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Author post-print (accepted) deposited in CURVE July 2014

Original citation & hyperlink:
Woolham, J. , Daly, G. and Hughes, E. (2013) Loneliness amongst older people: findings from a survey in Coventry, UK. Quality in Ageing and Older Adults, volume 14 (3): 192-204.
http://dx.doi.org/10.1108/QAOA-12-2012-0028

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Loneliness amongst older people: findings from a survey in Coventry, UK.

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Abstract

Purpose

To investigate factors associated with loneliness amongst people aged 55 and over living in Coventry, a medium sized city in the Midlands, UK.

Design/methods

Quantitative community survey of residents, involving postal and on-line questionnaire and distribution of questionnaire to local community resources used by older people and 'ballot boxes' for completed questionnaires in these locations.

Limitations

Survey was commissioned by a range of local statutory and voluntary sector providers and had a wider focus than loneliness. Some evidence of under-representation of males, people from minority ethnic groups and possibly people from lower socio economic groups is reported. Further qualitative research is needed to better understand consequences and causes of loneliness.

Practical implications

The study identified factors associated with loneliness that could be used to identify people who may be lonely in general or, for example, NHS or social care service populations.

Social implications

Loneliness and isolation were widespread and had pervasive consequences. Loneliness is often overlooked by agencies responsible for providing care and support to older people.

Originality/value

Loneliness is slowly becoming more recognised as a social problem in its own right and a contributory factor in poor health and wellbeing. This paper explores a the relationship between lonely and 'not lonely' people and a range of factors clustered within the four thematic areas of demographic background, reported health and well-being, access to personal resources and use of community resources of survey participants *.*

Key words

Loneliness, older people, social care, health.

Article classification

Research paper

Introduction

This paper reports on findings from a large community survey of older citizens aged 55 and over who lived in Coventry or were registered with a Coventry G.P, commissioned to inform the strategic development of services for older citizens in the city by a consortium of local statutory and voluntary organisations. The survey found that just under half (46%) of those who replied were living alone and just under a third of respondents admitted to feelings of loneliness at least 'every now

and then'. Our paper sets out to explore differences between lonely and non-lonely respondents and what factors – from a range of variables – might be most closely associated with loneliness.

The paper reports on these findings in four sections. In the first section, we refer to the current policy context in relation to the health and well-being of older people, and then more specifically towards the related issues of loneliness amongst older people in the UK, including a brief discussion of definitions, prevalence and causes. In the second section, the paper describes the design and methods used to collect the data. In the third, the findings are presented and, in the fourth, the significance of these findings is discussed with reference to other important UK research on loneliness.

Policy context

The health and well-being of older people has been a key focus of national policy over the last ten years (ADSS/LGA, 2003; Audit Commission, 2002; DH, 2001, 2004, 2005, 2006a&b, 2008; DWP, 2002; HMG, 2005, 2007; ODPM, 2000, 2005, 2006), perhaps most clearly enunciated in 'Opportunity Age: meeting the challenges of ageing in the 21st century' (HMG, 2005). The general policy direction has been shaped considerably by demographic factors and the implications for UK society of an ageing population. The specific implications for health and social care services have been powerfully expressed in the two Wanless Reviews (Wanless, 2004, 2005, 2006). Policies, legislation and governmental guidance over the same period have

reflected a desire to encourage the 'active ageing' of older people, and a stress on the importance of maintaining independence (and reducing dependency), of encouraging self management of health and social care needs, and empowerment and enablement, through, for example, personal budgets. These approaches have been shaped by a belief that demographic pressures will outstrip resources unless older people are encouraged to take more responsibility for their health and well-being.

More recently, the Coalition Government made little reference to older people in its manifesto (HMG, 2010, p. 26). However, there has, arguably, been a change of context and an emphasis on different forms of support for older people, for example, through its emphasis on the 'Big Society', localism, decentralisation and partnership. It has also promoted its 'Ageing Well' initiative, in which local authorities are being encouraged to improve their services for older people (Robertson and Wilkinson, 2010). Additionally, the Coalition Government has announced an intention to raise the state retirement age, to devolve power to local communities (DCLG, 2010) and in relation to public health (DH, 2010a). It has also presented its vision for social care for England (DH, 2010b), which renews the emphasis on some of the emerging policy themes described above. The Coalition Government's 'vision' includes an ambition that older people will 'age well' through having greater control over the provision of more personalised and preventive services, including the entitlement by everyone eligible to a personal budget in the form of a direct payment by 2013. It also set up a Commission on the future funding

of adult social care and support which reported back to the Government in July 2011 (Commission on Funding of Care and Support, 2011).

Within this overall policy direction, there has been an acknowledgment of the need to combat the social isolation, exclusion and loneliness felt and experienced by many older people in the UK through a focus on developing activities and services that promote older people's health and well-being (see: Wistow et al, 2003; Curry, 2006; JRF, 2005, 2008; Watt and Blair, 2009; Daly, 2009; Davis and Ritters, 2010; LGA 2012).

Defining loneliness

Loneliness has proved difficult to define (Cattan et. al, 2005; Rook, 1988; Victor et. al. 2000). Within the literature there remains an apparent lack of a single, agreed definition of either loneliness or social isolation. The vagueness of the notion of loneliness and its multiplicity of meanings has long been recognised (Donaldson and Watson, 1997, Routasalo and Pitkala 2003). In some respects loneliness can be distinguished in terms of 'objective' and 'subjective' components (though, this is, of course, problematic in itself – see Cattan, 2002 and Cattan et al, 2005). Loneliness can be considered as the 'subjective' feeling and experiences that are the consequence of a lack of companionship or close and genuine communication with others (Cattan et al, 2005; Townsend, 1962; Weiss, 1982). This is conceptually different from 'isolation' which can be conceived as being an 'objective' lack of contact or social interaction with other people. For the purposes of this paper, we regard loneliness as being the lived experience of feelings of lack of companionship,

social interaction and engagement whereas isolation is an 'objective' lack of engagement due to being isolated in the home with limited or no social interaction with others or access to external activities. The focus of our paper is on loneliness.

Prevalence

Loneliness amongst older people in the UK is a pervasive and long standing problem, though there have been multiple attempts to quantify this (Gray, 2009; Victor et al, 2000; Wenger et al, 1996). Victor et al (2000 p. 409) summarised the prevalence of isolation and loneliness identified in ten studies completed over a forty year period, finding that these studies reported prevalence rates for loneliness of between 2% and 16%, and social isolation rates of between 2% and 20%, though outside the UK one Swedish study has reported loneliness rates of 38% amongst older women (Holmen et al, 1992). More recently, one government sponsored study has suggested that very large numbers of older people are socially excluded in many ways (ODPM, 2006). Help the Aged (2008, p. 6,) reported that 'one third of older people report feeling out of touch with modern life and a further one in eight say they are often or always lonely'. It has been suggested that 10 per cent of people over 65 often feel lonely (ODPM, 2006: p. 55), and that 12 per cent of people aged over 50 years exhibited some degree of isolation (Barnes et al, 2006; Gray, 2009; ODPM, 2006; SEU, 2003, 2004, 2005). A study by Age Concern (2008) claimed that 1.2 million people over 50 years of age face multiple exclusion 'with the likelihood of social exclusion intensifying in later life'. As such, national and international policy has increasingly recognised the need to tackle the loneliness faced by many older people (Catten et. al., 2005; DH 2001; Walters et al. 1999).

Causes

There is also a considerable research literature on causation. Victor et al., (2000) have suggested that isolation and loneliness are associated with *personal characteristics* such as coping skills and personality, *demographic factors* such as age, gender, marital status, and social class*; life events* such as bereavement, retirement or migration, and *resources* – for example, financial and social networks. Poor health, poor mobility, living alone, age and gender have also been associated with loneliness in one U.S. study (Theeke, 2009).

Studies have also indicated that loneliness is more common among older people from lower socio-economic groups, those with fewer years of formal education, those who have never married, divorced men or childless older people (see Gray, 2009; Wenger et al, 2001). The ODPM (2006), drawing on the English Longitudinal Study of Ageing (ELSA) programme (Barnes et. al, 2006a&b; Scharf et. al, 2005), suggested that exclusion, variously from social, cultural, and civic relationships, from basic services, neighbourhood relations, financial products and material consumption, all conspire to produce loneliness.

Generally, current evidence suggests that older age is often associated with experiences of loneliness, and that this may often have multiple causes. The next section will describe a survey of residents in Coventry City aged 55 and over, and how we have re-examined the data to explore the relationship between loneliness and some of the factors associated with being lonely.

Design and methods

The survey used to collect data was commissioned by a consortium of local statutory and voluntary organisations including Coventry City Council, Coventry Primary Care Trust and Age Concern Coventry, who wanted information about the lifestyles, aspirations and views of this age group to inform a local multi-agency strategy for service provision.

The questionnaire was developed in response to the requirements of the commissioners of the study. Although face validity of the developed tool was tested by a member of the research team at local day centres (which led to minor amendments), no formal validation process took place.

Three different methods of collecting data were employed: a postal survey, an on-line questionnaire and use of public buildings such as day centres and libraries where questionnaires could be picked up, completed and left in a collection box. Samples for the postal questionnaire were drawn from three databases: people living in sheltered housing in Coventry, and people who had used (i) Coventry Social Services, or who had used (ii) either Age UK Coventry's 'Information and Advice' or (iii) its 'Trusted Trader' services over the previous 12 months. Databases were combined and cleaned to remove duplicate names, people with incomplete addresses or whose address lay outside the city council boundary (and who were not registered with a Coventry GP) before the sample was drawn. After removal of duplicate

entries, a total of 7,653 people remained, from which a random sample of 1,626 people were drawn. Data collection took place between March and May 2010. In the postal survey, each member of the sample was sent a personal letter that explained the purposes of the survey and inviting them to take part in the study, enclosed with a copy of the questionnaire and a pre-paid self addressed envelope for the return. A single reminder letter was sent out to non respondents about a fortnight after the initial mail-shot.

The online database, which used ‘survey monkey’ online software, was advertised through local statutory and voluntary sector groups working with older people, and within the University (a major employer in Coventry). The online survey made the same information available about the survey as that made available in the covering letters sent out with postal questionnaires.

Public buildings in Coventry likely to be used by older citizens, such as libraries and day centres throughout the city were asked to make copies of the questionnaire available in prominent locations for visitors to take and complete if they chose, and temporary collection boxes were left next to questionnaires for people to post their replies. Ethical approval was obtained before the survey began from Coventry City Council and Coventry University Ethics Committees.

The combined methods of data collection led to an unexpectedly high number of returns. The postal survey alone yielded a response rate of 39% (of the 1,626 people

invited to take part) and taken as a whole, the 1,558 people who replied constituted 2% of the entire 55+ population of Coventry.

Table 1. Responses by source (% are of the total response)

	Frequency & %
Postal survey	638 (41%)
Questionnaires left in public buildings	749 (48%)
On-line questionnaire	169 (11%)
TOTAL	1558 (100%)

Statistical methods

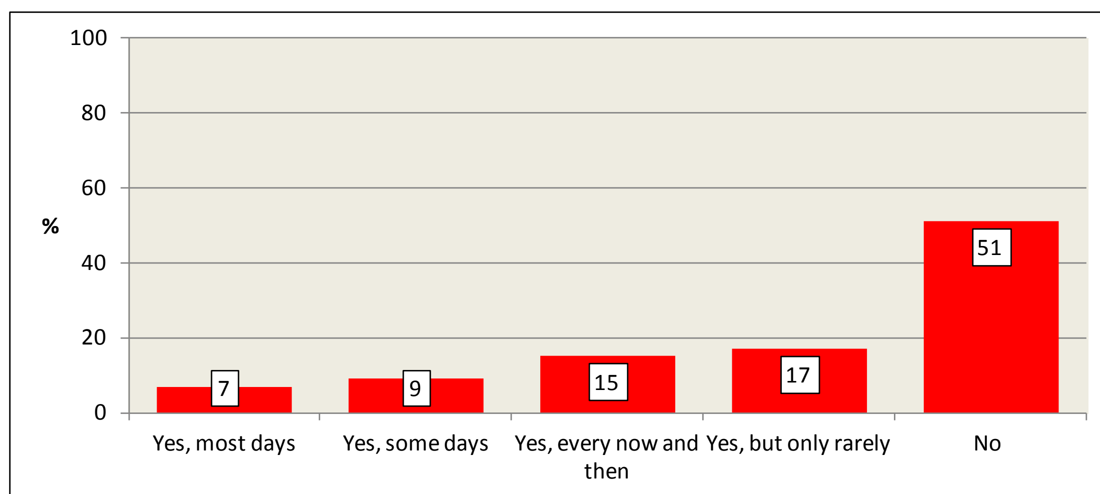
Completed survey data were entered on to an SPSS database for analysis. Initial analysis used descriptive statistics, including frequency and cross-tabulation of data. Chi Square (including Fisher's Exact test) was used to establish statistically significant relationships between variables and these were subsequently entered into logistic regression.

Findings

Our survey was not specifically designed to consider the prevalence of loneliness or factors that may have been associated with it, but to inform the local strategic planning of services for older people. However, our dataset included questions that enabled us to look at the extent to which some of the factors - identified in other studies as being associated with loneliness - were present in our data.

There is a degree of stigma attached to loneliness, with a perception that in some way loneliness is the 'fault' of the lonely person, arising perhaps from some kind of 'social inadequacy' or failing (Victor et. al., 2000 p.409). In our survey just under a third of respondents admitted to feeling lonely *at least* 'every now and then'. This potential stigma means our data may under-represent of the true extent of loneliness amongst respondents in Coventry.

Figure 1. Do you ever feel lonely and wish you had some company?



Loneliness, as might be expected, was strongly associated with social isolation. 46% of respondents lived alone, and 22% expressed a wish for more social contact with other people. Over two thirds (315/68%) of people who said they were experiencing some degree of loneliness *also* lived alone and 215/46% of this group wished for more social contact, compared to 103/10% amongst people who described themselves as not lonely. However, people who lived alone were not necessarily

lonely: Just over half (361/53%) of people who lived alone said they were not lonely (p=0.00). (df1 p>0.000). Social isolation was therefore only one factor associated with loneliness.

To investigate further, we created a dichotomous variable 'lonely or not' from the question: 'Do you ever feel lonely and wish you had some company?' by collapsing the original values of the question into a value of '1' for 'lonely most or some days' and a value of '0' as rarely lonely or not at all. We then compared the experiences of the 'lonely' with the 'not-lonely' groups to see if there were any observable differences on variables which other studies have indicated might be associated with loneliness. For convenience, we have clustered these into a small number of categories.

Demographic factors.

The first group of factors compared are demographic.

Table 2. Comparison of demographic factors amongst 'lonely' and 'not lonely' groups. *(*=not statistically significant at p=<= 0.05)*

	The 'lonely' (n= 240)	**The 'not lonely' (n= 1232)**
Mean age	72.2yrs	70.2yrs*
Gender (F)	166 (71%)	776 (64%)
Ethnicity (non white)	17 (7%)	68 (6%)*

Employment status (retired)	173 (72%)	875 (71%)*
Unpaid carer	31 (14%)	209 (19%)*

As can be seen in table 2, in respect of age, ethnicity and employment status, observed differences between the two groups were not large, though our study also found that the older people were, the more likely they were to be lonely: 32% of the 'not lonely' group were aged 75+ compared to 39% of those who were lonely. Women were more likely to be lonely and non-carers were a little less likely to be lonely. However, amongst these demographic variables, only the relationship between gender and loneliness was statistically significant. (Fishers = p= 0.043).

Health and well-being related factors

The second cluster of factors was related to health and well-being.

Figure 2. Comparison of health and well-being related factors amongst 'lonely' and 'not-lonely' groups.

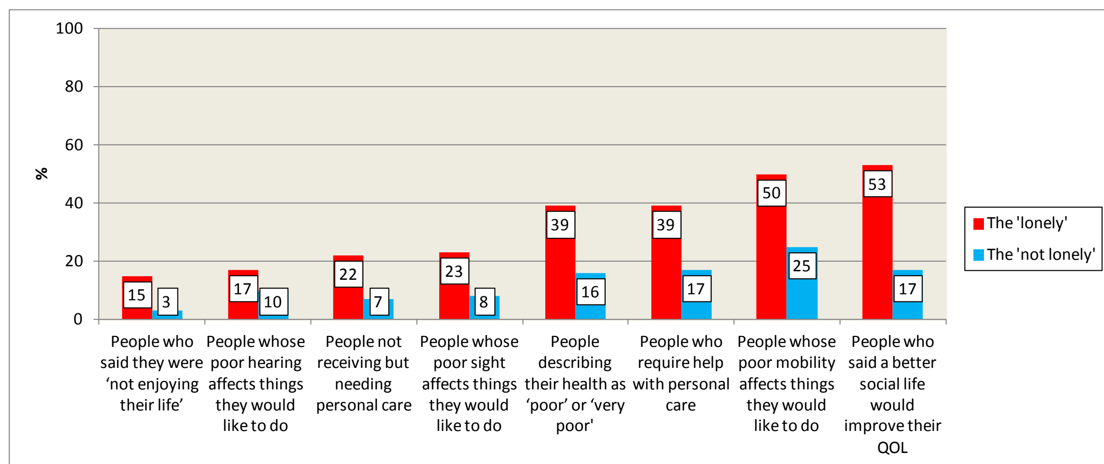


Table 3. Mean scores for lonely/non-lonely groups on health and wellbeing related Likert type scales.

	The 'lonely'	The 'not lonely'
Mean no. (range =1-7) of different types of exercise people did weekly/daily	1.96	2.46
Mean no. (range =1-5) of people troubled by not feeling productive or useful	3.06	1.77
Mean no. (range =1-5) of people troubled by being ill or living with a disability	3.43	2.45

As can be seen in figure 2 and table 3, in relation to each of the factors listed, the lonely group fared worse. Lonely people were more likely not to enjoy their lives, to describe their health as poor (and be much less likely to describe it as excellent), more likely to be affected by poor sight, hearing and mobility. They were more likely to be receiving help with personal care, more likely to feel that a better social life would improve their quality of life, and were less likely to exercise at least weekly. Each of the variables listed was statistically significant. ($p<=0.05$). Mean scores derived from two Likert type scales (range 1-5 with 1= not troubling & 5 = very troubling) also reflected the same picture: people who were lonely were more likely to feel unproductive and to be more badly affected by disability or illness.

Personal resources

Under the broad category of 'resources' we have included housing, personal finance, mobility, use of leisure time and use of (typical) local services.

Figure 3. Comparison of personal resource related factors amongst 'lonely' and 'not-lonely' groups.

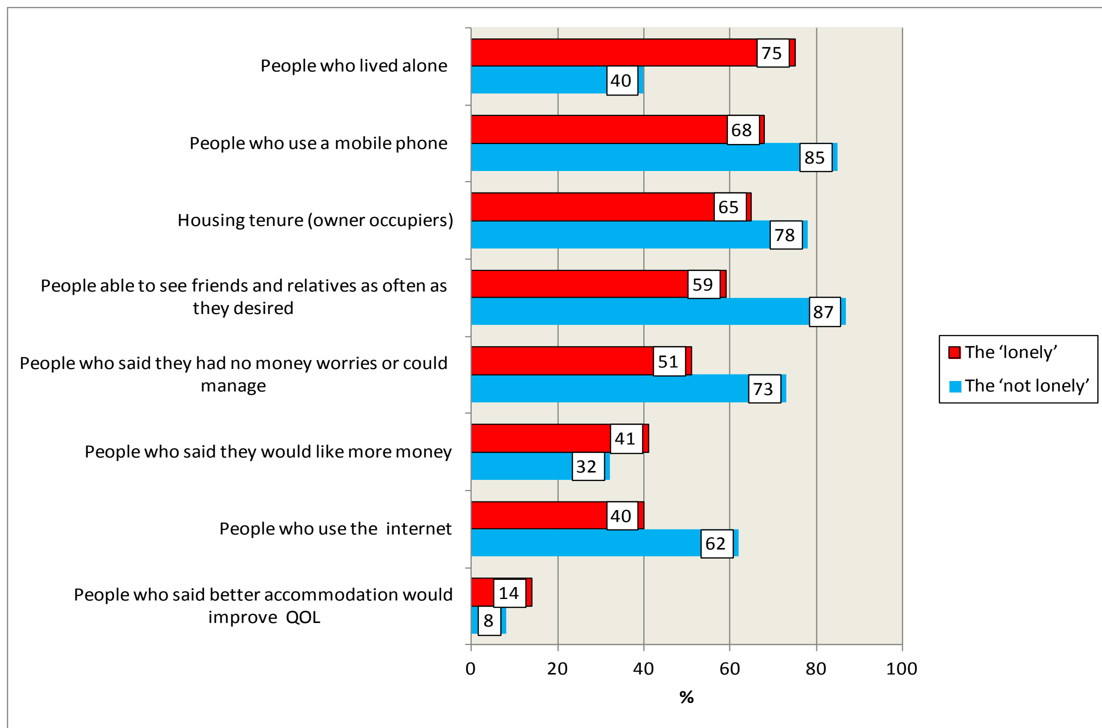


Table 4. Mean range of reported problems with accommodation amongst 'lonely' and 'not lonely' groups.

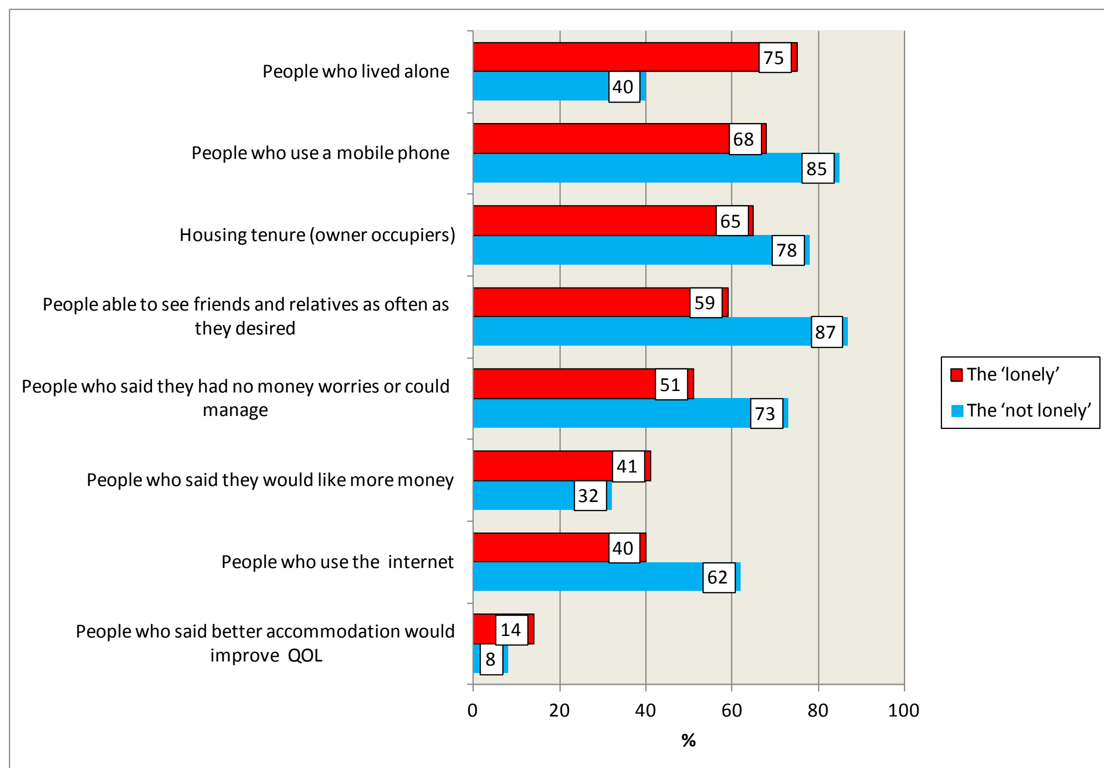
	The 'lonely'	The 'not lonely'
Mean no. (range = 1-14) of reported problems with accommodation	1.33	0.80

As can be seen in figure 3 and table 4, lonely people were more likely not to own their own property and report problems with their accommodation, less likely to feel they had enough money to live on, more likely to live alone, less likely to say they saw friends and relatives as often as they'd like, and much less likely to use modern technologies of communication. Each of the variables listed was statistically significant. ($p<=0.05$).

Community resources

Our data also enabled comparison to be made of use of community resources.

Figure 4. Comparison of community resource related factors amongst 'lonely' and 'not-lonely' groups



Lonely people also differed from not lonely people in access and use made of community resources and their views about some of these resources. They were less likely to participate in leisure activities, and less likely to use typical community facilities such as libraries, community centres and sports and leisure facilities. They were less likely to say that faith played an important role in their life. Lonely people were also more likely to say they never normally left their home and more likely to feel that lack of access to transport was a barrier. They were also more likely to feel that a more visible police presence would make them feel safer. Again, all but three of the variables listed were statistically significant. ($p<=0.05$).

To summarise, our findings therefore broadly resonate with those of others, whose work we have referred to already. On a range of measures there were marked differences between 'lonely' and 'not lonely' groups. Although not all observed differences were large, or statistically significant, there were greater levels of loneliness related to age (with older people reporting being more lonely), ethnicity (with non-white ethnic groups reporting slightly higher levels of loneliness), employment status (with retired people reporting being more lonely than those still working), gender (with older women reporting being more lonely than older men), carers as compared to non-carers (with non-carers reporting being more lonely than those with caring responsibilities). However, as we have shown above, amongst these demographic variables, only the relationship between gender and loneliness was statistically significant. We also found that lonely people were less likely to enjoy their lives, more likely to describe their health as poor, more likely to be more badly affected by disability or illness and more likely to be receiving personal care. Lonely

people were also less likely to exercise, more likely to feel unproductive and to believe that a better social life would improve their quality of life. In addition, lonely people were less likely to own their own property and more likely to report problems with their accommodation, less likely to feel they had enough money to live on, more likely to live alone, less likely to say they saw friends and relatives as often as they'd like, and much less likely to use modern technologies of communication. Finally, lonely people also differed from people who were not lonely in access and use made of community resources and their views about some of these resources. Lonely people were less likely to participate in leisure activities, and less likely to use typical community facilities such as libraries, community centres and sports and leisure facilities. They were less likely to say that faith played an important role in their life. Lonely people were also more likely to say they never normally left their home and more likely to feel that lack of access to transport was a barrier. They were also more likely to feel that a more visible police presence would make them feel safer.

These findings alone suggested to us that loneliness had pervasive effects. To explore which of these variables were most strongly predictive of loneliness, a further range of dichotomous variables were created from the categorical variables summarised above which were then entered into a logistic regression.

Table 5. Regression model on probability of feeling lonely

Variables	β	Wald	df	Sig.	Adjusted Odds	95% C.I.for EXP(B)

					ratio (Exp(B))		
						Lower	Upper
Not enjoying life (v enjoying life)	-1.789	84.028	1	.000	5.983	4.081	8.771
Not needing help with personal care (v needing help)	.762	17.721	1	.000	0.467	.327	.665
Able to see friends & relatives (v not being able to see friends & relatives)	.678	17.499	1	.000	1.969	.370	.698
Not living alone (v being alone)	-1.292	58.361	1	.000	0.275	.197	.383
Constant	-.230	2.521	1	.112	0.794		

Table 5 demonstrates the variables that *remained* in the model and were therefore predictors of loneliness. Exp[B] represents the odds ratio of being in the 'lonely group' if people responded 'yes' or 'no' to these variables. For variables 'not living alone versus living alone, and 'not needing help with personal care versus needing help with personal care', the odds ratio is reversed thus: (1/0.275=3.663, & 1/0.467=2.14 respectively).

In our sample the strongest predictor of loneliness was the dichotomous variable 'enjoying life or not enjoying life'. The group whose responses were 'not enjoying life' were almost 6 times as likely to be reporting to be lonely (some or most days). People who lived alone were 3.7 times more likely to report being lonely (some or most days). The other predictors were 'needing help with personal care' (2.14 times

more likely to be lonely); and 'not being in touch with people as often as liked' (almost twice as likely: 1.969).

The Hosmer and Lemeshow goodness of fit test[1] revealed a chi square statistic of 8.537 (6, N=1550), p=0.201; indicating a satisfactory fit for the model. The model accurately predicted 85% of responses overall.

To summarise, factors in our study that *predicted* loneliness from our regression analysis were;

- Living alone
- Not enjoying life
- Needing help with personal care
- Not being in touch with people as often as liked

The variables that *failed to predict* loneliness were:

- Gender
- Age
- Being a carer
- Being an owner occupier
- Overall health
- Having mobility problems
- Not having enough money
- Satisfaction with amount of social contact

[1] This is a test of the predictive value of the regression analysis

- Being retired
- Living independently or not
- Use of technology (mobile phone, internet, computer)
- Needing help for emotional or mental health problems

Discussion: the significance of these findings

This paper is based on analysis of a city-wide survey that aimed to gather information about the needs and aspirations of people over 55 in order to inform and refresh Coventry's Older Peoples' Partnership Strategy The survey was not designed specifically to look at loneliness and factors associated with it, and some of its limitations need to be described. In order to perform the logistic regression some variables had to be collapsed into dichotomous ones and, therefore, there is a risk that the dichotomous variables created do not have quite the same meanings as the respondents' original understanding of the questions. There is also a danger, when performing secondary analysis of this kind that significant findings may occur which are actually 'false positives'. In addition, there are several other limitations to our survey and the data it produced. The survey questionnaire was several pages long and would have taken around 15-20 minutes to complete. It was also only available in English language. Because of this, older people with impaired capacity, poor literacy or disabilities affecting writing ability would struggle to complete it. Secondly, the samples we used to collect our data may have led to some degree of sampling bias, despite the size of the data set. Finally, there may be response bias arising from the method we used to collect our data (people from higher socio-

economic groups or whose first language is English being more likely to participate). It is also seems reasonable to think that the most lonely and socially excluded older residents of Coventry would have been less likely to take part in the survey. Our findings should, therefore, be considered within the context of these limitations.

We found that 15.5% of the sample reported loneliness on 'most' or 'some' days. The range of loneliness in other studies already reported above (Victor et. al., 2000) have been up to 38% in older women, but our overall 'rate' seems to be at the higher end of the range of UK studies reviewed by Victor et. al., though possibly an under-estimate. Had we been able to achieve a more representative sample, we may have found more significant predictors of loneliness. Therefore, whilst some significant findings have been found, the generalisibility of these may be limited. However, the findings do largely concur with those of previous studies.

In our study, the greatest predictor of loneliness was an admission by respondents that they were not enjoying life as much as they felt they could be. However, it is difficult to establish temporal relationships between these associations: i.e. did feeling lonely lead to feeling that life was not so enjoyable, or was not enjoying life a possible proxy for depressive feelings, which could lead to self-imposed isolation and therefore loneliness? On the other hand, living alone seemed to be strongly associated with loneliness. Another limitation of our survey was that data on marital status was not collected. We were, therefore, unable to break down the 'living alone' variable further into categories based on widowhood or divorce.

Whilst health status did not predict loneliness in our study, needing help with personal care did, which might indicate a chronic condition that may impede independent living and socialising. This variable may be an artefact of age group: we found that the older people were, the more likely they were to need personal care, and to be lonely. However, age as a variable failed to predict loneliness.

The implications of these secondary findings suggest that there is a need to explore further the factors associated with loneliness amongst older adults. This would require a more robust methodology than was possible in our study to collect data on loneliness and factors that may be associated with it. In addition, qualitative methods would usefully examine more deeply into the association between life satisfaction and experience of loneliness, as well as the other factors identified from this analysis. Interviews with older adults who reported or did not report loneliness specifically would also help identify protective factors against loneliness and potential approaches to help people avoid being lonely (especially for those with long term conditions who require help with personal care). Finally, further research might aim to engage more vulnerable and 'hard to reach' members of the older adult population such as those people living in residential care, those with long term health conditions and disabilities, and those from black and minority ethnic groups.

Living alone was also associated with not being a carer. Most people who identified themselves as a carer were caring for a family member. The paper has already indicated that the older people were, the greater their likelihood of living alone.

Women were also more likely to live alone - which may reflect differences in average lifespan between men and women.

Conclusions

Evidence from other studies suggests that loneliness is endemic amongst older people in the UK. Our study, based on data collected from a large survey population of older people living in the city of Coventry identified high numbers of older people living alone and self-reported rates of loneliness that are broadly consistent with other UK studies. Our data enabled us to profile 'lonely' and 'non-lonely' respondents by demographic background, health and well-being, personal resources and community resources. We found strong statistically significant differences between the two groups on a range of variables obtained from our data, which we then entered into logistic regression. This indicated that amongst these statistically significant variables, four variables were particularly strongly associated with loneliness. These were living alone, not enjoying life, needing help with personal care and not being able to keep in touch with people as often as desired.

We have argued that further research – particularly of a qualitative nature- and focussed on groups of people often under-represented in community surveys such as ours - would be useful in mapping the full extent of loneliness as well as helping to establish a deeper understanding of the factors associated with loneliness amongst older adults, in addition to identifying and testing out potential measures to prevent the onset of loneliness. Although the claims we make for our findings are modest,

we believe that they might usefully support clinicians, social workers and other local care and health professionals in identifying lonely people in order to offer support to them to overcome loneliness before its effects become too consequential.

References

Association of Directors of Social Services (ADSS) (2003); All Our Tomorrows: Inverting the Triangle of Care. London, ADSS.

Age Concern (2008a) Out of Sight, Out of Mind, London: Age Concern

Age Concern (2008b) The Age Agenda 2008, London: Age Concern

The Audit Commission, (2002) Integrated Services for Older People – building a whole systems approach across England, London: Audit Commission

Barnes, M., Blom, A., Cox, K. and Lessof, K. (2006a) The Social Exclusion of Older People: Evidence from the First Wave of the English Longitudinal Study of Ageing, London: ODPM

Barnes, M., Blom., A., Cox, K., Lessof, C., Walker, A. (2006b) *New Horizons: The Social Exclusion of Older People: Secondary Analysis of the English Longitudinal Survey of Ageing.* London, National Centre for Social Research and the University of Sheffield.

Catten, M. (2002) Supporting Older People to Overcome Social Isolation and Loneliness, London: Help the Aged

Catten, M., White, M., Bond, J. And Learmouth, A. (2005) *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions*, Ageing and Society, Vol. 25, No. 1, pp. 41–67

Commission on Funding of Care and Support (2011) Fairer Care Funding: The Report of the Commission on Funding of Care and Support.

Curry, N. (2006) '*Preventative Social Care – is it cost effective*?' Background Paper, Wanless Social Care Review, London: Kings Fund

Daly, G. (2009). *LinkAge Plus: Benefits for older people – Department for Work and Pensions Research Report. No. 554.* London:

Davis, H. and Ritters, K. (2010*) LinkAge Plus national evaluation: End of project report, Department for Work and Pensions Research Report No 572*, London: Department for Work and Pensions

Department for Communities and Local Government (2010) Localism Bill: Local Government and Community Empowerment, London: Department for Communities and Local Government

Department of Health (2001) The National Service Framework for Older People London, HMG

Department of Health (2004), Choosing Health - making healthier choices easier, London: Department of Health

Department of Health (2005), Independence, Wellbeing & Choice: our vision for the future of social care for adults in England, London, TSO.

Department of Health (2006a) A New Ambition for Old Age: Next steps in Implementing the National Service Framework for Older People, London, TSO.

Department of Health (2006b) Our Health, Our Care, Our Say: a new direction for Community Services Cmnd 6737 London, TSO.

Department of Health (2008) Transforming Social Care, London: Department of Health

Department of Health, (2010a), 'Healthy lives, healthy people', London: Department of Health

Department of Health (2010b), A Vision for Adult Social Care: Capable Communities and Active Citizens, London: Department of Health

Donaldson, J.M. & Watson, R, (1996) *Loneliness in elderly people: an important area for nursing research* Journal of Advanced Nursing Vol. 24 (5) p, 952-959.

Department for Work and Pensions (DWP), (2002); Simplicity, Security and Choice, London: Department for Work and Pensions

Gabriel, Z. and Bowling, A. (2004) *Quality of life from the perspectives of older people*, Ageing and Society, Vol. 24, pp. 675–691

Godfrey, M. Townsend, J., Surr, C., Boyle, G. and Brooker, D (2005) *Literature and policy review on prevention and services*, completed for the UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern England.

Gray, A. (2009) *The Social Capital of Older People*, Ageing and Society, Vol. 29, pp. 5–31

Help the Aged (2008) *Learning for Living – Helping to prevent social exclusion among older people,* London: Help the Aged

HMG (2005) Opportunity Age: meeting the challenges of ageing in the 21st century, London: Cabinet Office

HMG (2007) Putting People First - A shared vision and commitment to the transformation of Adult Social Care, London: Cabinet Office

HMG (2010) The Coalition: our programme for government, London: Cabinet Office

Holmen, K., Ericsson, K., Andersson, L., & Winblad, B. (1992) *Loneliness among elderly people living in Stockholm: A population study.* Journal of Advanced Nursing, 17, pp. 43–51.

Joseph Rowntree Foundation (2005) *The Older People's Enquiry – That little bit of help,* JRF November 2005

Joseph Rowntree Foundation (2008) '*What are today's social evils*?', JRF April 2008

Local Government Association (2012) Combating Loneliness: A guide for Local Authorities, *London, Local Government Association*.

Office of the Deputy Prime Minister (2000), Quality and Choice in older people's housing, London, Department of Health/ODPM

Office of the Deputy Prime Minister (2005) Supporting People, London: ODPM

Office of the Deputy Prime Minister (2006) A Sure Start to Later Life: ending Inequalities for Older People London, Social Exclusion Unit, ODPM

Robertson, M. and Wilkinson, H. (2010) *Local Delivery of Joined-Up Services for Older People,* Department for Work and Pensions Research Report No 713, London: DWP

Rook, K. S. (1988) *Toward a more differentiated view of loneliness*, in Duck, S. W. (ed.), Handbook of Personal Relationships, pp. 571–81, London: Wiley

Routasalo, P. and Pitkala, K., H. (2003) *Loneliness among older people*, Reviews in Clinical Gerontology, Vol. 13, pp. 303–311

Scharf, T., Phillipson, C., & Smith, A.E., (2005) Multiple Exclusion and Quality of Life amongst Excluded Older People in Disadvantaged Neighbourhoods. London, S.E.U., ODPM.

Social Exclusion Unit (SEU) (2003) Making the Connections: Final Report on Transport and Social Exclusion, Office of the Deputy Prime Minister

Social Exclusion Unit (2004) Mental health and social exclusion, London: Office of the Deputy Prime Minister

Social Exclusion Unit (SEU) (2005) Excluded Older People. Social Exclusion Unit Interim Report, Office of the Deputy Prime Minister

Theeke, L.A., (2009) *Predictors of Loneliness in U.S. Adults Over Age Sixty-Five* Archives of Psychiatric Nursing, Vol. 23, No. 5 (October), 2009: pp 387–396.

Townsend, P., (1962) The Last Refuge, A Survey of Residential Institutions and Homes for the Aged in England and Wales, London: Routledge and Kegan Paul).

Victor, C., Scambler, S., Bond, J., & Bowling, A., (2000) Being *alone in later life: loneliness, social isolation and living alone* Reviews in Clinical Gerontology **10**; 407–417

Victor, C., Scambler, S., Bowling, A. and Bond, J, (2005) *The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain*, *Ageing and Society,* Vol. 25, No. 3, pp. 357-375

Walters, R., Cattan, M., Speller, V. and Stuckelberger, A. (1999) Proven Strategies to Improve Older People's Health, London: Eurolink Age

Wanless, D., (2003) Securing Good Health for the Whole Population. Population Health Trends London, H.M., Treasury.

Wanless, D. (2004) Securing Good Health for the Whole Population: Final Report, London: HM Treasury

Wanless, D., (2006) Securing Good Care for Older People: taking a long term view, Kings Fund, London, 2006.

Watt, P.A. and Blair, I. (2009) The Business Case for LinkAge Plus, Department for Work and Pensions Research Report No 573, London: Department for Work and Pensions.

Weiss, R. S. (1982) *Issues in the study of loneliness*, in Peplau, L. and Perlman, D. (eds), Loneliness: A Source Book of Current Theory, Research and Therapy. pp. 71–80, New York: Wiley

Wenger, G. C., Burholt, V. and Scott, A. (2001) The Ageing Process: The Bangor Longitudinal Study of Ageing 1979–1999, Centre for Social Policy Research and Development, Institute of Medical and Social Care, University of Wales, Bangor, Gwynedd: University of Wales, Bangor

Wenger, G. C., Davies, R., Shahtahmasebi, S. and Scott, A. (1996) *Social isolation and loneliness in old age*, *Ageing & Society*, Vol. 16, No. 3, pp. 333–58

Wistow, G., Waddington, E. and Godfrey, M. (2003) Living well in later life: from prevention to promotion, Leeds: Nuffield Institute for Health