

The needs of older people with acquired hearing and sight loss

This publication presents findings from a research study funded by Thomas Pocklington Trust and carried out by Sue Pavey, Dr Graeme Douglas and Dr Liz Hodges from the University of Birmingham and Sarah Bodsworth and Dr Isabel Clare, University of Cambridge.

Summary

This research study explored the needs of older people with acquired hearing and sight loss. Data were derived from secondary data sources and 20 case studies involving life story interviews. Findings indicated that many older people with hearing and sight loss appear to experience high levels of psychological distress. In general, the study found that older people with hearing and sight loss experience difficulties in relation to access to information, communication and mobility, as well as often dealing with additional health problems and disabilities. This can lead to isolation, dependence, loss of control and fear for the future.

Background

This report presents results from a project entitled 'Experiences of people with hearing and sight loss'. The aim of the project was to increase the knowledge base concerning the experiences, needs and goals of older people with both sight and hearing loss, with the focus on acquired loss, and to raise awareness of their needs and those of people living and working with them.

The project had two distinct phases:

- Phase 1 analysed two pre-existing datasets relating to 609 older people with hearing and sight loss.
- Phase 2 focused on case studies of 20 older people with hearing and sight loss.

Method

Phase 1: Analysis of datasets

Phase 1 involved a secondary data analysis which drew upon two key sources of data identified by the research team – the ‘Network 1000 dataset’ and the ‘Cambridge dataset’.

The ‘Network 1000 dataset’ is the outcome of a large-scale survey of the opinions and circumstances of visually impaired people in Great Britain.¹ This telephone-based survey explored many facets of people’s lives, including health and disabilities such as hearing loss. Some 27% (n=254) of the sample described themselves as having difficulty with their hearing, and almost half of these said they wore a hearing aid. The vast majority were over the age of 50 (n=205).

The ‘Cambridge dataset’ was collected in 2005 by Sarah Bodsworth and Dr Isabel Clare at the University of Cambridge. A postal questionnaire adapted to the preferred format of each participant was sent to the entire membership of Deafblind UK. The questionnaire explored the mental health needs of participants using an established measure (the GHQ-12).² Of the 539 responses, 404 of the participants were over 50 and had acquired their hearing and sight loss in later life.

Therefore, in total the secondary data analysis gave access to data relating to 609 participants over the age of 50 with acquired hearing and sight loss. In addition, qualitative data collected in both studies provided a different, ‘unprompted’ insight into the issues of relevance to this group.

Phase 2: Case studies

Phase 2 focused on case studies of 20 people with acquired hearing and sight loss. In summary, the participants had the following characteristics:

- Ages ranged from 58 to 92 years (14 participants were in their 80s);
- 11 women and 9 men;

¹ Douglas, G., Corcoran, C., Pavey, S. (2006) Network 1000. *Opinions and circumstances of visually impaired people in Great Britain: Report based on over 1000 interviews*. Birmingham: Visual Impairment Centre for Teaching and Research, School of Education, University of Birmingham (mimeo). ISBN 0704426048/9780704426047.

² Goldberg, D. P. (1972) *The Detection of Psychiatric Illness by Questionnaire*. Maudsley Monograph, 21, Oxford: Oxford University Press.

- 18 described themselves as being of white British origin, while two described themselves as Indian;
- 7 lived alone, 12 with family (spouse or children) and one lived in a residential home;
- All but one had health problems or disabilities in addition to their hearing and sight loss;
- The participants lived in a variety of urban and rural locations.

The research team recruited participants through a range of settings within the statutory and voluntary sectors in the hope of recruiting people who had experienced a range of services. The recruitment process was extremely time-consuming and to some extent demonstrated the challenges faced by older people with hearing and sight loss in that some organisations found it difficult to identify individuals with hearing and sight loss, it was difficult communicating information effectively to potential participants, and a number of potential participants had poor and deteriorating health.

Life story interviews were chosen to allow participants to speak of their past and present lives, and their hopes and/or fears for the future. Interview schedules were designed which enabled the researcher to gather some key demographic data, e.g. about participants' visual and hearing impairments, but more importantly to enable participants to talk openly and freely about their lives. These interviews involved visiting the participants' homes and took between one and four hours. In addition to these extensive interviews, further information was gathered from some participants in a second interview, by collecting 'diaries', and from other people linked with the participants (either family members or professionals). Towards the end of the study, a group of professionals with an interest in deafblindness met to discuss and validate some of the findings, by suggesting illustrative examples, new themes and a professional perspective. This round table discussion was an important further source of information.

Analysis

Some of the secondary data analysis involved descriptive statistical analysis of the available data, and where possible comparison to wider populations without hearing and sight loss.

Much of the data available from the secondary data sources, and particularly that collected through the case study work was qualitative, i.e. large volumes of researcher notes and audio recordings. The transcripts were exported into the qualitative data analysis software program NVivo for further analysis. The data were analysed following a grounded, generative approach in which the data were coded to draw out themes.

Findings from Phase 1: datasets

Network 1000

Because the Network 1000 project recruited participants from the registers of blind and partially sighted people, the proportion of people with additional difficulties with their hearing was of interest in itself (24% in the 50-64 age group, 32% in the 65-74 age group, and 53% in the 75+ age group). It is also interesting that few identified difficulty in hearing as a disability until they were prompted; this was particularly true of older people. In most respects, those with hearing loss appeared to differ relatively little from those without hearing loss, with some notable exceptions:

- Participants with hearing and sight loss were older and left their home less often compared with those who had sight loss alone.
- Unsurprisingly, those with hearing and sight loss seemed to have greater difficulty communicating by telephone.
- The majority of those with hearing as well as sight loss had additional health problems or disabilities.
- Over half of those with hearing as well as sight loss wore a hearing aid.
- Analysis of qualitative data revealed that difficulties with travel, transport and mobility were common amongst those with both hearing and sight loss. Difficulties with independent living skills were also prevalent, as were difficulties in communication and reading.

Cambridge dataset

The key focus of the Cambridge dataset was to use an established measure to identify the mental or psychological health of the participants. This was accompanied by demographic data about the participants, and qualitative data that described the thoughts and feelings of participants about their hearing and sight loss, and their daily lives. The following points from the analysis are of particular interest:

- Almost 50% of the sample was at or above the conservative threshold that indicates they are experiencing above-normal levels of psychological distress and would therefore benefit from further assessment.
- As with the Network 1000 sample, the participants tended to be older, with a mean age of 80.
- Many felt that their hearing impairment was worse or more 'disabling' than their visual impairment.
- Analysis of qualitative data revealed that issues relating to communication and the resulting isolation and loneliness were identified as key factors affecting participants.
- Feelings of loss of independence and resulting dependence upon others were also commonly expressed.
- Many described difficulty due to the lack of awareness and negative attitudes of mainstream service providers and the general public towards them and their sight and hearing loss.

Findings Phase 2: Case Studies

The case study and related data enabled the research team to draw out 13 different broad themes:

1 Vision, hearing and other disabilities and health problems

"I thought to myself, 'that means you're disabled doesn't it?' I hadn't thought of myself as being disabled – you adapt, you have to adapt don't you? You try not to do the things you can't do".
(Betty, 86)

The participants' levels of hearing and sight varied, though none were profoundly deaf, partly because of the way the sample was constructed. With some exceptions, it was common for participants to have limited knowledge of the medical conditions which caused their sensory loss, e.g. they rarely knew the medical name of their condition.

The vast majority of participants reported additional health problems or other disabilities, e.g. arthritis; heart, bowel or stomach problems; mobility problems, some of which were clearly very debilitating.

Generally there were positive views of both hearing aids and low vision aids which enabled the participants to do things which were otherwise impossible, such as reading their own mail or participating in conversations. Nevertheless, there was discussion about some of the inadequacies of the technology, and clearly a number of the participants did not know how to operate the aids that they had been given correctly or required further hearing or low vision assessments.

Linked to this, in most cases the participants' hearing and sight had deteriorated over the previous year (indeed, often their general health was also deteriorating). In view of this, many would probably have benefited from assessments in relation to low vision aids, lighting and hearing aids, but attendance at appropriate clinics may have been problematic given common mobility and travel difficulties.

The data revealed that the participants used a variety of different interpretations of their disabilities when questioned about them. Often the participants described their disability in medical terms (e.g. associated with an illness), while others reflected upon a loss of part of themselves and the skills they once had. Many also linked their disabilities with old age. Nevertheless, many participants appeared to rationalise their disabilities with pragmatism (e.g. 'nothing can be done', 'you've got to get on with it'), or by reference to their faith, and reflected that they were in a relatively fortunate situation compared with others whom they considered worse off. Exceptions to this may be those participants who had hearing or sight loss from a younger age.

Linked with general health factors was the fact that many participants were very vulnerable to falls within their homes; only a few had a safety system in place (e.g. personal alarm services) or modifications to the home (e.g. handrails). In fact, in some cases the presence of a personal alarm service caused participants anxiety as they did not know how it worked and they sometimes did not want to disturb their family, who would be called in an emergency.

2 Identification

In terms of identification as sight and hearing impaired, it is interesting to note that many participants were unsure whether or not they were registered as deafblind, whereas most had a clearer understanding of their registration as blind or partially sighted. This may be explained partly by the fact that the statutory requirement for deafblind registers is relatively recent, and also the process of registration may feel less formal or important, and therefore less memorable to people because it does not involve medical staff.

Reasons for low registration as a deaf or hard of hearing person, or certainly lower awareness of such registration, are even more speculative. We are confident that many of the sample were not registered, perhaps because the sample contained people whose hearing was relatively less impaired than their sight – for example, there were no people with profound hearing loss in the sample. Also, fewer people in the population as a whole are registered as deaf or hard of hearing compared with those registered blind or partially sighted.

3 Communication and social interaction

“I go for days and days and days [without company]”
(Pamela, 86)

“After you’ve gone it will be just like a morgue again”
(Colin, 92)

An extremely strong theme to emerge from the research was the communication challenges faced by many respondents. Communication in groups was very difficult, though difficulties with mobility and travel beyond the home for those who lived alone meant that opportunities for communication were limited. The telephone was problematic for some, but others had overcome the problems of access, e.g. by adding amplifiers. Difficulty with communication meant that some of the respondents felt very isolated.

4 Leaving the home and getting out and about

"I can walk with the Zimmer to the door, but that's it, I can't go any farther without somebody helping. [...] last year or this year earlier on they took me to the crematorium so I could see where my wife was but I couldn't see it, I couldn't see it. [...] But otherwise I haven't been out since then, it's difficult" (Colin, 92)

"They [young people] just knock you over. They don't have any respect for older people" (Emily, 87)

Participants often described difficulties they face on leaving the home, which include personal / health barriers, e.g. low energy levels, difficulty walking, and fear of falling. Nevertheless, many used strategies to help them when travelling, e.g. ringing ahead, asking people for help, using public transport or taxis. It was common for people to go out with others, in particular partners they were living with. Some said that a fear of crime prevented them from going outside.

5 Activities within and beyond the home

"My best friend now is the radio" (Jeremy, 80)

"I'm picked up and taken to church every Sunday" (Lionel, 78)

Many participants described leisure activities relating to the spoken word, e.g. talking books, radio and television. People often talked about the importance of people (e.g. friends, family) visiting their homes. Contact with religious groups was highlighted by many as very important, particularly its role in connecting them with a community of people. Many reiterated difficulties they had leaving their home and how this reduced their opportunity to do things outside. Some, not surprisingly given the lack of variety in their life and reduced opportunities to go out, talked positively and at length about holidays and breaks that they had enjoyed. Others did not see the need or thought it too difficult/too much trouble to go on holiday.

6 Daily living and sources of support

“He’s [husband] terribly good at helping me with any problems. He said yesterday ‘what will happen to you if I get knocked off my perch?’ And I tell him ‘I have three wonderful children, they’ll see me right!’ ... He does help me a lot” (Betty, 86)

“[My communicator-guide] just talks, just talks and asks me what I want, anything I want doing ... She’s marvellous” (Colin, 92)

While people had or required differing levels of support, family members provided a key source of support for many participants, whether they actually lived with participants or nearby. Discussions about support revealed many different views about independence and dependence. Some participants expressed great concern about being ‘a burden’ to family or friends.

Having support to go shopping was highlighted as a need by many. Many professionals who were contacted talked about the importance of offering support to enable participants to go shopping with a helper, rather than having someone doing the shopping for them, as this can lead to a reduction in the food choices the participants can make, thereby increasing their feelings of dependence and reducing their sense of power and choice further.

Nevertheless, there was some evidence that while participants were keen to maintain their independence including financial independence, this can lead to unusual decisions and potential vulnerability to people who might exploit them. For example, two participants who did not want to rely on others described spending a lot of money on technical equipment which they could have had on free loan.

Many participants were in contact with a support service for people with sight loss and/or sensory loss, but the referral routes were not always clear and in some cases participants still required support for particular needs that were not being met. This demonstrates that participants who have difficulty with communication and accessing information often need help to access support services.

It is clear that there was very little awareness of rights or involvement in processes through which the participants could influence services. Those who did discuss their ‘rights’ in this manner, e.g. awareness of the Disability Discrimination Act (DDA), or participation in access forums/groups were, with one exception, younger participants.

The importance of including people with acquired hearing and sight loss in service decision-making was highlighted by many professionals who attended the round table discussion. This kind of participation may be difficult for many of the older people involved in this research who appear to align themselves with a culture which emphasises personal responsibility and a reluctance to ask others for help. Nevertheless, professionals who attended the round table discussion described many examples of where this had been successful.

7 Daily living and independent living skills (ILS)

“That’s what I’ve been trying to say about them [voluntary organisation] – that they’re so friendly and definitely a company to help but you don’t feel you’re being a bother to them because none of them make you feel like that” (Emily, 87)

It was clear that the participants faced many challenges, both large and small, on a daily basis. Being able to complete what might seem to outsiders to be small, simple tasks can mean a lot to older people who have lived their lives independently. Clearly, the participants’ sight and hearing loss (but particularly the sight loss) made many of the tasks difficult, and this was often exacerbated by additional health problems and disabilities affecting the participants’ strength, dexterity and mobility.

Of central importance to the participants was the need to retain independence; therefore solutions aimed at overcoming any difficulties should attempt to enable the participant to carry out the task independently where possible, taking additional disabilities and health problems into account. For example, solutions could include provision of ILS training and specialist equipment, or other strategies to assist when hearing loss prevents the use of audible specialist equipment.

Some of the participants were concerned that they were a burden upon their family. Input from services, in particular communicator-guides and volunteers to help around the home, are of key importance in enabling participants to live independently without having to rely solely upon the support of family members, who often live far away. Professionals may also have to play a role to ensure that participants understand that using services does not constitute failure in terms of living independently.

8 Accessing information

"[SSD Deafblind service] and the [VO for VI people] organised an amazing course called 'Finding Your Feet', for those of us recently registered blind. [...] Was a wonderful course, it really helped – was for me and for [husband], for partners as well – to help them come to terms with what happened and also to know what's out there and available" (Fiona, 59)

"Technology is a positive but you've got to be able to know how to use it and find the right kind of people who can help to teach you the technology" (Lawrence, 60)

Some participants had attended courses for those who were newly registered or diagnosed, usually as visually impaired. Since participants usually had only little knowledge about hearing loss and the services available, it would be prudent to offer courses which covered these subjects. Those who attended courses appeared to have gained considerable value from them, and they seemed to remember more about what they had been told than those who received information only at the point of diagnosis. The courses also provided opportunities for socialising and communication with other people with sensory impairments, which was very important for some people. These courses sometimes provided support to partners/carers, which gave them a greater understanding of how sensory loss affected their relative both practically and emotionally. By improving the understanding of how to facilitate independence, the courses may also improve communication and reduce the feeling that the participant is a burden upon the family.

Whilst only four participants were using computers, it was clear that IT offered them many opportunities and that they were using it very effectively. They had either been helped by family members to set up and use the computer, or had experience using them in their pre-retirement occupation. For others, there is a need for provision of one-to-one support for older people with sight and hearing loss to enable them to be included in the opportunities that technology affords.

9 Access to and participation in medical services

"[I said to the nurse,] 'I'm very sorry but I did not hear as you were walking out of the room and I am deaf', and she turned to me very crossly indeed and said 'Well, you do not look deaf!'"
(Betty, 86)

When participants were asked to reflect on medical services they had accessed, these experiences were often related as harrowing and emotionally painful personal journeys. In some cases the stories perhaps reflected the participant's own confusion about the treatment they were receiving: participants had relatively limited knowledge of their medical conditions. There were both negative recollections (e.g. insensitive staff, lack of continuity, poor communication) and positive recollections (e.g. 'wonderful' staff). It may be that some dissatisfaction and confusion experienced by participants when accessing medical services was linked to poor communication and hearing loss. This may reflect that patients in eye clinics with hearing loss may be finding it more difficult to understand the information given to them by staff. In a different study Wallace et al.³ noted that of the patients attending their hospital-based glaucoma clinic, 'poor compliance with medication was significantly higher in those with hearing loss'.

In terms of medical services and their hearing loss, for some participants it was clear that visits to hearing specialists were difficult due to their sight loss. Maintenance of hearing aids can also be difficult. There was a general feeling amongst some of the participants that prioritising those with sight loss for hearing aids is important. However, many seemed vague about the services on offer relating to hearing loss. In the case of hearing aids in particular, there was a lot of confusion in terms of referral routes, the boundaries between NHS and private services, and cost.

In terms of receiving general medical services, many of the participants were unclear and passive regarding referral routes and there were a number of examples where they had encountered difficulty in getting these services (e.g. Colin, who finally received a flu jab at home after his communicator-guide intervened). The experiences were mixed, however, since other participants appeared to receive regular visits to ensure they were up to date with required vaccinations and general health check-ups.

³ Wallace, E. Paterson, H., Miller, S., Sinclair, A., Sanders, R. and Hinds, A. (2008) Patient profile and management in advanced glaucoma. *British Journal of Visual Impairment*, 26(1): p.7.

There were also mixed experiences regarding hospital admissions; most were negative and often linked to staff not identifying the communication needs of patients. In addition, the difficulties some of the participants faced were not related to staff failing to identify that they had hearing and sight loss, but rather a lack of understanding about the implications of their sensory loss, and additional support they would need in terms of communication and information whilst they were in the hospital.

10 Social and emotional needs

“How would I describe myself? I don’t know. It just goes day by day” (Norris, 87)

“I was only 62 when [husband] died. I sometimes sit and think, where have the years gone and how have I managed, and how have I coped?” (Emily, 87)

Many of the participants felt somewhat negative about their current life and prospects for the future. This seemed to be particularly true, though not exclusively, for those who lived alone.

Unsurprisingly, given the age of this group, experience of bereavement was also common. Key coping strategies appeared to be drawing upon positive memories and their religion, the latter playing a strong role in many of the participants’ lives.

In terms of the future, many felt they lived day to day, and coped with their anxieties about the future by refusing to let themselves think about it. However, many expressed anxiety about their health and sight (in case either deteriorated further); about becoming a burden upon their families (particularly their children); and being able to stay in their own homes rather than having to go into residential care. Interestingly, the last two anxieties are incompatible in that, for many, the only way they could remain in their own homes is with the support of their families. It is likely that such tensions play on participants’ minds, causing further anxiety. Even participants with a high level of care put in place by social services required a lot of daily support from their family in order to stay in their own homes. An example of this was Colin, who had daily support from his daughters in terms of cleaning the house and preparing his daily meals for the paid carers to give to him.

11 Residential care homes

“I just hope that I can carry on as I am doing, I would dread having to give up my home and go into a home and see... I don't even think about it, I daren't” (Emily, 87)

The participants seemed overwhelmingly negative about the thought of moving into a residential home. This appears to be linked to feelings of losing independence, and was seen as the ultimate price when participants lost ‘the fight’ to carry on living independently in their own homes. It is difficult to decipher precisely why the participants felt this way, but it is likely that negative experiences of visiting homes, coupled with negative portrayals of such care in the media, have heightened their anxiety.

One participant (Pamela) did live in a residential home. Her experiences of living there for over 15 years suggest current dissatisfaction with the care she receives, though interestingly she would still not want to move elsewhere if such an option were available. This suggests the importance of the ‘familiar’ and ‘routine’ for older people who have lost their hearing and sight. However, it was clear that she was frustrated by her lack of power and ‘voice’ within the home compared to how she perceived things to have been when she first arrived. It is difficult to speculate about problems in the home and why they have emerged in recent years. However, Pamela’s hearing and sight have deteriorated over that time and it might be that staff have failed to recognise or respond to her changing needs, and this has resulted in her increasing isolation and loneliness. Certainly, professionals at the round table discussion felt that training issues for staff in residential homes were a problem for many.

12 Views of the participants' families

"I had to stop work for a while because his condition was getting worse" (Daughter-in-law of Kulvir, 80)

Though it was a small dataset, the data from interviews with the families gave an indication of how much support they give to the participants on a daily basis. There were various issues that would relate to carers generally, e.g. the need for respite care, and advice and support about the caring role, but an issue particularly relevant with this older group is that the spouses were themselves vulnerable to ageing and the complications of deteriorating health and disabilities. It was clear that the participants in the study who had spouses had more comprehensive care and companionship, and appeared happier than those who lived alone. However, there was a feeling that this support was delicately balanced because at any point it could be reduced or taken away. This anxiety was expressed by a number of participants but most clearly realised by participants who had recently suffered the death of partners.

13 Professionals' views of services

Although the sample of only nine professionals is small, the responses illustrated a range of ways of managing caseloads and making use of registers of deafblind people.

The professional respondents provided the research team with a list of the different services they aim to provide. Encouragingly, these services mirror many of the issues and needs raised in the interviews with the participants who have hearing and sight loss. The difficulty may therefore be that time and resources are not sufficient for the professional to assess the needs of, or provide the resources for, each person in the depth that is required. Some of the professionals felt frustrated because this was all they could manage.

Awareness training of staff in allied sectors was also seen as an important role, e.g. for generic staff in day centres, residential homes and hospitals. However, scarce resources and clients who need potentially high levels of support meant that professionals felt unable to carry out this work very often.

Discussion

The findings from both phases of the research reflect the difficult circumstances that many people with hearing and sight loss experience, whether the problems are related directly or indirectly to their sensory loss. The secondary data analysis demonstrated that many older people with hearing and sight loss appear to experience higher levels of psychological distress than people of a similar age without sensory impairments. This striking observation offers a powerful backdrop to much of the qualitative data gathered in the case study work – perhaps it is hardly surprising that people with hearing and sight loss may often suffer from psychological distress, given that many of the findings described above could easily be associated with feelings of isolation, lack of control and even depression. It is useful to use the Department of Health definition⁴ of how hearing and sight loss has an impact upon ‘access to information’, ‘communication’, and ‘mobility’ as a useful vocabulary for capturing some of the overarching issues from the research:

- **Access to information.** For example, many participants had limited knowledge of their medical conditions. Many relied on the spoken word for access to information (e.g. talking books, radio, television), but this was difficult for some, particularly as their hearing deteriorated. Many participants valued specially designed courses which catered for their information needs, and these were especially welcomed when other family members were able to attend.
- **Communication.** For example, many participants felt socially isolated. This was particularly true of those who lived alone. This was exacerbated for those who found it difficult to use the telephone. Some found it hard to communicate with others when accessing services, e.g. communicating with hospital staff.
- **Mobility.** For example, difficulty with mobility meant that many participants rarely, if ever, left their home. For some, moving around their home and performing simple tasks also proved difficult, especially as many had other health difficulties which affected mobility, strength and dexterity. This resulted in many participants feeling isolated and dependent on others, while other participants found it difficult to access services, e.g. assessments for hearing and low vision aids.

⁴ Department of Health (1997) *Think Dual Sensory: good practice guidelines for older people with dual sensory loss*. DoH, London.

Clearly these challenges interact and self-perpetuate – difficulty with communication and mobility means that people communicate with fewer and fewer people, and access less information, which leads to further loneliness and seclusion. At a time in their lives when many are experiencing or fearing bereavement, people very often had strong feelings of wanting to remain independent and often feared that in future they might become dependent or a burden on others. For some, receiving support was seen as failure, and for many the thought of moving into a residential home seemed the epitome of such failure. Unsurprisingly, such pressure can lead to distress, and this was demonstrated clearly elsewhere in the research.

Undoubtedly, the findings of the study provide clear evidence of people facing very difficult challenges. Nevertheless it would be simplistic to ignore some of the positive findings. Most notably, the participants often showed remarkable resourcefulness, pragmatism and determination in spite of the challenges they faced. For many it was the companionship of a partner or family which was critical. Many also valued the support they had received from services (for example, attending courses, receiving hearing and low vision aids, receiving specialist equipment, visits and advocacy from communicator-guides). Sadly, some participants did not benefit from this kind of support.

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How to obtain further information

A summary report, in the form of 'Research Findings', entitled 'The Needs of Older People with Acquired Hearing and Sight Loss' by Sue Pavey, Dr Graeme Douglas and Dr Liz Hodges from the University of Birmingham and Sarah Bodsworth and Dr Isabel Clare from the University of Cambridge is available from:

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Copies of the two reports that inform this publication are available to download from <http://www.education.bham.ac.uk/research/victar/research.shtml> and are entitled as follows:

1. Secondary data analysis with a focus upon the needs of older people with acquired hearing and sight loss: An analysis of the 'Network 1000' and 'Cambridge' datasets.
2. The needs of older people with acquired hearing and sight loss: findings from 20 case studies.

Copies of this report in large print, audio tape or CD, Braille and electronic format are available from Thomas Pocklington Trust.

Background on Pocklington

Thomas Pocklington Trust is a leading provider of housing, care and support services for people with sight loss in the UK. Each year we also fund a programme of social and public health research and development projects.

Pocklington's operations offer a range of sheltered and supported housing, residential care, respite care, day services, resource centres and volunteer-based community support services.

We strive to improve continuously the quality standards in our operational centres to meet the changing needs and expectations of our current and future service users. We are proud to be an Investor in People and a Positive about Disability organisation.

Our research and development programme aims to identify practical ways to improve the lives of people with sight loss by improving social inclusion, independence and quality of life, and improving and developing service outcomes as well as focusing on public health issues.

In this publication, the terms 'visually impaired people', 'blind and partially sighted people' and 'people with sight loss' all refer to people who are blind or who have partial sight.



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