Loneliness – the state we're in

A report of evidence compiled for the Campaign to End Loneliness

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Age UK Oxfordshire is an independent local charity, working to ensure that people grow older in comfort, with support where they need it, and with chances to have a life worth living.

The vision of the Campaign to End Loneliness is for fewer people to feel lonely in older age and for more people to maintain their friendships and connections through times of life change. Led by a coalition of organisations, Age UK Oxfordshire, Independent Age, Sense, Manchester City Council and WRVS, the Campaign is funded by the Calouste Gulbenkian Foundation. The Campaign's work draws on research and practice from across the UK and is delivered through a small core team in collaboration with a wide range of organisations. For more information, visit our website: www.campaigntoendloneliness.org.uk

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1 *Building the platform of knowledge*

Five years ago Baroness Rabbi Julia Neuberger read with mounting anger a report by Help the Aged showing a rise in loneliness among older people. She called for attention in the press: 'The situation requires all sorts of action by government, national and local, and by the myriad voluntary organisations up and down the country'; and she sounded a 'clarion call to get our heads together and make a difference'.

The Campaign to End Loneliness, launched in 2011 by five charities and now supported by over 250 organisations, is our response to that clarion call. The Campaign has put aside organisational barriers and brand egos to tell the tale of a massive gap in our lives. For individuals, a painful gap between the bonds we crave with others and the ones we actually have. For communities, an ugly tear in our social fabric.

The Campaign started with the pursuit of evidence and understanding. Its programmes of awareness-raising, influencing and encouraging good practice remain rooted in that soil. The challenge of loneliness is complex. Older people are often wrongly treated as a homogeneous group. Solutions are not automatic and predictable. The Campaign has explored this diversity of issues. This report seeks to capture what we know, at this moment. And it gathers together perspectives from leading figures and responsible agencies who came together at a conference in Oxford in 2012 entitled 'What do we know about loneliness?'.

This conference was the latest step by the Campaign to End Loneliness to assemble and promote the evidence base, as a platform for action. The current report, *Loneliness – the State We're In*, now takes this on to a further stage, building on the research report *Safeguarding the Convoy* with which the Campaign was launched in 2011.

Thankfully, the research community is constantly on the move, pursuing new knowledge. So this report is work in progress, important as much for the questions we have not yet asked and researched as for the answers we lay out here. The vital thing is to keep the dialogue going, to share what we know between academics, policy-makers and people trying to make that difference in their services and support day by day. Too often learning fails to travel. Research is published and press-released, but too rarely seized and turned into daily practice. This needs to change.

This is a public policy challenge to those spending the taxes we pay. The knowledge we present here shows that loneliness harms health,

with a physical effect equivalent to that of smoking or alcoholism, and more severe than not exercising or obesity. At a profounder personal level it means the loss of hope, energy and contribution from so many daily lives spent in quiet desperation.

Loneliness is part of the web of 'social exclusion': that combination of linked problems which together bode ill. We have known for some time from the work of Professor Alan Walker and others that our most vulnerable citizens often experience a pernicious cocktail of disadvantage: living alone and/or without children, poor health, no access to transport, not owning your home, low income, no phone, and older old age. Loneliness is of course something we can all face, and there is some evidence that young adults experience similar levels of loneliness to much older people. Social and community policies must grapple with these complex interlocking problems wherever they appear in the life course.

So it is for all of those in government national and local who are responsible for health and well-being to read and act. The new leaders of our health, housing, environment and social care systems need to place social isolation alongside the standard menu of public health challenges, as urgent and in need of action. This requires strategy, programmes and targets, not lip-service in speeches or policy documents.

If we believe that this misery matters, then we are all part of the Campaign to End Loneliness.

For those now leading Clinical Commissioning Groups, Health and Well-being Boards and their sub-groups, Public Health and Social Services departments, the evidence lies in front of you. We ask you to act.

For all of us there is an opportunity to take one step closer to one another. This report aims to help us all understand the journey better, and learn how we might take those few but momentous steps.

Paul Cann
Chief Executive, Age UK Oxfordshire

2 *Understanding loneliness*

Different theories are used to explain loneliness: evolutionary theory, psychodynamic theory, interactionist perspectives and cognitive discrepancy theory. One of the most popular explanations is cognitive discrepancy theory, whereby loneliness is regarded as a discrepancy between desired and achieved levels in the quality and quantity of social relations.[1] Loneliness is therefore subjective. It is the felt experience of particular individuals.

Loneliness and isolation

The terms 'isolation' and 'social isolation' occur frequently in public policy discussions. The word 'loneliness' tends to be avoided. This is perhaps because it relates to emotions and the view may be that the state has no legitimate concern with these. The literature stresses the distinction between loneliness and isolation, not least because the appropriate response to designing and measuring interventions will be different for each.[2]

Isolation describes the absence of social contact i.e. contact with friends or family or community involvement or access to services. Loneliness and isolation are clearly different. Some people express loneliness even though they have frequent contact with family and friends. This is perhaps because they consider that these relationships are not providing the emotional support that they need. Other people have few contacts but are not lonely. As Victor says, loneliness 'is distinct from but related to living alone, being alone, isolation and solitude'.[3] However, isolation can lead to loneliness.

Older people experiencing isolation require practical help and resources (such as transport provision). Older people experiencing loneliness require social support and extended social networks, which might be provided through befriending or group activities).[4] There are also different types of loneliness which again may require different interventions: emotional loneliness and social loneliness. Emotional loneliness is the absence of a significant other with whom a close attachment is formed (a partner or close friend). Social loneliness is the lack of a wider social network of friends, neighbours or colleagues.[5]

[1] Peplau L A and Perlman D (eds) (1982). *Loneliness: a sourcebook of current theory, research and therapy.* Wiley, Interscience.

[2] Cattan M (2001). *Supporting Older People to Overcome Social Isolation and Loneliness.* Help the Aged. http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/supporting%20older%20people%20to%20overcome%20social%20isolation%20and%20loneliness%20(2001)_pro.pdf?dtrk=true

[3] Victor C conference presentation:http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[4] Cattan M (2001). *Supporting Older People to Overcome Social Isolation and Loneliness: executive summary.* Help the Aged. http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/supporting%20older%20people%20to%20overcome%20social%20isolation%20and%20loneliness%20(2001)_pro.pdf?dtrk=true

[5] Weiss S (1973). *Loneliness: the experience of emotional and social isolation.* The MIT Press, Cambridge, Mass.

> *'Loneliness and social isolation... exist in the form of multiple realities constructed and reconstructed by individual older people within the context of their different lives and life histories.'*
>
> **Victor C, Bond J and Scambler S (2009).** *The Social World of Older People.* **Open University Press, Maidenhead**

Men and women may also experience loneliness differently. Studies have linked male loneliness to the lack of a spouse or partner.[6] Women tend to develop relationships with a wider network of people.[7]

Transience versus *persistence*

Cacioppo describes loneliness as part of being human, and argues that 'the pain of loneliness protects the social body', encouraging us to adapt our behaviour. For many, loneliness is a transitory experience. Only if it becomes a persistent state does it have a deleterious effect.[8]

Loneliness is 'individually constructed i.e. it is a condition, but it may be transient, situational (and acute) or chronic', according to Cattan.[9] Scharf confirms this, maintaining that for participants in one of his studies loneliness can be viewed as a chronic condition: 'being lonely typically represents the continuation of longstanding difficult relationships with family members and limited relationships with friends and neighbours... [or it] can be linked to the impact of particular life events or age-related losses' (for example, becoming a widow).[10]

Some, including de Jong Gierveld, suggest that 'in general, older adults are prepared to cope with loneliness – such as by enlarging their network of personal relationships with new acquaintances and friends or by improving the quality of already existing relationships'. She quotes a study which found that immediately after the death of their partners 60 per cent of widows and widowers were lonely. Thanks to the efforts of the widowed people themselves and the support of children, friends and neighbours in the period immediately following the death of their partner, loneliness decreased a little. Nine months after bereavement about 40 per cent of widowed women and men were still lonely but 20 per cent had succeeded in recovering from loneliness.[11]

Prevalence

A number of research studies conducted at different times in different parts of the UK, suggest that 5–16 per cent of the older population is lonely. Using these studies, it is possible to estimate that overall about 10 per cent of the general population aged over 65 in the UK is lonely all or most of the time.[12] This equates to over 900,000 older people.

The number of isolated older people at risk of loneliness is likely to be much larger. Many older people have little contact with friends and family. Seventeen per cent of older people are in contact with family,

[6] Tijhius MAR, de Jong Gierveld J, Festas EJM and Kromhout D (1999). Changes in and factors related to loneliness in older men. The Zutphen Elderly Study. *Age and Ageing* 28 (5) http://www.researchgate.net/publication/12771669_Changes_in_and_factors_related_to_loneliness_in_older_men._The_Zutphen_Elderly_Study

[7] de Jong Gierveld J (1986). Husbands, lovers and loneliness, in Lewis RA, Salt RE (eds) *Men in Families*. Sage, New York.

[8] Cacioppo JT conference presentation.

[9] Cattan M conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[10] Scharf T (2011). Loneliness: an urban perspective. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness.* Age UK Oxfordshire http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[11] de Jong Gierveld J, Fokkema T and Van Tilburg T (2011). Alleviating loneliness among older adults. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness.* Age UK Oxfordshire http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[12] Victor C (2011). Loneliness in old age: the UK perspective. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness.* Age UK Oxfordshire http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

friends and neighbours less than once a week, and 11 per cent are in contact less than once a month.[13]

Another issue is whether older people can get out of their homes and engage in social or recreational activities. Twelve per cent of older people say that they feel trapped in their own home and 9 per cent they feel cut off from society.[14] Six per cent report that they leave their house once a week or less.[15]

A person living alone is not necessarily lonely. However, research shows that those who do live alone are more likely to be lonely.[16] About 3.8 million older people live alone.[17] Sixty per cent of women and nearly half (49 per cent) of the general population aged 75 and over live alone.[18] 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 84+.[19]

Has loneliness increased?

Comparison of the results of studies completed respectively in 1948 and 2005 of loneliness among older people shows that the percentage reporting that they often or always felt lonely was 8 per cent in 1948 and 7 per cent in 2005. There are, however, wider variations in the percentages reporting that they sometimes or never feel lonely. In the earlier survey 13 per cent reported that they sometimes felt lonely; the figure in 2005 was 31 per cent. In 1948 79 per cent said they never felt lonely. By 2005 this had reduced to 61 per cent.

Victor argues that the extent of loneliness has remained broadly static over the last six decades. She points to a number of surveys over the period suggesting that approximately 8–10 per cent of the older population are always or often lonely, demonstrating that the figure has shown remarkably little variation over time. She suggests that 'the picture may not be worse, perhaps just different'.[21] One of the factors which make it different is that the populations now moving into old age are changing. For example, many urban communities now comprise a certain number of older people from ethnic minority communities who settled in the UK from the 1960s onwards. Also, more people with serious physical disabilities or poor health, who previously would have died in childhood, are now surviving into old age. Another factor is the increasing percentage of older people who have been married more than once and who as a result may have complex family structures and relationships.[22]

[13] Victor C et al (2003). *Loneliness, Social Isolation and Living Alone in Later Life*. Economic and Social Research Council.

[14] Age UK (2012). *Later Life in the United Kingdom*. Age UK http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK factsheet.pdf?dtrk=true

[15] ibid.

[16] de Jong Gierveld, J Fokkema T and Van Tilburg T (2011), op. cit.

[17] Office for National Statistics (2012). *General Lifestyle Survey*: Household Tables 2010 (Table 3.3). ONS. http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-226919

[18] Office for National Statistics (2012), op. cit. (Table 3.4).

[19] DCLG (2010). *Department for Communities and Local Government Household Projections 2008 to 2033* England (Table 3): http//www.communities.gov.uk/documents/statistics/pdf/1780763.pdf

[20] Victor C (2011), op. cit.

[21] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[22] Victor C (2011), op. cit.

Ethnic minority communities

Research has been conducted examining loneliness among different groups who migrated to the UK in the 1960s, 1970s and 1980s, including Indian, African, Chinese, Caribbean, Bangladeshi and Pakistani communities. This shows that levels of loneliness among ethnic minority elders are generally higher than for the rest of the population – 15 per cent reporting that they always or often feel lonely.[23]

Other research, examining quality of life among older people, finds that even when ethnic minority groups have large social networks and household sizes they are less likely to say that they take part in social activities that they enjoy – 44 per cent as against 79 in the general population. Similarly, 55 per cent of ethnic minority respondents say that they have someone who gives them love and affection, while the figure is 88 per cent for the general population.[24]

While it might be assumed that the experience of loneliness is the same for all minority communities, this is not the case. Elders from the Indian subcontinent are less lonely than older people originating in the UK. Seven per cent of Indian elders report that they are often or always lonely (compared to 24 per cent for the Chinese population).

The children of these immigrants, the second generation, are also likely to have a different pattern of response. Younger people from ethnic minority groups, those in the 45–64 age group, report much lower levels of loneliness than those aged over 65.[25]

[23] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also:
Victor C R, Burholt V, and Martin W (2012) Loneliness and ethnic minority elders in Great Britain: an exploratory study,
Journal of Cross-Cultural Gerontology 27 (1) http://www.springerlink.com/content/6q4302657026jk27/
[24] Bowling A conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[25] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

3

The impact of loneliness on health and quality of life

There are two main theoretical models which explain how a lack of social connections or loneliness affects health and quality of life across the life course.

The buffering hypothesis is that social relationships may provide resources (informational, emotional or tangible) that promote adaptive behaviour or neuroendocrine responses to acute or chronic stressors (e.g. illness, life events, life transitions). This is also known as the stress regulator hypothesis. Social connections are a stress regulator and reduced stress encourages us to engage in healthier behaviours: for example, we eat more healthily.[26]

The main effects model says that social relationships may protect health through more direct means, such as cognitive, emotional, behavioural and biological influences.

The effects of lack of social connections on mortality and morbidity apply regardless of age. However, similar to other lifestyle or behavioural factors, their effect becomes more evident over time. Age may also be a salient factor to consider because events which are likely to increase loneliness, such as bereavement and giving up work, tend to occur after the age of 50.[27]

A biological perspective

Cacioppo presents a biological perspective on loneliness. He points out that social species have evolved biological mechanisms that promote their gravitational pull towards each other. Penguins provide a good example. They rotate as they huddle together, taking turns to be on the outside of the group where it is coldest. This enables all to survive. Being isolated from others is unsafe for a social animal. In every animal species, including humans, death occurs earlier among those who are isolated.[28]

The imperative for connection with others affects health in two ways. People are less likely to engage in safe behaviours if isolated. Loneliness also makes it harder for people to regulate behaviours such as drinking, smoking and over eating.[29] Loneliness also creates changes in the brain and body which can contribute to or precipitate ill health.

[26] Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[27] Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[28] Cacioppo JT conference presentation.

[29] Cacioppo JT and Patrick W (2008). *Loneliness: human nature and the need for social connection*. Norton and Company Inc, London.

Physical health

Lonely people have higher cortisol levels. Cortisol fights inflammation, breaks down fats and sugars and gives you energy. If levels are persistently high, however, it can become dysfunctional and even lead to early organ deficit. Loneliness also affects gene expression in immune cells. For instance, in early evolutionary times the pathogen to which lonely people were most likely to be exposed was bacteria. When someone feels chronically lonely, gene expression is altered to protect against bacterial (in contrast to viral) infection – making the person more prone to viruses.[30]

Loneliness has been shown to produce changes in the body that increase the risk of heart disease.[31] Lonely middle-aged and older adults also have a higher risk of hypertension and higher levels of loneliness are associated with greater increases in systolic blood pressure over time.[32]

Lonely people also have more disrupted sleep because they are more prone to wake up during the night, perhaps because they do not feel safe and protected.[33] Loneliness is therefore associated with less restorative sleep and with daytime fatigue.[34]

Mental health

Depression affects 1 in 5 older people living in the community and 2 in 5 living in care homes.[35] Lonely individuals are more prone to depression.[36] And the lonelier a person is, the more likely they are to experience increased depressive symptoms. Their degree of loneliness this year predicts how depressed they are likely to be next year.[37] Notably, the direction of causality has been determined through experimental and longitudinal studies. Loneliness leads to increased depressive symptoms.[38]

Loneliness affects cognition. Specifically, the brains of lonely people become more vigilant for social threats and more focused on self-preservation. As a result, lonely individuals can be less attentive to what other people are feeling and what they might actually need. Lonely people also perceive negative interactions to be more negative and positive interactions with others to be less positive. Both these effects inevitably have an impact on relationships.[39]

[30] Cacioppo JT conference presentation

[31] Ong AD, Rothstein JD, Uchino B (2012). Loneliness accentuates age differences in cardiovascular responses to social evaluative threat. *Psychology and Aging* 27 (1): http://www.ncbi.nlm.nih.gov/pubmed/22004517

[32] Hawkley LC, Thisted RA, Masi CM, Cacioppo JT (2010). Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. *Psychology and Aging* 25(1) http://www.ncbi.nlm.nih.gov/pubmed?term=Hawkley%20LC%2C%20Thisted%20RA%2C%20Masi%20CM%2C%20Cacioppo%20JT%20(2010)%20Loneliness%20predicts%20increased%20blood%20pressure%3A%205-year%20cross-lagged%20analyses%20in%20middle-aged%20and%20older%20adults.%20Psychol%20Aging%2025(1)

[33] Cacioppo JT conference presentation.

[34] Cacioppo JT, Hawkley LC, Berntson GG, Ernst JM, Gibbs AC, Stickgold R, et al. (2002). Do lonely days invade the nights? Potential social modulation of sleep efficiency. *Psychological Science* 13(4)
http://psycnet.apa.org/journals/hea/29/2/124/

[35] Mental Health Foundation. Mental Health Statistics: older people. Online, found at: http://www.mentalhealth.org.uk/help-information/mental-health-statistics/older-people/

[36] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006). Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. *Psychology and Aging* 21(1)
http://www.ncbi.nlm.nih.gov/pubmed/16594799

[37] Cacioppo JT conference presentation

[38] Cacioppo JT, Hawkley LC, Thisted RA (2010). Perceived social isolation makes me sad: cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging and Social Relations Study. *Psychology and Aging* 25 (2):
http://www.ncbi.nlm.nih.gov/pubmed/20545429

[39] Cacioppo JT conference presentation.

Loneliness can also be linked to cognitive decline and dementia in older people. There is evidence that socially engaged older people experience less cognitive decline[40] and are less prone to dementia. The risk of Alzheimer's disease more than doubles in older people experiencing loneliness.[41]

Mortality

A meta-analysis of 148 studies of social relationships and mortality which combined results across multiple studies found a 50 per cent increased likelihood of survival for those with strong social connections after an average follow-up time of 7½ years. This was consistent regardless of initial health status (and other factors including gender and country of origin). The study shows that having weak social connections carries a health risk:

- equivalent to smoking up to 15 cigarettes a day
- equivalent to being an alcoholic
- more harmful than not exercising
- twice as harmful as obesity.

Furthermore, few studies have measured the effect of relationship quality on mortality. However, it is clear that negative relationships have a detrimental effect. If you isolate the positive effects of relationships, the correlation between social connections and reduced mortality is likely to be much greater.[42]

Quality of life

Increasingly the concern is not only with people's health but also their quality of life. Bowling has developed a new quality-of-life measure for older people based on research examining their needs and aspirations. The research looked at:

- social and family relationships
- social roles and activities
- health and functional ability (enablers)
- home and neighbourhood (perceived social capital)
- psychological well-being and outlook (life satisfaction, contentment, optimism, social comparisons)
- income
- independence and being in control of one's own life
- religion, culture and children.

Social relationships were ranked by most people as the key dimension of quality of life. Eighty-one per cent said they gave quality to life – for example, 'for companionship', 'to make life bearable' and for 'confidence'. Twelve per cent said that they had poor social relationships which reduced their quality of life.[43]

[40] James BD, Wilson RS, Barnes LL, Bennett DA (2011). Late-life social activity and cognitive decline in old age. *Journal of the International Neuropsychological Society* 17(6) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206295/

[41] Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007). Loneliness and risk of Alzheimer disease. *Archives of General Psychiatry* 64(2) http://www.ncbi.nlm.nih.gov/pubmed/17283291

[42] Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Holt-Lunstad J, Smith TB, Layton JB (2010) Social relationships and mortality risk: a meta-analytic review. PLoS Medicine 7(7). http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316

[43] Bowling A conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Bowling A, *Good Neighbours: measuring quality of life in older age*, ESRC and ILC (2010) http://www.ilcuk.org.uk/index.php/publications/publication_details/good_neighbours_measuring_quality_of_life_in_old_age

4

Risks and influences

In order to be able to prevent or alleviate loneliness, a good understanding is needed of its risks and influences.

Categories of risk

Victor suggests that an older person may be either lonely or not because of a combination of different types of factors

- interpersonal engagement, e.g. the quality of their relationship with family, friends and neighbours

- life-stage events, e.g. retirement, widowhood, sensory impairment, physical health

- wider social structures, e.g. poverty, the quality of health and social care, ageism

- social environment, e.g. living arrangements, community connectedness, hobbies/interests, pets, housing, car, holidays, seasons.

Cutting across these categories are the intrapersonal factors (personality and cognitive variables and sense of identity etc.)[44] For example, some may have adopted a life of solitude by choice and enjoy it. Others may feel the disconnection intensely.[45]

Notable risk factors and triggers

A number of personal characteristics tend to influence whether an individual is lonely or not. These include living alone,[46] being single, divorced, never married,[47] and living on a low income[48] or in residential care.[49] Key transitions, which tend to occur in older age, can also trigger loneliness; these include retirement, becoming a carer and bereavement.[50]

The evidence suggests that particular groups are more likely to be at risk. A direct correlation exists between low income and loneliness and isolation among older people.[51] There is also evidence that ethnic minority elders may be among the most lonely[52] and that gay men and lesbians are at greater risk of becoming lonely and isolated

[44] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[45] Cacioppo JT conference presentation.

[46] de Jong Gierveld, J Fokkema T and Van Tilburg T (2011), op. cit.

[47] Scharf T, Phillipson C, Kingston P, Smith AE (2002). *Growing Older in Socially Deprived Areas: social exclusion in later life*. Help the Aged: http://www.ageuk.org.uk/documents/en-gb/for-professionals/communities-and-inclusion/id2255_a_growing_older_in_socially_deprived_areas_social_exclusion_in_later_life_2002_pro.pdf?dtrk=true

[48] Age UK (2010). *Loneliness and Isolation Evidence Review*: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

[49] The Residents and Relatives Association (R&RA) (2010). *Together But Alone: isolated older people in care*: http://www.vai.org.uk/wp-content/uploads/2010/11/R-RA-TOGETHER-BUT-ALONE-REPORT.pdf

[50] Cann P and Jopling K (2011). The challenge. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness*. Age UK Oxfordshire http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[51] Age UK (2010), op. cit

[52] Victor C, Burholt V, Martin W (2012). Loneliness and ethnic minority elders in Britain: an exploratory study, *Journal of Cross Cultural Gerontology* 27 (1) http://www.library.nhs.uk/booksandjournals/details.aspx?t=Great+Britain&stfo=True&sc=bnj.pub.MED&p=1&sf=srt.unspecified&sfld=fld.title&sr=bnj.pub&did=22350707&pc=303&id=9

as they age because they are more likely to live alone and have less contact with family.[53] There is also a steep rise in loneliness among the older old – those who are 80+.[54]

Health and disability play a role. Poor health,[55] reduced mobility,[56] cognitive and sensory impairment,[57] including dual sensory impairment,[58] all increase older people's chances of being lonely.

Geography also has an influence: for example, older people are more likely to be lonely if they live in a deprived urban area or an area in which crime is an issue.[59] In rural areas levels of loneliness decrease as population density increases,[60] Research conducted in Canada indicates that living alone, a perception that future income is inadequate, poor health and low life satisfaction predicted loneliness in rural areas. On the other hand, being widowed and in poor health predicted loneliness in urban areas.[61]

A more fine-grained analysis

It is suggested that we need a more fine-grained analysis of risk factors and influences.[62] Some studies have sought to achieve this: for example, research examining distinguishing factors for those for whom the feeling is transient and those for whom it is persistent. This research, based on the Bangor Longitudinal Study on Ageing, identified contributing factors for four distinct patterns of loneliness and isolation:

- not isolated or lonely at any time – factors include being indigenous to an area, married, with adult children living nearby

- not isolated but lonely – factors include being a retirement migrant, caring for a dependent spouse with little help, living with adult children working full-time

- became more lonely and isolated over time – factors include bereavement, deteriorating health, impairment of mobility, vision or hearing

- isolated but not lonely/overcame loneliness – factors include being childless, having a self-sufficient personality, having either satisfying relationships with friends/neighbours or being a lifelong isolate (who, for example, spends Christmas alone by choice).[63]

[53] Stonewall (undated). *Lesbian, Gay and Bisexual People in Later Life*: http://www.stonewall.org.uk/documents/lgb_in_later_life_final.pdf

[54] Age UK (2010), op. cit

[55] Victor C, Scambler SJ, 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*, 25 (3) http://eprints.ucl.ac.uk/1639/1/cambridgeUP.pdf

[56] Tijhius MAR, de Jong Gierveld J, Festas EJM and Kromhout D (1999), op. cit.

[57] Victor C, Scambler SJ, Bowling A and Bond J (2005), op. cit.

[58] Sense (2011). *Seeing Me: guidance on sight and hearing difficulties for staff who care for older people*: http://www.sense.org.uk/Resources/Sense/Campaigns/Campaigns%20for%20older%20people/Documents/Seeing_me_checklist_07.pdf

[59] Scharf T (2011), op. cit.

[60] Burholt V (2005). Factors contributing to loneliness for older men and women in rural North Wales. Paper presented at the invited symposium, New Perspectives on Loneliness in Later Life, at the XVIII World Congress of Gerontology, Rio de Janeiro, Brazil 26–30 June, 2005

[61] Havens B, Hall M, Sylvestre G and Jivan T (2004). Social isolation and loneliness: differences between older rural and urban Manitobans. *Canadian Journal on Ageing*, 23 (2): http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/canadian_journal_on_aging/v023/23.2havens.pdf

[62] Burholt V conference presentation:http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[63] Burholt V (2011). Loneliness of older men and women in rural areas of the UK. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness*. Age UK Oxfordshire (2011) http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

[64] Distel MA, Rebello Mesa A, Abdellaoui A, Derom CA, Willemsen G, Cacioppo JT, Boomsma D (2010). Familial resemblance for loneliness.

Protective factors

Marriage, children and siblings are associated with lower loneliness.[64] Marriage is a central relationship for most adults. For many their spouse may be their only confidant.[65]

Preliminary analyses from an unpublished meta-analysis of 240 studies suggests a 26 per cent reduced chance of mortality for married people compared to others (who are divorced, single, widowed etc.) after a follow-up period of just over eight years. The results indicate no significant gender differences.[66] However, sometimes marriage can be associated with greater loneliness due, for example, to the ill health of the spouse, infrequent emotional support, infrequent conversations and disagreement.[67]

Holt-Lunstad suggests that a diversity of relationship types is protective, i.e. a range of different social ties and roles and interconnections between them.[68]

The role of the family

There is much discussion about the role of the family, and particularly adult children who live with parents (co-residence), in preventing or alleviating loneliness among older people in the Mediterranean region and Eastern Europe. However, little is known about how support is exchanged in these living arrangements and their impact on loneliness.

Using the Generations and Gender Survey (under the auspices of the United Nations in Geneva), de Jong Gierveld compared France, Germany, Russia, Bulgaria and Georgia. The research examined different intergenerational support types (upward, from children to parents, and downward, parents to children and get-togethers) and living arrangements (co-residence and living independently).

In Eastern Europe it is more likely for mothers aged 60–79 years to live with one or more of their children aged 25+. This would suggest that levels of loneliness should be lower in these countries. But the findings show higher levels of loneliness in Eastern than in Western Europe. They also show that while adults living alone are the most lonely, older adults living with a partner are the least lonely.[69]

The research found that co-residence provides some protection but not to the same degree as having a partner. Both older people living with their children and independently are more likely to be providing support to their children than they are to be receiving it from them. However, older adults who are primarily on the receiving end of support are the most lonely.

Behavioural Genetics 40 (4): http://www.ncbi.nlm.nih.gov/pubmed/20145989

[65] McPherson M, Smith-Lovin L and Brashears ME (2006). Social isolation in America: changes in core discussion networks over two decades. *American Sociological Review*, June, 71 http://asr.sagepub.com/content/71/3/353.short

[66] Holt-Lunstad J conference presentation:http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[67] de Jong Gierveld J, Brose van Groenou, M, Hoogendoorn AW and Smit, JH (2009). Quality of marriages in later life and emotional and social loneliness. *Journal of Gerontology: Social Sciences*, 64B(4):http://depot.knaw.nl/7520/

[68] Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[69] de Jong Gierveld J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

How risk factors lead to loneliness

The research evidence points to a range of risk factors associated with loneliness but knowledge of the mechanisms by which these risk factors lead to loneliness is limited. Burholt and Scharf's research based on the Irish Longitudinal Study of Ageing (TILDA) attempts to address this.

The research considers predisposing factors that put people at risk of loneliness (age, marital status, health etc.) and also social interaction (contact with friends, neighbours and family) and social participation (such as seeing films or plays, or travelling for pleasure).

It is assumed that poor physical health decreases participation, while lower participation leads to loneliness. The research found that increasing numbers of chronic conditions do tend to lead to a decrease in social participation. However, it also shows that while poor physical health does mean lower participation, this does not impact necessarily on social interaction. Generally, therefore, there is not as strong a relationship as might be assumed between physical health and loneliness.

The research also confirms that being located in a rural area makes it more difficult for people with chronic conditions to access social resources and also that depressive symptoms intensify the direct effect of poor health on loneliness. It also shows that depression has an indirect impact, negatively affecting people's perceptions of the social resources available to them.[70]

Expectations and attitudes

Expectations and attitudes are crucially important. People who expect that they should be surrounded by emotionally supportive family and friends, and who have these expectations to a greater or lesser extent disappointed, are more likely to report that they are lonely. This may explain why some groups of ethnic minority elders in the UK report higher levels of loneliness than the general population.[71]

Bowling's research also demonstrates the importance of attitude. She points to the importance of having a 'can do' attitude in later life: 'Those older people who reported high self-efficacy had a three times higher quality-of-life score.'[72]

[70] Burholt V and Scharf T conference presentations: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[71] Victor C R, Burholt V, and Martin W (2012), op.cit
[72] Bowling A conference presentation:http://www.campaigntoendloneliness.org.uk/loneliness-conference/

5 *Preventing and alleviating loneliness*

While the main focus of research has been on interventions to reduce loneliness, there appears to be no research about how to prevent it in the first place.[73] However, while there are no studies specifically examining how loneliness might be prevented, it is possible to derive pointers from existing research.

Preventing loneliness

Holt-Lunstad says that 'one message [from the research] seems to be to concentrate on existing clear and positive relationships'. Supporting older people to maintain and sustain these relationships could therefore be an important first step.[74]

Another theme in the research is the value of helping people 'to build up reserves of social support and psychological resources and self-efficacy to compensate when unable to do things'.[75] There is a significant policy emphasis on the need to help and support people to make sensible financial plans for their later life. Perhaps planning to maintain social connections and activities should be given a similar profile?

Another factor to consider is the importance of supporting older people through difficult transitions which are associated with loneliness and depression, notably bereavement.[76]

Cattan says that loneliness is not simply a matter for individuals, 'it is socially, culturally, economically and geographically constructed – these factors impact on an individual's ability to accumulate social capital'.[77] Examples of policies that affect whether older people are lonely or not are transport and urban planning, since these have an impact on older people's ability and willingness to participate socially. Getting such policies right by 'age-proofing' them could make a significant difference to reducing loneliness among older people.

Interventions to alleviate loneliness

A variety of different sorts of services can help to reduce the risk of loneliness evolving into serious, long-term health problems (i.e. to reduce its prevalence and to improve quality of life). These include but are not limited to those outlined in the box on the next page. Some of these have a specific remit to address loneliness – others such as the health promotion or wider community engagement initiatives contribute as a secondary effect.

[73] Cattan M conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[74] Holt-Lunstad L conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[75] Bowling A conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[76] Cann P and Jopling K (2011), op. cit.
[77] Cattan C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

Services which help to reduce loneliness and isolation

Information and signposting services

- websites or directories including information about social support services
- telephone helplines providing information about social support services
- health and social support needs assessment services (postal or web-based questionnaires or visits)

Support for individuals

- befriending – visits or phone contact; may include assistance with small tasks such as shopping
- mentoring – usually focused on helping an individual achieve a particular goal, generally short-term
- buddying or partnering – helping people re-engage with their social networks, often following a major life change such as bereavement
- Wayfinders or Community Navigator initiatives – helping individuals, often those who are frail or vulnerable, to find appropriate services and support

Group interventions – social

- day centre services such as lunch clubs for older people
- social groups that aim to help older people broaden their social circle, and possibly focusing on particular interests, such as reading
- Group interventions – cultural
- initiatives that support older people to increase their participation in cultural activities (e.g. use of libraries and museums)
- community arts and crafts activities
- local history and reminiscence projects

Health promotion interventions

- walking groups for people over 50
- healthy eating classes for people over 50

Wider community engagement

- projects that encourage older people to volunteer in their local community (for example, local volunteer centres and Time Banks).

Source: *Loneliness and Isolation: a toolkit for health and wellbeing boards*, The Campaign to End Loneliness (http://www.campaigntoendloneliness.org.uk/toolkit/

A range of techniques or tools are being used in such projects. Increasingly, technology plays a role: for example, in the provision of telephone befriending services or through projects that seek to support older people's digital engagement, helping them to maintain contact with family and friends who live at some distance through Skype and email.[78]

Many of the initiatives which seek specifically to address loneliness among older people are run by voluntary organisations. A significant proportion of these initiatives rely on volunteers for both delivery and management. Many of these volunteers are older people seeking to support their peers. Other initiatives may be intergenerational, i.e. seeking to bring older and younger people together to share their skills and experience.

Often interventions are small-scale and fragmented. However, in some areas they are integrated into a strategic approach. Notable examples include work led by local authorities in Manchester, Birmingham and the Royal Borough of Kensington and Chelsea to identify and meet need.[79]

The use of technology

One area in which the evidence base is thin is the use of different forms of technology to address loneliness. However, a general lesson is that we should not make assumptions or generalisations about the value of technology in addressing loneliness and isolation.

Cacioppo suggests that the more online contact people have, the lonelier they are, while the more confidants people interact with face-to-face, the less lonely they are. His hypothesis is that online could be valuable where it maintains or fosters offline connections.[80] One study shows that greater use of the internet by older people to communicate with family and friends is associated with a reduction in social loneliness, whereas using it to find new friends results in increased emotional loneliness.[81]

It is important to distinguish between different sorts of technology and how they are used. For example, although more evidence is needed there are indications that telephone and internet support groups may be effective in reducing loneliness among housebound older people, older people living with HIV/AIDS and people living in communal housing.[82]

Effective interventions

A 2005 review of the literature examining interventions found evidence that particular types of intervention were effective: namely, groups that provide educational/problem-solving or targeted support activities to particular groups (women, care-givers, the widowed, the physically inactive, or people with serious mental health problems).

[78]Cattan M conference presentation. http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[79]For further information and more examples see http://www.campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2012/03/A-guide-for-local-authorities-combating-loneliness.pdf and http://www.campaigntoendloneliness.org.uk/toolkit/

[80]Cacioppo JT conference presentation

[81]Sum S, Matthews RM, Hughes I, Campbell A (2008) Internet use and loneliness in older adults. *Cyberpsychology and Behaviour* 11 (2): http://www.ncbi.nlm.nih.gov/pubmed/18422415

[82]Cattan M (2011). Alleviating loneliness and isolation in older people. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness.* Age UK Oxfordshire: http://campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2011/07/safeguarding-the-convoy_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

It concludes that there is less clear evidence for the effectiveness of one-to-one interventions e.g. befriending services or telephone advice.[83]

The lack of robust evidence about one-to-one as opposed to group services may, however, have more to do with evaluation design and methods rather than the efficacy of the method.[84] People working with older people on a one-to-one basis often report evidence of the positive impact of this type of support,[85] and a SCIE briefing examining effective interventions to address loneliness and isolation supports the view that such support has positive outcomes. The briefing concludes that people who use befriending and community navigator services report feeling less lonely (while the impact of mentoring services is less clear). It also says that community navigator services prove effective in identifying individuals who are socially isolated.[86]

Another study examining the effectiveness of interventions to reduce loneliness takes a different approach. It considers reviews covering four main intervention strategies: improving social skills, enhancing social support, increasing opportunities for social contact and addressing maladaptive social cognition. It finds that the most effective interventions address maladaptive social cognition, using cognitive behaviour therapy (where maladaptive social cognition is counterproductive behaviour or behaviour that interferes with everyday life).[87]

The characteristics of effective interventions

The 2005 review concludes that interventions are more likely to be effective if they have particular characteristics – namely, if they:

• enable some level of participant and/or facilitator control or

[83]Cattan M conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

See also Cattan M, White M, Bond J, Learmouth A (2005), Preventing social isolation and loneliness amongst older people: a systemic review of health promotion interventions, *Ageing and Society*, 25. http://50plus.kro.nl/data/media/db_download/23_a33c42.pdf

[84]Cattan M conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

[85]Campaign to End Loneliness and Oxfordshire County Council (2012). *Research Hub Bulletin*, Winter 2012. http://www.campaigntoendloneliness.org.uk/wp-content/uploads/downloads/2012/05/Research-Bulletin-Winter-2012.pdf

[86] Windle K, Francis J and Coomber C (2011). *SCIE Research briefing 39: Preventing Loneliness and Social Isolation: interventions and outcomes.* http://www.scie.org.uk/publications/briefings/files/briefing39.pdf

[87]Masi CM, Chen HY, Hawkley LC, Cacioppo JT (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*, 15 (3) http://psr.sagepub.com/content/15/3/219

consult with the intended target group before the intervention

- are theoretically grounded
- enhance self-esteem and personal control. [88]

A more recent review, conducted in 2011, reached very similar conclusions, i.e. that effective interventions:

- are based on social activity or support in a group
- include older people as active participants
- are theoretically grounded.[89]

The SCIE briefing also seeks to define the characteristics which help to determine whether interventions are effective or not, highlighting:

- the flexibility and adaptation of services
- strong partnership arrangements
- the involvement of older people in the planning, development, delivery and assessment of interventions.[90]

The emphasis on older people participating in the design of services to meet their needs is a consistent theme of these reviews. A range of issues is likely to surface as a result of such participation. For example, based on qualitative research she has conducted with older people, Victor suggests that loneliness has a strong temporal dimension. Older people report they are loneliest in the evenings and at weekends. This finding obviously has implications for service provision.[91]

Another study takes a different tack, identifying the characteristics of ineffective interventions based on an evaluation examining 18 different initiatives in the Netherlands:

- a failure to thoroughly examine the problem and to ask whether the issue is social or emotional loneliness and the factors giving rise to it
- a failure to consider the pros and cons of different interventions (in each case only one was considered)
- not seeking to profit from the learning of other projects
- an exclusive orientation towards broadening the social network of participants (therefore alleviating social loneliness without attending to emotional loneliness).[92]

Reduced loneliness equals lower public spending

Evidence indicates that interventions to alleviate loneliness can significantly reduce spending on health services. Older adults who are socially disconnected and who feel lonely rate their physical health as

[88]Cattan M conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/
See also Cattan M, White M, Bond J, Learmouth A (2005), Preventing social isolation and loneliness amongst older people:
a systemic review of health promotion interventions, *Ageing and Society*, 25. http://50plus.kro.nl/data/media/db_download/23_a33c42.pdf
[89]Dickens AP, Richards SH, Greaves CJ, Campbell JL (2011). Interventions targeting social isolation in older people: a systemic review.
MBC Public Health, 11 http://www.ncbi.nlm.nih.gov/pubmed/21843337
[90] Windle K, Francis J and Coomber C (2011), op. cit
[91] Victor C conference presentation. http://www.campaigntoendloneliness.org.uk/loneliness-conference/
[92]de Jong Gierveld, J Fokkema T and Van Tilburg T (2011), op. cit.

lower than that of others.[93] As a result, lonely people are more likely to visit their GP and to use other health services. For example, one study demonstrates that loneliness is a predictor of use of accident and emergency services independent of chronic illness.[94]

Research suggests that relatively low-cost approaches to addressing loneliness and isolation among older people can result in:

- fewer visits to the doctor, lower use of medication, lower incidence of falls and reduced risk factors for long-term care[95]
- fewer days in hospital, physician visits and outpatient appointments[96]
- fewer admissions to nursing homes and later admissions.[97]

These and other services designed to promote the health, well-being and independence of older people, thereby preventing or delaying the need for intensive or institutional care, also make a significant contribution to reducing health inequalities.[98]

The box below provides information about two research studies examining the cost-effectiveness of services.

Cost-effectiveness

SCIE concludes in its briefing that research into cost-effectiveness is sparse but it cites two studies that indicate that services to address loneliness among older people can be cost-effective:

1 An assessment of **befriending services** which cost about £80 per person per year estimated that within the first year such services would provide some £35 in savings. When the quality-of-life improvements resulting from the reduction in depression were factored in, the monetary value was calculated at about £300 per person per year. The economic benefits of community navigator services were calculated as even greater.[99]

2 A study of older individuals involved in **group activities** estimated that the total cost of health service use (hospital bed days, physician visits and outpatient appointments) per person in the group was €1,522 per year, compared with €2,465 for the control group. This statistically significant difference between the groups of €943 was greater by €62 than the costs of the intervention – €881 per person.[100]

[93] Cornwell EY, Waite LJ (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behaviour* 50(1) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756979/?tool=pubmed

[94] Geller J, Janson P, McGovern E and Valdini, A (1999). Loneliness as a predictor of hospital emergency department use. *Journal of Family Practice* 48 (10)
http://www.jfponline.com/pages.asp?aid=2697

[95] Cohen, GD, Perlstein S, Chapline J, Kelly J, Firth KM, Simmens S (2006). The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. *The Gerontologist* 46 (6) http://gerontologist.oxfordjournals.org/content/46/6/726.abstract

[96] Pitkala, KH et al. (2009). Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial. *Journal of Gerontology: Medical Sciences*, 64A (7) http://biomedgerontology.oxfordjournals.org/content/64A/7/792.abstract

[97] Russell DW, Cutrona CE, de la Mora A, Wallace RB (1997). Loneliness and nursing home admission among rural older adults. *Psychology and Aging* 12(4).http://www.ncbi.nlm.nih.gov/pubmed/9416627

[98] Marmot M (2010). Fair society, healthy lives. *The Marmot Review*. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[99] Knapp M, Bauer B, Perkins M, Snell T (2010). *Building Community Capacity: making an economic case*, PSSRU Discussion Paper 2772, London: PSSRU: http://www.pssru.ac.uk/pdf/dp2772.pdf

[100] Pitkala KH et al. (2009), op. cit

6 Conclusion: inviting your responses

Our understanding and knowledge of loneliness and isolation among older people has improved over recent years thanks to the efforts of a small group of academics, researchers, voluntary and public sector organisations, and funders. The aim of this report is to summarise what we know so far as a foundation for further work.

The majority of the report is based on the research events and publications produced by the Campaign to End Loneliness. We intend that it should prompt a dialogue involving the academic community and researchers working in the voluntary, public and private sectors. We hope this debate will instigate action to fill the research gaps and produce a better understanding of how to approach the controversies in research into loneliness.

The Campaign will produce regular updates or supplements to this report (through its Research Bulletin). We would therefore welcome your responses to the following questions:

1 Have we missed research evidence that should be included?

2 Are you currently undertaking relevant research that should be referenced in future?

3 Below we set out two different agendas, one concerned with **research gaps and issues** and one with **how research is conducted**: have we got the content of these right?

Research gaps and issues

There is sufficient robust research to support the argument that loneliness and isolation among older populations is a major social, health and quality-of-life issue on which action is needed. We also have the start of a body of research identifying risk factors and influences and examining the effectiveness of different responses. Nevertheless, we could usefully develop and deepen the evidence base in these areas, while work to date also identifies some significant research gaps and issues that need to be addressed:

1 We need to increase our understanding of how loneliness and isolation among older people contribute to ill health and disability and use of health and social care services. This work might take a variety of forms. It could, for example:

• take issues of concern to health and social care practitioners and examine in detail their relationship with loneliness: for example, dementia, mental health, physical activity and falls

- examine the relationship between loneliness and use of health and social care services, either in a particular geographical area or focusing on either health or social care or a particular service

- determine the likely cost in terms of increased use of services to the NHS and social care of loneliness among older people.

2   We need further research into risk factors and influences, for example, examining the relationship between ill health (particularly mental ill health) and loneliness.

3   We would like to see further work that examines how transitions can increase the risk of loneliness: for example, the transition period immediately pre-retirement. This should help to identify people at risk and offer targeted support.

4   We need to better understand how people can be helped to plan for their older age to ensure that they have the attitudes, behaviours, opportunities and resources that they need.

5   We need to develop the evidence base for the effectiveness of different interventions. This work might take a variety of forms. It could, for example:

- fill gaps in the current evidence base: for example, by examining the effectiveness of one-to-one services, including befriending and tele-befriending (while there are some studies they are generally regarded as having methodological problems), or those interventions using technology or adapting technology-based services, including telecare and telehealth

- deepen the evidence base by increasing our understanding of what approaches work for which groups of older people in which particular circumstances.

6   We need research into the specific issues and support needs relating to loneliness and cognitive impairment, and/or sight and hearing loss.

7   We need further investigation into loneliness among older people living in residential care or sheltered housing, as little research appears to have examined the dynamics of loneliness and isolation in institutional settings.

8   We need further research into the cost-effectiveness of different interventions, examining difference approaches, as little evidence is available at present.

Framing and conducting research

We could also significantly develop the knowledge base through greater attention to the way in which research is framed and conducted. For example:

1   Practitioner collaboration with academics or specialist researchers can help to ensure that research methodologies are sound.

2   Academic partnerships with voluntary organisations and/or public sector bodies can help ensure the relevance of research.

3   Framing the research in a way that makes data comparable across different studies would also be very valuable: for example, using an established scale for measuring loneliness. One of these is the de Jong Gierveld scale. Such scales have been tested and are regarded as robust research tools.

4   Service evaluation quality could be improved if SCIE's basic recommendations were followed:

• in order to assess whether specific programmes are able to change individuals' quality of life, or impact on their care pathway, participants need to be asked their views before the start of the intervention as well as following it

• standardised quality-of-life measures should be used, which will allow for measurement of change as well as supporting comparisons across programmes. The measurement tools EQ-5D (a health-related quality-of-life tool) and ASCOT (a social care-related quality-of-life tool) have been identified and nationally 'adopted' within the health and social care outcomes frameworks as tools to measure service quality, and will in future allow for a broader comparison across delivery models

• ideally, a comparison or control group (preferably randomly chosen) should be included in any rigorous evaluation to enable researchers to separate out what would have happened to the individuals concerned had the service not been provided.

• if cost-effectiveness is to be determined, elements such as set-up and implementation expenses need to be measured and also the level and extent of informal carer support provided alongside the intervention.

We hope this report has provided a stimulus for your own work on loneliness and isolation among older people and we look forward to your comments on:

• the comprehensiveness of the research evidence presented in this publication

• research you are currently conducting

• research gaps and issues that require further attention

• how to increase the impact of spending on research through careful attention to how it is framed and conducted.

Address for responses: **anna@campaigntoendloneliness.org.uk**