Evidence Review: Loneliness in Later Life

Contents

Key stats (updated July 2014)

- Over 1 million older people say they are always or often feel lonely [1]
- Nearly half of older people (49% of 65+ UK) say that television or pets are their main form of company[2]
- Loneliness can be as harmful for our health as smoking 15 cigarettes a day[3]
- People with a high degree of loneliness are twice as likely to develop Alzheimer's as people with a low degree of loneliness [4]
- 86% of over 65s say they are satisfied with their personal relationships. This is the lowest of all age groups.[5]
- Only 46% of over 65s said they spent time together with their family on most or every day, compared to 65-76% for other ages. 12% of over 65s said they never spent time with their family.[6]
- Over 65s also spent less time with friends: only 35% spent time with friends most or every day in the last 2 weeks, and 12% never did.[7]
- People who took part in more health-maintaining and independence-maintaining behaviours were less likely to feel isolated and more likely to feel that their community was a good one to grow old in.[8]
- Nearly half (49%) of all people aged 75 and over live alone[9]
- 9% of older people feel trapped in their own home [10]
- 6% of older people (nearly 600,000) leave their house once a week or less [11]
- 30% say they would like to go out more often [12]
- According to research for DWP, nearly a quarter (24%) of pensioners do not go out socially at least once a month [13]
- Nearly 200,000 older people in the UK do not receive the help they need to get out of their house or flat [14]
- 17% of older people have less than weekly contact with family, friends and neighbours [15]
- 11% have less than monthly contact [16]
- 41% of people aged 65 and over in the UK feel out of touch with the pace of modern life and 12% say they feel cut off from society [17]

Age UK Loneliness Evidence Review   Susan Davidson and Phil Rossall   Revised July 2014

1 Introduction

This review is a summary of available evidence from research on loneliness in later life and it is intended to serve as an evidence base and promote discussion on the topic. The review focuses on loneliness in the community.

Why loneliness?

Loneliness and isolation, or social isolation, are often discussed together and even used interchangeably. While they are related, they are distinct concepts.

Loneliness can be understood as an individual's personal, subjective sense of lacking desired affection, closeness, and social interaction with others. Although loneliness has a social aspect, it is also defined by an individual's subjective emotional state. Loneliness is more dependent on the quality than the number of relationships.

Social isolation refers to a lack of contact with family or friends, community involvement, or access to services[18][19][20].

It is possible to be lonely but not to be socially isolated - research shows that older people in large households and care homes are **more** likely to report loneliness. It is also quite possible to be socially isolated but not lonely. Some people who live on their own or in remote places may not feel or report loneliness.

To put it another way, "…an individual may be lonely in a crowd, socially contented while alone."[21]

Loneliness can be a temporary, recurrent, or persistent (chronic) state but social isolation does matter as it can be a risk factor for loneliness.[22][23] It also affects a large number of older people:

36 per cent of people aged 65 and over in the UK feel out of touch with the pace of modern life and 9 per cent say they feel cut off from society. [24] Half of all older people (about 5 million) consider the television as their main form of company. [25]

Only 46 per cent of people 65 and over said they spent time together with their family on most or every day, compared to 65-76 per cent for other ages. 12 per cent of people 65 and over said they never spent time with their family.[26] People aged 65 and over also spent less time with friends: only 35 per cent spent time with friends most or every day in the last 2 weeks, and 12 per cent never did.[27]

Loneliness causes feelings of disconnectedness from others, and not belonging,[28] but it is not just an unpleasant experience. Persistent loneliness can have profound impacts on physical and mental health, and quality of life.

For example, loneliness can be as harmful for our health as smoking 15 cigarettes a day[29], and people with a high degree of loneliness are twice as likely to develop Alzheimer's than people with a low degree of loneliness[30].

These issues are discussed in more detail in the 'Impacts of loneliness' section below.

In our recent studies we have found that the three top concerns of older people were; bodily pain, loneliness and memory loss[31].

Why do we get lonely?

Research on twin and non-twin siblings suggests that loneliness is approximately 50 per cent inherited and 50 per cent environmental[32][33]. This means that a person's response to environmental triggers is only partly due to their social situation, and is also partly due to inherited factors. This helps to explain why some people are happy to be alone, and others are not (but other environmental factors such as upbringing also play a role). However, the fact that loneliness is not 100 per cent heritable means that it can be affected by changes to environmental conditions (such as interventions to reduce loneliness).

It is thought that loneliness is an adaptive indicator (self-defence mechanism), like pain or hunger, which signals that something is wrong and prompts the person experiencing it to correct the problem[34].

Being alone has been (and can still be) a threat to survival because humans depend on one another for food, shelter, security, and so forth. As a highly social species, cooperation is needed to improve survival, and this requires trust, communication, planning, and working together[35]. Thus, loneliness may be essential for species survival, because like thirst and hunger, it prompts the person experiencing it to try to alleviate it.[36] It is when loneliness becomes chronic that it damages health and well-being.

2   Measuring loneliness

Measuring and quantifying loneliness

Loneliness among older people has been quantified in a number of ways, from survey questions measuring subjective loneliness to validated multi-dimensional instruments, as well as making up part of wider measures of psychological health and well-being. This section discusses the different types of measures that are used in quantitative research.

Direct measures of subjective loneliness

Surveys have consistently shown that around 6-13 per cent of older people report that they are often or always lonely[37]. These include recent estimates by Age UK that 650,000 to 800,000 people aged 65+ in the UK say they are always or often lonely: 7 per cent in 2011 and 2012[38] and 6 per cent in January 2013[39] and Wave 5 of the English Longitudinal Survey of Ageing (ELSA) where 8 per cent said they felt often lonely.[40]

A similar question in the same wave of ELSA asking about loneliness 'in the past week' gave a higher estimate of 15 per cent, but this gives less of an idea of problem or sustained loneliness, i.e. that which is likely to affect health and well-being.

Forthcoming research will explore the longitudinal aspects of loneliness, (changes over time) and give a clearer idea of transitions into and out of loneliness and the prevalence of sustained loneliness[41].

Multi-dimensional instruments to measure of loneliness

De Jong-Gierveld Loneliness Scales

First published in 1985, the De-Jong Gierveld scale is an instrument for measuring loneliness, based on an 11 point scale[42]. Measuring subjective loneliness by drawing on a cognitive approach, this is based on 2 types of loneliness – emotional and social.

A 6–item version of the scale was published in 2006 to make it easier to include in surveys where there is insufficient space for the 11 item scale. [43] This version of the scale has been used internationally by the United Nations.

UCLA Loneliness Scales

Another commonly used instrument for measuring loneliness is the UCLA Loneliness Scale, named after the University of California, Los Angeles where it was originally developed to measure loneliness among college students. It was based around statements made by lonely people to describe their experience. First published in 1978, the most recent version is the third version published in 1996.[44] This version included wording revisions specifically designed to make it easier to administer in surveys of older people. The full version of the UCLA scale contains 20 items.

A 3-item version of the scale was developed by Hughes *et al* from the University of Chicago for use in the 2002 US Health and Retirement Study, and has been replicated in ELSA[45].

Loneliness as part of wider well-being scales

Loneliness affects an individual's well-being and is included as a dimension in a number of other multi-dimensional instruments to measure this, or these include other dimensions which correlate closely. These include:

Ryff Scales of Psychological Well-being

Ryff's scales of Psychological Well-being were designed to measure six theoretically motivated constructs of psychological well-being (e.g. autonomy and purpose in life)[46]. The original questionnaire included 120 items, but reduced versions have been developed for between 18-120 items. ELSA uses a 43 item version which includes a question on loneliness.

CES-D Depression

The CES-Depression scale is a commonly used scale looking at how the respondent felt over the past week, to measure depression. The main version has 20 items. ELSA uses an 8-item version of the CES-Depression scale.[47] This includes the question on loneliness in the past week.

CASP-19

CASP-19 is a wide-ranging measure of quality of life in older age. It covers 4 domains – Control, Autonomy, Self-realisation & Pleasure[48]. It does not measure loneliness but provides data on variables associated with loneliness (e.g. 'my health stops me doing what I want to'). It is included in ELSA (the English Longitudinal Study on Ageing).

The Warwick-Edinburgh Mental Well-being Scale aims to measure two perspectives of mental well-being itself. These two perspectives are hedonic perspective (which focuses on the subjective experience of happiness and life satisfaction) and eudaimonic perspective (which focuses on psychological functioning, good relationships with others and self-realisation).

The appropriate measures should be chosen on the basis of the purpose and problem; it is important to think about the interpretation of the results and whether the measure is validated.

From here on, references to loneliness are of older people, unless otherwise stated.

3 Factors associated with loneliness in later life

We are undertaking a research project focusing on factors associated with being often lonely and the interrelation between factors. We will be undertaking analysis of loneliness prevalence rates by for example, older people in a/not in a relationship, older age groups, self-perceived health/financial status, just to mention a few.

Many existing studies, have found the following factors to be correlated with older people saying they feel lonely:

(Order of list does not reflect the strength of the association with loneliness.)
- Age
- Ethnicity and language
- Sex
- Living arrangements and marital status
- Geography
- Housing
- Health
- Income
- Providing informal care
- Sexual orientation

Age: The likelihood of expressing self-perceived loneliness increases with age.[49]

Gender: Men and women are affected differently: older women are more likely to say they feel lonely than older men.[50][51]

Living arrangements and marital status: People who live on their own are more likely to say they are 'often' lonely.[52] 63 per cent of adults aged 52 or over who have been widowed, and 51 per cent of the same group who are separated or divorced report, feeling lonely some of the time or often.[53] People's attitudes to death may affect their response to bereavement.[54] The experience of living alone appears to contribute towards being excluded from social relationships.[55]

Housing: Older people living in residential care report feeling more lonely than those in the community[56].

Geography: Some studies indicate that living in a rural area correlates with loneliness;[57] however, this is a complex issue,[58] as various other studies suggest the opposite. For example, one study has shown that in rural areas, levels of loneliness decrease as population density increases.[59] Lonely people are more likely to be lonely if they live in a deprived urban area or an area in which crime is an issue[60]. And, being widowed and in poor health predicted loneliness in urban areas.[61] Age UK's exploratory analysis of ELSA data[62] has found that the incidence of older people who are 'often' lonely is slightly higher in urban than rural areas, though the difference is slight. More research is needed to unpick this.

Health: Health and disability play a role. Poor health, reduced mobility, cognitive impairment, and sensory impairment increase older people's chances of being lonely.[63 64 65]

Income: A direct correlation exists between low income and loneliness and isolation among older people.[66]

Providing informal care for others: There is no clear evidence of a relationship between the provision of informal care by older people and risk of being lonely. There is, however, limited evidence from Sweden that being an older carer is associated with a lower risk of loneliness, as caregivers in the study had a larger social network than those not providing informal care.[67]

However, a recent report for Carers' Week 2013 shows that 61 per cent of the carers surveyed found it difficult to maintain friendships as a result of their caring responsibilities.[68] However, this survey was not specific to older carers, with only 17 per cent of the sample aged 65 or over.

Ethnicity and language: There is evidence that ethnic minority elders may be among the most lonely.[69 70]

Sexual orientation: Gay men and lesbians seem to be at greater risk of becoming lonely and isolated as they age.[71]

Key transitions, which tend to occur in older age, can also trigger loneliness; these include retirement, becoming a carer, and bereavement.[72]

Other factors associated with loneliness

There is evidence that social exclusion plays a role in the reporting of feelings of loneliness. Although it cannot be claimed that social exclusion causes loneliness, it was found "that overall exclusion was a significant predictor of well-being and loneliness."[73] Moreover, evidence from ELSA 2002 and 2008 surveys indicates that social exclusion is characterised by seven domains i) social relationships; ii) cultural; iii) civic activities and access to information; iv) local amenities; v) decent housing and public transport; vi) common consumer goods; and vii) financial products.[74] A comparison of results between 2002 and 2008 found that experiencing exclusion in three or more of these areas was associated with almost a three-fold increase in the risk of becoming lonely.[75]

A related concept is 'social detachment', in which people fail to participate in social activities. A longitudinal study[76] of ELSA data suggests four domains of participation: civic participation (membership of political party, trade union, neighbourhood watch, church, volunteering), leisure

activities (education, arts, social or sports club, gym, etc.), cultural engagement (going to cinema, art gallery, theatre, etc.), and social networks (not having or not being in contact with friends, family, children).

The findings demonstrated that majority of older people are not detached from social life. However, a significant number are:
- 20 per cent detached from 3 or more domains
- 50 per cent detached from civic participation and leisure activities
- 5 per cent detached from social networks

Social detachment has similar risk factors for loneliness in later life as those posited above:

For example, people who were single, separated, divorced or widowed were more likely to be 'detached' than those living together as a couple. Those who were poorer, unhealthier, or with lower levels of education were more likely to be 'detached' from civic, leisure and cultural engagement.

Access to public or private transport has a significant impact on engagement/detachment.

Our own initial analysis indicates that wealth is the most consistent driver of movement into social detachment across domains: poorer individuals are more likely to move into social detachment than those who are richer, except in the social network domain.

A special example of community engagement is getting people from different generations to interact. Generally, interaction between younger and older people is low, and the majority of people in one study said that that different generations find it hard to communicate outside of families.[77] In theory, interventions that support intergenerational interaction could improve community engagement and reduce loneliness.

4   The impact of loneliness on older people

As noted above, existing health conditions or impairments can lead to a curtailment of independence and can limit social roles, resulting in feelings of loneliness.[78] Conversely, chronic feelings of loneliness can result in deterioration of health and well-being, and a shorter lifespan.[79]

Feeling lonely has been shown to increase blood pressure and risk of cardiovascular diseases,[80] elevates cortisol and stress levels which weakens the immune system,[81] impairs sleep quality (which causes memory problems) leading to negative effects on metabolic, neural and hormonal regulations,[82] and heightens feelings of depression, anxiety, and increased vulnerability.[83]

Self-perceived loneliness doubles the risk of developing Alzheimer's disease.[84][85] There is evidence that loneliness and social isolation are associated with reduced cognitive function,[86] while socially engaged older people experience less cognitive decline and are less prone to dementia.[87] It is thought that cognitive health is facilitated directly through enhanced brain stimulation, and indirectly through lowered stress reactions,[88][89] improved coping mechanisms, and healthy behaviours.[90]

Having weak social connections also carries a health risk: those with strong social connections have a 50 per cent increased likelihood of survival after an average follow-up time of 7½ years.[91]

It has been found that loneliness often relates to feelings of 'anger, sadness, depression, worthlessness, resentment, emptiness, vulnerability and pessimism'.[92]

Studies have also found that loneliness leads to poor lifestyle behaviours; for example, alcohol has been shown to be used by people in order to alleviate a sense of a meaningless life, depression, anxiety and loneliness.[93] [94] Studies have also found a link with drug abuse and bulimia and loneliness. Lonely adults are more likely to be overweight and smoke,[95] and are less likely to exercise.[96] There is a proven link between loneliness, depression and suicide.[97] [98]

But loneliness does not just directly affect health and well-being; it can also become a vicious circle: research has shown that lonely people are more likely to view social encounters with more cynicism and mistrust,[99] [100] [101] rate others and themselves more negatively, and expect others to reject them[102]. In addition, lonely people tend to adopt behaviours that increase, their likelihood of rejection[103]. These beliefs and behaviours are referred to as 'maladaptive social cognition'.

5   What works?

There is a lack of robust and reliable evidence on the evaluation of services for older people in general and the evidence collated here is the best available.

Research shows that loneliness is not an immutable trait but rather can be improved (or worsened). Interventions that enhance a feeling of social connectedness can alter self and others' perceptions, improve the quality of social interactions, and reduce feelings of loneliness.

Interventions are often categorised in the literature in four ways, as attempts to: improve social skills; enhance social support; increase opportunities for social interaction; or address maladaptive social cognition (defined as behaviour that is counter-productive or interferes with everyday living).

A rigorous quantitative meta-analysis[104] suggests that certain interventions in all of these categories can be effective at reducing loneliness, regardless of age and other characteristics of the participants, but interventions that attempt to change maladaptive social cognition are the most effective.

However, studies of interventions we have found for older people in the UK are only of the type that try to increase opportunities for social interaction. It may be because these are the easiest and most cost-effective to implement (for reaching a larger number of people).

If schemes to target loneliness in older people are to be effective, they must involve older people at every stage, including planning, development, delivery and assessment.[105] [106]

It has been acknowledged too that interventions are more effective when they are tailored to the target group. For instance, one ESRC research study highlighted the crucial role of community centres for minority ethnic older women in 'offering a meeting point for sharing identity, language, culture and experiences.' [107] [108]

It is worth noting that interventions not specifically targeted at combating isolation and loneliness can still have a tangible positive effect on them.[109] [110]

Below is a summary of findings about the most common 'social interaction' interventions for older people. A discussion about social support networks and sources (but not interventions) is in Appendix A.

Group activities

Group interventions target many people at once, so they may be more cost-effective than one-on-one interventions. In addition, with a focus on the activity rather than 'loneliness', they can avoid a negative stigma and thus attract more participants.

Specialised groups targeting older people

This is a very broad category, including services such as day centres, lunch clubs, social clubs, creative activities (arts and crafts, etc.), self-help and support groups, and health/exercise groups (including walking clubs).

Evaluations provide mixed results: some show improvement on loneliness measures, some do not. But even groups that do not have 'addressing loneliness' as a core function can nevertheless do that; for example, people who took part in health-maintaining and independence-maintaining behaviours were less likely to feel isolated and more likely to feel that their community was a good one to grow old in.[111] A systematic review of groups from art to exercise to writing found that 95 per cent of the participants (mean age of 80) reported that their feelings of loneliness were reduced.[112]

Community engagement

This encourages people to use existing community programmes, such as libraries, civic participation, and volunteering.[113] Again, studies show that these can improve loneliness and change lifestyles.[114]

The Joseph Rowntree Foundation and the Joseph Rowntree Housing Trust has set up a programme looking at how community activities could contribute to the well-being of people at risk of or experiencing loneliness and how they could play a central role in activities, thereby enhancing community well-being.[115]

An area for further research is whether spirituality can prevent loneliness from turning into depression[116].

One-on-one interventions

For frail or housebound older people, group participation is not an option. In addition, some people prefer individual rather than group interactions. Various studies have shown that one-to-one interventions can be very effective in reducing loneliness and the associated negative health and well-being effects.[117]

Befriending

Befriending has been defined as 'an intervention that introduces the client to one or more individuals, whose main aim is to provide the client with additional social support through the development of an affirming, emotion-focused relationship over time'.[118] The intervention differs between programmes, but usually involves volunteers or paid workers visiting an individual in their own home (or place of care) or telephoning on a regular basis. There is good evidence that befriending can have positive outcomes, including reducing depression.[119] [120]

An evaluation[121] of the AGE UK telephone befriending service 'Call in Time', in which a volunteer makes weekly phone calls to an assigned older person, found that recipients reported many benefits from the service:

The older people said they valued the ability to talk, listen and share information with another human being who they felt they could trust and rely. This contact provided them with a sense of belonging, made them feel more confident and less alone and anxious.

However, many felt that the service should not be called 'befriending'. People wanted a normal conversation, and did not want to be 'problematised'.

Other key benefits older people said about the service:
- They feel they are not forgotten.
- They know they have a friend who cares who is not family.
- They know they have a friend who is trustworthy and reliable.
- They have greater peace of mind.
- They can engage in ordinary conversation.
- They no longer feel a burden to society.
- Their emotional and physical health is improved.
- Their general well-being and quality of life is improved.

Benefits were also reported by the volunteers who made the calls. They had a high level of satisfaction and said that the volunteering increased their self-confidence and interpersonal skills, and had a raised awareness of needs and opportunities within the community.

Gatekeeping (Community Navigator or Wayfinder initiatives)

These "are usually volunteers who provide 'hard-to-reach' or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services and helping individuals to find appropriate interventions."[122] Provision depends on locality and need, and could be, for example, face-to-face visits or telephone calls to discuss what the older person needs, and what is available in the community.

Some studies have shown that that Wayfinder and Community Navigator services are effective at finding socially isolated and lonely people, who became less lonely and socially isolated following contact.[123][124]

Another example is the Village Agent programme enacted by South Lakeland Age UK. Trained Village Agents know their community and the resources and services available. They visit older people in their homes and provide social interaction, plus help identify and arrange for things the client needs, such as a GP visit, transportation, and so forth. Village Agents can also spot potential hazards in the home, and suggest and arrange handyperson visits to fix or adapt the home as needed.

Internet

Interventions focusing on internet use have had mixed results. For example, one evaluation in Finland and Slovenia that taught older people to use the internet to keep in touch with others, such as through email, was shown to have the potential to reduce loneliness.[125]

Despite the lack of clear cut evidence, the weight of evidence shows that internet use helps older people to combat social isolation and there is some good evidence of its positive effects on loneliness.[126]

Those older people who do possess IT skills could be part of the solution; one study which piloted projects in Denmark, Finland, Italy and Spain has looked at new services and infrastructure that public authorities will be able to develop in collaboration with external businesses using older people themselves as active content providers, viewing them as a resource who can provide their own everyday life support services.[127]

In future, when a greater proportion of this age group is connected online, opportunities will arise for identifying those at risk of loneliness, along the lines of an app "EmotionDiary" which has already been developed for identifying those using Facebook who are depressed.[128]

Interventions for special groups

Men

Loneliness is reported by around 5-7 per cent of older men. Research has shown that social isolation, loneliness, and stressful social ties are common in men and associated with poor physical and mental health, higher risk of disability, poor recovery from illness and early death. [129]

But finding social activities that are acceptable by older men is a challenge. Older men are less likely to join groups and find making friends more difficult than older women.[130]

In addition, there can be a strong perception among older men that social organisations specifically for older people are places where one is 'done to', rather than places that facilitate active pursuits.[131]

Participation in work-like activities gives men a sense of achievement and belonging. Studies demonstrate that successful interventions for which facilitate learning new skills, using/improving acquired skills, sharing knowledge with peers, promote a sense of accomplishment, and provide opportunities social engagement in a fun and engaging manner.[132]

One example is a programme called 'Men in Sheds', which began in Australia and now has groups in the US, Canada, Ireland, and the UK:

> The core elements of Men's Sheds are that they are voluntary and social organisations providing hands-on activities for men aged 50 years of age and older who are co-participants in a defined space. Sheds provide a space for older men to meet, socialise, learn new skills and take part in activities with other men. Most Sheds are equipped with a range of workshop tools. Shed programmes aim to improve men's physical, emotional, social and spiritual health and well-being. The role of a Shed in encouraging and engaging men in informal adult learning activity is thought to be particularly important. Some Sheds also provide health related information and 'signpost' men to relevant services. In almost all cases, they are tailored to their local context, rather than being standardised.[133]

An evaluation of the UK pilots found:[134]

- A number of older men noted that prior to coming to the Shed they were predominately sedentary.
- Participation helped raised health awareness through formal presentations by external people and informal chats amongst the older men.
- Participants indicated that it provided vital support, provision of connect to other men, mental and cognitive stimulation.
- Participants indicated that it retuned a sense of purpose, achievement and self-worth.

Government policy

Several studies highlight the fact that changes in circumstances of the life course in relation to social exclusion can begin to occur in middle age, and that policies to prevent or address social exclusion should be based around the concept of ageing rather than being targeted specifically at older people. One study suggests that campaigns to de-stigmatise loneliness should be run, emphasising the support available.[135]

Loneliness should be a topic of concern to the newly established Health and Well-being Boards as loneliness increases the need for social care services and residential care.

One study advocates the development of a widowhood strategy - a specific set of strategies and policies to help older people adjust to the loss of a partner.[136]

The Local Government Association has developed a 'Framework for Action' which identifies three tiers of actions: at the strategic level across local authorities; at the level of the community; and at the level of the individual.[137]

6   What are the challenges and barriers?

Difficulties in finding lonely older people

The first challenge is getting to older people who need help with loneliness. Age UK research available in spring 2014 aims to identify the factors associated with loneliness that will help us to identify older people at risk of loneliness at the neighbourhood level.

A couple of projects mentioned in the 'Interventions' section try to address this: Wayfinders and Community Navigators.

Other avenues for identifying those vulnerable to loneliness could be organisations which interact with older people; for example, local councils hold data on those living alone based on records on reduced council tax for single occupancy, and groups such as social services, charities, local welfare groups, bereavement counselling services, faith organisations, substance misuse support groups, and GPs will encounter people who are lonely or at risk of chronic loneliness. However, these agencies will only reach those who are already engaged with the services or groups. An added obstacle is that many of the risk factors and predisposing circumstances are not recorded in official records.

Outreach programmes are required to reach the 'socially excluded' as they do not, by definition, have access to the institutions and structure used by the 'socially included'. These could make use of

telephone surveys and knocking on doors. Face-to-face contact in these programmes is an important factor in helping combat loneliness, especially for those who have problems interacting with groups or are housebound[138].

GPs could be in the best position to provide anticipatory care, as they should be aware of the patients' personal circumstances – for example, health (based on frequency/patterns of presentation by patients) or bereavement[139].

It has been suggested that loneliness is 'contagious' and can spread through social networks[140]. If this is the case, identifying one lonely person could lead to others - there may be a pattern to clusters of loneliness. However, social networks are now both geographical and virtual, so different approaches will be required in future to identify the structure of networks.

Attitudes of older people

One study[141] found several barriers to older service users identifying and planning for need, which could be relevant for seeking help with loneliness:

- An attitude of 'making do' with what they have
- Not wanting to be a 'burden' on others
- Fear of admitting need and denial about the implications of ageing
- Low expectations of services and a feeling of personal responsibility for their choice of residence
- A tendency for initial reliance on community and family support
- Limited awareness of relevant local services
- Fear of external action being taken if they do express a need
- Stigma around admitting loneliness

Health and disability

There is a complicated relationship between health and loneliness including mobility problems, long-term health conditions, sensory impairment, cognitive impairment etc.

Transport

As with any group or community engagement, getting to the venue can be a problem for older people. [142]

Flexibility and choice

Older people tend not to criticise services upon which they depend. However, at least one study on loneliness interventions mentioned that some participants found services to be too rigid, for example with scheduled visits.[143] This is a common theme is any services for people of any age.

For barriers to older people engaging in services in general, see Age UK Engagement's published evidence review (2011)[144].

7   The future

What are the future trends?

It is predicted that between 2008 and 2033 there will be a 44 per cent increase in the number of 65–74-year-olds living alone, a 38 per cent increase in those aged 75–85 and a 145 per cent increase in those aged 85+.[145]Although the proportion of people feeling lonely has remained fairly constant in the past, these figures may indicate that there might be an increase in the future.

Gaps in the evidence base

There is little robust research on those interventions that have included Black and Ethnic Minority Elders, older people in rural areas, or the most frail and excluded, such as those living in care homes.[146]

We could not find any UK evaluations that included a cost/benefit analysis. However, there are a couple of articles on cost modelling.

Knapp and colleagues did a decision-modelling on the financial impact of befriending and Community Navigators. When factoring in cost savings for services and quality of life factors, they determined that befriending gave an added value of around £300 per person per year, well above the £80 cost.[147] They estimated that the economic benefit of Community Navigators was £900 per person per year.

Pitkala and colleagues looked at savings to health services based on participated in a particular group intervention, and estimated that it saved 943 Euros per person, and only cost 62 Euros.[148]

Scope for future research

Robust evaluations of programmes are needed, including cost and benefits analyses…

Appendix A: Social support

'Social support' refers to one's social networks, including the quality and content of the relationships.[149] Social support can provide a person with information, tangible assistance, and emotional comfort. It has also been connected with the experience of loneliness[150][151]. Social networks provide the structure for connection and potential support.[152]

Although loneliness is tied to one's social network, a perception of loneliness depends on how individuals view the quality of those relationships[153]. In fact, some argue that loneliness is a good indicator of social support quality.[154]

Social support can be divided into two types: emotional and instrumental support[155]. Emotional support refers to caring and understanding from others, while instrumental support is receiving help with needs and daily activities (e.g., cooking, transport, shopping). Both types of support may be present in the same relationship. The type of support one receives also impacts on an individual's sense of loneliness, and on cognitive and mental health outcomes: emotional, rather than instrumental, support seems to be key.[156][157]

Social networks and the support they offer have been shown to significantly affect the physical and mental health of older people[158][159][160]. For example, poor quality social connections and fewer social activities increase the risk of cognitive decline in people aged 65+ [161][162].

It is important to note that it is not just the number of social connections or activity that has these effects, but rather the person's perceptions about the quality and satisfaction with one's relationships[163][164]. Emotional closeness is also more important than frequency of contact[165][166].

In addition, not all social relationships are positive; they can be difficult or damaging[167][168]. Some types of social networks increase risk of loneliness and mental illness, for example family-dependent with few friends or community connections.[169]

There is also the complexity of older people wanting to maintain a feeling of independence, not be a 'burden' to friends or family, nor use stigmatised forms of social support (such as meals on wheels). Even older people with large, positive support networks can be reluctant to utilise them for assistance with instrumental tasks such as shopping, meal preparation, and eating, because they do not want to seem reliant on assistance.[170] In these cases, formal support systems like assisted shopping may be more attractive.

The type of social relationships that people find satisfying have been shown to vary by gender: men seem to tend to be more satisfied with group experiences, whereas women tend to focus on the quality of one-on-one relationships.[171]

A practical implication for interventions from the research is that attempts to reduce loneliness should not focus just on the quantity of social support relationships, but instead try to stimulate a few close and emotionally supportive relationships. Another suggestion is to try to de-stigmatise formal instrumental support and associated feelings of loss of control and independence they can induce.[172]

Strengthening social support should be part of health and social care settings as well as in the community, because of the profound effect of loneliness on health and mental well-being, and cognitive decline.

Sources of social support

The subgroups most commonly involved in providing informal support for older people are kin, friends, neighbours, and members of the community. Older people may also be in receipt of informal support from the third sector or through membership of official support groups.

Kinship

In the hierarchy of support provision, older people cite kin as the main contributors over friends, neighbours and the local community[173] [174]. Kin can be further divided into spouse, adult children, siblings, and extended kin. While each of these groups tend to provide different types of support to older people, often kin provide more intimate care than other groups.

Spouse

The spouse is the most immediate source of social support in proximity and reliability[175] [176]. Spouses are the most important sources of intimate closeness, companionship and well-being[177]. Couples are more likely to be able to provide each other with a safe, warm, and comfortable environment to live, plentiful access to healthy foods, and other activities related to well-being. Those who are married are also more likely to benefit from a greater sense of privacy. However, as in all relationships, these positive aspects of support depend on a positive relationship.

Spousal support is the most flexible, dependable, and favourable form of social assistance. To be recognised and loved is a key element of social support which no doubt serves to promote positive psychological health. It has often been shown that our mental health exerts influence over our physical health[178] [179].

However, it is important to keep in mind that the availability of this support is fully conditional on the age and helping capabilities of the spouse. Characteristic of ageing, the onset of illness, and disability exert significant strain on older couples. Older people are required to provide much more hands-on, instrumental support for their spouse. As health care problems at older ages are often more chronic rather than acute[180], this raises additional challenges to couples.

Other kin and networks may provide different forms of support that are affectional, material, or informational[181] [182] [183].

Adult children

In informal support provision, older people often turn to their adult children before siblings and other relations[184]. Following the loss of a spouse through separation or death, it is frequently the offspring of the older person who become enlisted with the primary caring responsibilities.

Children may be able to offer assistance with tasks such as shopping or house cleaning[185]. At the other end of the spectrum, offspring may also be providers of personal care[186].
Frequently, support from adult children comprises that which is emotional, concerned with companionship and household maintenance[187]. The support roles can vary depending on the age, health and caring demands of the older parents, the age of the care-giving children, and the social class and income of both the parents and children.

Sometimes, adult children or the older parent will move to reduce the travelling distance between themselves. In some cases cohabitation is the adopted solution, with the adult children moving in

with their older parents or vice versa. This has reduced over the last few decades; it has been argued that Northern European and Protestant countries are less likely to take up intergenerational cohabiting between older people and their adult children[188].

There may be a reluctance in older people to reside in the homes of their offspring regardless of culture, religion and societal norms. This is primarily because of the perceived caring burden that they may impose on their adult children. It is widely acknowledged in the literature that intergenerational cohabitation is normally initiated as a last resort, mostly when the subject experiences significant loss in functional independence.

Siblings

The sibling relationship is the most prolonged of the life course. Provided one does not lose contact with a sibling, exposure could remain for a large proportion of one's life. Sibling support, especially at youngest old ages, consists mainly of emotional support and social verification. Contact rates likely vary based on the support needs of either or both siblings in addition to the proximity and caring resources available across the social tie. The fact that researchers have measured sibling contact by use of the telephone and postal service along with visits, infers that these are perhaps the most typical methods of contact.

Forms of social support at youngest and middle old ages may consist of morale boosting, assistance with shopping, home repairs, and finances, as well as advice giving and help with decisions in the role of a confidant[189]. The role of siblings as auxiliary helpers is prone to upgrade to a more primary role depending on the availability of social support elsewhere in the network for the older person in question[190][191]. In these scenarios siblings may alter their role as providers of psychological support to the mainstay of tangible support with duties including nursing and offering personal care. Older people who are childless are, of course, much more likely to rely on siblings for social support[192].

Extended kin

'Extended kin' constitutes members of the family such as grandparents, grandchildren, aunties, uncles, nieces, nephews and so forth.

Social interaction with extended family tends to be mostly affective and dominated by traditional obligations to maintain relations with all parts of the family. This is again due to ease of access to the more proximal elements of the familial supportive network. In the UK and other Protestant European countries, extended kin do not naturally live close to (or with) one another. In more Catholic dominated countries, extended kin may be more proximal to one another.[193]

Neighbours

Informal support relationships between neighbours are characterised by reciprocity[194][195] rather than the mutual, obligatory relationships which bind relatives. The relationships between neighbours are considered to be exchange relationships[196]. The exchange of goods and services between neighbours becomes *quid pro quo*.

The role played by neighbours tends to be supplementary to existing pathways of care such as that of the family or formal services[197], and can lessen the burden of care on the family[198][199].

Owing to the proximity of neighbours to each other, in practical terms they are the best placed to provide non-technical support[200]. This non-technical support can range from assistance with the shopping or transport to gardening[201] [202].

In addition to instrumental support, neighbours offer the opportunity for an older person to socialise. Perhaps not quite to the extent that friendship is important, forms of social interaction over the fence and other types of social liaison can act to validate one's social identity[203] [204] [205]. Contact with neighbours might provide the older people with feelings of usefulness and eliminate loneliness and worry[206].

Neighbours also play an important role in acting as the first line of defence in a crisis[207]. Critically, neighbours are able to 'sound the alarm' in an emergency. In some cases, neighbours play a surveillance role, and are vital at times of unpredictable or idiosyncratic need where fast and flexible decision making may be involved[208]. The presence of neighbours may reassure family and friends that their loved one is well monitored.

The age and health of the neighbour determines whether they may be able to provide support (or expect to receive support) and what the nature of that support may be. Ideally, for the continual exchange of neighbourly supportive relationships there must be a balance in reciprocity[209]. However, it is often likely to be the case that neighbouring supportive relationships are imbalanced due to the fact that the respective neighbours differ in age, health, and need. Reciprocation varies by the type of support and the capabilities of both persons to be able to reciprocate[210] [211].

Friendship

A friend has been defined as 'a person, not kin, with whom you feel close, talk personally and on whom you can count'[212]. It is extensively recognised in the literature that to have friends and acquaintances within one's social network is associated with higher levels of morale and life satisfaction. Possession of a confidant is connected to reduced feelings of loneliness and concern[213] [214]. However, their affectional functions are usually surpassed by spouses[215].

Friends are often of a similar age, which means that age-related experiences are shared[216]. This commonality consolidates the advisory position of a friend and importantly helps to alleviate feelings of isolation when they feel that certain stresses are shared and understood through similar experiences[217].

Support of friends is less likely to be instrumental. Personal care could undermine the dynamics of a social tie which had always been reciprocal.

Local community

The local community consists of voluntary organisations, social groups, religious settings and the wider neighbourhood (one's neighbours as a collective). Community activity relates to attendance at local events such as religious ceremonies or celebratory occasions. An older person's voluntary involvement is an important measure not just of this facet of social network interaction, but a quantification of one's integration into his or her community.

Primarily the local community provides a source of emotional, informational, and nontechnical support, but importantly also gives rise to the opportunity for daily social interaction which may promote mental well-being. The feeling of 'neighbourhood' or 'community' gives an older person a

sense of place and belonging which, in turn, might alleviate sentiments of loneliness and social isolation[218].

Involvement in the local community typically represents a reciprocal exchange. This gives the older person the opportunity to socialise, maintain a sense of social validation and usefulness (in some cases offering the chance to give something back to a community from which the older individual may benefit), and receive informational advice from esteemed members of the neighbourhood. Members of the community may also play a surveillance role for older individuals with whom they are regularly acquainted; for example, noticing a decline in the physical ability of the older person[219] [220].

Community-level interaction is somewhat dependent on functional ability, which may include getting to and from an event. At ages 80 and over when typically the onset of age-related health issues may start to impede an older person's independence, a withdrawal from community activity is to be expected. However, the time invested in the community may reap reward as younger members of the community involved in voluntary work (commonly that which the older person in question may have previously been involved) may offer assistance with transport and at day centres, 'meals on wheels', house maintenance and so forth.

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