountable for the standard of nursing advice you give.
- Regulated nurses and midwives must also practise within their scope at all times (there are limited exceptions, eg. where care is provided in an emergency).

Code of Conduct

- The Code of Conduct for nurses is a set of standards defined by Council describing the behaviour or conduct that nurses are expected to uphold.
- Respect the dignity and individuality of health consumers, and their cultural needs and values
- **Work in partnership with health consumers to promote and protect their health and well being**
- Maintain consumer trust by providing safe and competent care and respect their privacy and confidentiality
- Work respectfully with colleagues to best

  meet consumers needs, act with integrity

  and maintain public trust and confidence

  in the nursing profession.

Loneliness - signs of

- People may be involved, sociable, and living with others and still feeling lonely
- Physical signs that may have an element of loneliness – getting ill more often, more frequent health appointments, focusing on feeling unwell, eating poorly, sleeping poorly
- Feelings within - Not being comfortable alone, sense of isolation or emptiness, feeling misunderstood, low self esteem, struggling in a social setting, feeling being pushed to the outside of a group,
- Interactions with others – withdrawing, transactional conversations only, attention seeking, lacking social skills, overfocused, showing poor judgement, less tolerance
- Addictive behaviours – hoarding, shopping, TV bingeing, drug and alcohol, gambling, excessive surfing of internet, excessive use of a helpline, overly focused on a material item e.g. doting on a car as a substitute for deeper relationship

Loneliness in late life

- Loneliness in late life – associated with lower income, higher prevalence of functional limitations, being single in old age
- A study of patterns of stability and change in loneliness in old age looked at several groups - those who became lonely, those who overcame loneliness, the persistently lonely, and the persistently not lonely
- The ‘persistently lonely’ were more likely to be living alone, widowed, experiencing poorer health and have lower perceived control over ability to meet their own social needs.
- Changes to living arrangements and perceived control were predictors of entry into loneliness.

Late life Loneliness - risk factors

- Living alone
- No (surviving) children
- Widowhood
- Deteriorating health
- Life events (loss and bereavement)
- Sensory impairments (hearing loss) and physical disabilities
- Psychological factors – self efficacy and self esteem
- Being female, having a low income, being a member of a minority ethnic group, being gay or lesbian, living in a deprived area
- Being aged over 75
- Having a confidante is a protective factor for loneliness

Loneliness in residential care

- Little is known about levels of loneliness in residential care
- Social isolation likely to be less, but residents may still experience loneliness
- Some studies suggest levels of loneliness are higher in residential care, perhaps as a result of reduced social support (change in social networks and decrease in family contact, loss of carer and level of intimacy with them) and poor health, frailty and diminished cognitive capacity that may limit social interaction
- Frequent contact with staff is associated with less social loneliness
- Social relationships with other residents can be more protective than their external relationships, and provide a sense of security and identity
- Resident-staff interactions relevant, so turnover and casual staff can impact as well as cultural differences between residents and staff

Types of Interventions

- Many and varied, aimed at reducing isolation and loneliness
- Group based activity, self help groups
- One-to-one interventions (home visiting)
- Providing services (transport)
- Community development focus (developing networks and peer support)
- Computer based programmes
- Promoting self efficacy (self help, bereavement support, counselling)
- Behaviour modification or skills development (enhance social or communication skills)
- Developing community capacity

Loneliness - what do older people say

- What do older people experiencing loneliness think about interventions to reduce loneliness?
- UK study on 28 community dwelling older adults – they knew about local social and community resources but most did not see community and primary care based services as helpful to them at this stage
- Primary care was **not** seen as relevant because **loneliness was not seen as an illness**, consults were too short, a good relationship was necessary to discuss sensitive issues (practice nurses fared better here)
- Group based activities with a **shared interest** were thought preferable to one on one support (befriending) or groups with a social focus
- Loneliness was seen as **a private and complex matter** they wished to manage without external support
- Descriptions of support as being for loneliness discouraged engagement

Interventions in residential care

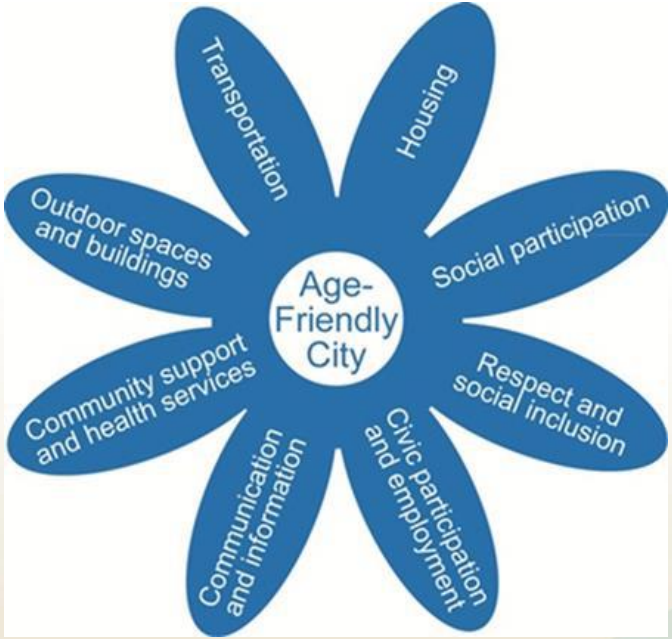
- Family friendly policies and practices
- Organised activities to support interaction between residents
- Strategies for residents to maintain links with wider community
- Contact with animals
- Opportunities for interaction with people of all ages

Success factors in interventions

- Involving older people in planning
- Having well trained and resourced facilitators and coordinators
- Utilising existing community resources
- Targeting specific groups (with interests in common)

- Facilitating maintenance of contact between residents, families, friends, pets
- Interventions that increase sense of personal responsibility and choice

Age friendly cities and communities



Looking ahead

- Need for more **research** e.g. on factors that increase or reduce risk, and on the meaning of loneliness to older people themselves

- *Service providers* need ways to **target** those most at risk and direct programmes and services accordingly, and **involve** older people in planning and implementing programmes

- *Practitioners* need **strategies** that will help reduce the individual causes of loneliness or isolation and build on the protective factors

- *Care providers* need ways to help people maintain or regain a sense of **meaning and purpose** in their lives, and to assess how **interactions** promote more meaningful and positive relationships

Thinking broadly

- *Policy and planning* – to consider **structural enablers** in communities that will create the conditions to prevent loneliness
- Creating communities for all ages and age friendly communities
- Supporting volunteering and positive ageing
- Neighbourhood approaches
- Explore the potential for alternate living arrangements to enhance meaningful connections
- Ageing in place WITH connection and support
- Multi generation housing

Final comments

- Loneliness is an individual experience and causes vary from person to person.
- A ‘one size fits all’ approach will miss the mark – instead need a variety of strategies and flexible and innovative thinking.
- In care settings – consider quality of life indicators, not just a focus on quality of care.
- Important is cooperation and collaboration between service providers, researchers and government at all levels to understand the extent of the problem and interventions.
- Nurses have a duty of care to those in their care.
- Duty ‘to provide’ care to prevent and reduce loneliness – we all share this.