White Rose Research Online

eprints@whiterose.ac.uk
https://eprints.whiterose.ac.uk
Universities of Leeds, Sheffield and York

Deposited via The University of Leeds.

White Rose Research Online URL for this paper:
https://eprints.whiterose.ac.uk/id/eprint/100116/

Version: Accepted Version

Article:
Chana, R, Marshall, P and Harley, C (2016) The role of the Intermediate Care Team in detecting and responding to loneliness in older clients. British Journal of Community Nursing, 21 (6). pp. 292-298. ISSN: 1462-4753

https://doi.org/10.12968/bjcn.2016.21.6.292

Reuse
Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown
If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

UNIVERSITY OF LEEDS
University of Sheffield
UNIVERSITY of York

Article Published in British Journal of Community Nursing
2016 Volume X (X) XX-XX

Exploring the role of the Intermediate Care Team in detecting and responding to loneliness in older clients

Richard Chana, Paul Marshall, Clare Harley

Corresponding Author: Dr Clare Harley, School of Healthcare, University of Leeds, UK
c.harley@leeds.ac.uk

Abstract ----------

The Intermediate Care Team (ICT) supports patients in their own homes to manage complex needs. They are ideally placed in the community to identify older adults at risk of loneliness. However, little is known about how ICT professionals perceive, detect, or respond to loneliness in their clients. This study explores ICT professional's attitudes to loneliness in the context of perceived service priorities and their experiences of managing loneliness in their clients. Eight ICT professionals (n=2 physiotherapists, n=3 occupational therapists, n=3 nurses) took part in semi-structured interviews. Data was analysed thematically using framework analysis, applying the Theory of Planned Behaviour as an interpretive framework. ICT professionals believed loneliness was a significant issue for many of their older clients but was a low priority for ICT services. Study participants believed that loneliness often goes undetected because it is an issue that is difficult to measure objectively. Barriers to managing loneliness included high work-load, unsatisfactory referral systems, and lack of close working with social-care and independent sector services. Introducing brief but reliable loneliness assessments into routine practice, receiving training on detecting and managing loneliness, and improving working relationships with social care and independent sector services were highlighted as strategies that could improve the detection and management of loneliness in ICT clients.

***Key words*:** Loneliness, older people, intermediate care team, qualitative research

----

Introduction

Loneliness is a complex subjective emotion, typically experienced as an unpleasant feeling of anxiety about the lack of connectedness or communality with others (Beaumont, 2013). Isolation and loneliness are related but distinct concepts. Isolation describes a lack of social contact with family, friends, or broader social networks (Valtora and Hanratty, 2012). Loneliness is thought to occur when there is a discrepancy between a person's desired and perceived level of emotional and social contact with others (Perlman and Peplau, 1984). It is, therefore a very personal and subjective experience.

Whilst loneliness is distinct from being or living alone, living alone is a significant predictor of loneliness, particularly in older adults (Victor et al., 2000). In the UK it is estimated that 51% of people over 75 years of age live alone (National Health Service, 2013). Other changes in life-circumstances that are common in advancing age may increase social isolation and therefore contribute to loneliness. These include loss of a spouse or retirement, which reduce the opportunity to share thoughts, concerns and daily experiences with others: 17% of older people report they have contact with family, friends, or

neighbours less than once a week and 11% report such contact occurring less than once a month (Victor et al., 2003). Limitations to mobility, through physical impairment or loss of transportation can affect people's independence and can disconnect them from family and friends (Smith, 2012) or activities they formerly enjoyed (Meakins and Gorman, 2004): 9% of older adults report feeling cut off from society; 12% say they feel trapped in their own home; and 6% report leaving their house just once a week or less (Davidson and Rossall, 2015).

Loneliness can have a profoundly negative impact on a person's health and wellbeing (Windle et al., 2011). Loneliness has the potential to increase anxiety and depressive symptoms (Bekhet and Zauszniewski, 2012), increase systolic blood pressure (Hawkley et al., 2010), increase rates of cognitive and motor decline (Buchman et al., 2010; Shankar et al., 2013), and increase risk of mortality and morbidity (Luo et al., 2012). Older people who live alone are at greater risk of the development of disability and disease and therefore may benefit from early intervention from public involvement and inclusion schemes (Lillyman and Land, 2007). For example, it is recommended that lonely people are supported to reconnect with the social world, which may include attendance at a day centre, a lunch club, or a home visiting service (Owen, 2006). Early intervention is important to prevent problems associated with loneliness from escalating (Department of Health, 2006).

Detecting and addressing loneliness is a difficulty problem. Loneliness can go undetected in the community as those who are lonely are likely to be socially isolated and hard to reach. Community healthcare professionals, who are often a vital link between the patient and the outside world, are in an ideal position to develop trusting relationships with patients and facilitate communication about loneliness (Owen, 2006; Aebischer, 2008). The Intermediate Care Team (ICT), which includes nurses, occupational therapists, and physiotherapists, are ideally placed to come in to contact with older adults at risk of loneliness. However, previous research suggests that healthcare professionals are not always aware of the risk of loneliness in their patients (Murphy, 2006) and they may struggle to manage issues of loneliness due to time pressures and competing workload demands (Ebersole, 2002). As a result, there is a risk that lonely patients who are involved with community healthcare services may not be identified or offered the support they need (Owen, 2006). Very little is currently known about how professionals working within ICT services perceive or address loneliness in their clients or prioritise issues of loneliness alongside their other workload commitments.

The aim of this study was to explore the attitudes of ICT professionals regarding loneliness, to understand the perspectives of the broader organisation regarding loneliness, and to understand whether there are specific barriers that may prevent ICT professionals from actively detecting and

managing loneliness in their clients. This new knowledge has the potential to inform the development of strategies to improve quality of care, healthcare outcomes, and patient satisfaction within ICT services.

Methods

Sample and data collection

This study took place in a single Community Healthcare NHS Trust in the North of England. Eligible ICT professionals were those working with adults aged 60+ years presenting with complex health and social care needs. Purposive sampling obtained a representative sample of professionals in the service (nurses, occupational therapists, and physiotherapists).

Participants attended one-to-one audio-recorded semi-structured interviews to explore their perceptions and experiences of loneliness in their clients. An interview topic guide was developed using the Theory of Planned Behaviour (TPB) (Ajzen, 1991) to systematically explore participants' beliefs, attitudes, and behaviours regarding loneliness in light of their motivations and environmental/workplace context.

Ethics

The University of Leeds Ethics Committee approved the particulars of this study and R&D approval was granted by the participating NHS Trust. All participants gave written informed consent prior to study participation. All study data including interview transcripts were anonymised and no participating professional has been identified within this article.

Analysis procedure

All interview recordings were transcribed verbatim and checked for accuracy. Conventions of dialogue (e.g., non-language utterances, pauses) were included for context but not analysed. Framework analysis (Ritchie and Spencer, 1994) was used to apply thematic codes to the data through a dual deductive and inductive approach. This focussed on mapping data to the TPB (deductive) whilst identifying new and emergent themes (inductive). Data analysis was carried out through five stages: familiarisation with the textual data, identifying common themes across the interviews, indexing the themes, charting the themes and identifying relationships between themes, and interpreting the themes.

Findings:

Eight ICT professionals (n=2 physiotherapists, n=3 occupational therapists, n=3 nurses) participated in the interviews. Professionals had a minimum of seven years working in ICT (range 7-11 years). The demographics of the participants are summarised in Table 1.

Table. 1 Participant demographics

Participant study number	Job Title	Age Range (years)	Number of Years Working as a Healthcare Professional (Number of Years working in ICT)
1	Physiotherapist	26-35	10 (7)
2	Nurse	46-55	15 (7)
3	Occupational Therapist	46-55	24 (11)
4	Nurse	36-45	14 (10)
5	Occupational Therapist	26-35	11 (11)
6	Occupational Therapist	26-35	10 (7)
7	Nurse	36-45	16 (9)
8	Physiotherapist	46-55	17 (11)

We present study findings as four key themes: the attitudes of ICT professionals towards loneliness; the perceived attitude of the ICT service towards loneliness; the perceived control of ICT professionals in detecting and managing issues of loneliness; and suggestions for overcoming barriers. Within each theme we present the range of views as subcategories, as summarised in Table 2. In the following section we describe the concepts within each theme and provide exemplar statements from study participants.

Table 2. Understanding the detection and management of loneliness in ICT services

Key themes	Subcategories
Attitudes of ICT professionals towards loneliness	A very relevant issue for ICT clients
	Complex cyclical relationship between loneliness, mental health, and physical health
	Identifying and referring loneliness is a professional priority but managing it is not
	Barriers to referring loneliness to other services
Perceived attitude of the ICT service towards loneliness	Loneliness is a low priority for ICT services
	ICT funded to meet commissioning priorities
Perceived behavioural control of ICT professionals in detecting and managing issues of loneliness	A conflict between personal and service attitudes towards loneliness in ICT clients
	Patient-barriers to managing loneliness: variability in need and willingness to engage
	Variability in HCPs ability to identify and address loneliness
Overcoming barriers	A need for training
	A need for objective assessment of loneliness

Attitudes of ICT professionals towards loneliness:

A very relevant issue for ICT clients

All study participants demonstrated an understanding of the complex relationship between social isolation, emotional isolation, and loneliness. They described loneliness as a state of isolation caused by a lack of people to share and partake in common interests with, as well as a lack of social role within society. Loneliness was described with compassion and it was clear that their understanding of loneliness was based on the personal experiences of their clients. It was clear that loneliness was considered a very relevant issue for ICT clients:

> *"Often the key reason why patients were reluctant to, for us, to discharge them really, they liked the company, they liked to know that their day was going to be broken up by visits and, there is no shadow of a doubt that they, loneliness was an issue, and it did make it very difficult then to, kind of, withdrawal services"* [1 Physio]

> *"I'd say round about twenty five percent, actually, of health problems could perhaps be avoided if we looked into social isolation and looked into addressing the loneliness."* [3 OT]

Cyclical and complex relationship between physical health, mental health, and loneliness

The relationship between mental health, physical health, and loneliness was described as complex and cyclical. For example, lonely clients were described as being less likely to be active, which could result in physical deconditioning that could result in a fall or lack of self-care, which in turn would lead to increased isolation and loneliness:

> *"It will impact on everything, like, mobility wise there will be increased falls risk, wouldn't there, if you're not getting out and about and getting exercise and keeping your muscles strong, and you're just stuck in the house all day. It's going to make everything worse isn't it?"* [4 Nurse]

> *"You're lying in bed, probably not wanting to eat very much, then that affects people, some people become incontinent, where they are not looking after themselves, not cleaning, not washing, not dressing, and again it becomes a cycle."* [2 Nurse]

Poor mental health was also associated with poor sleep, becoming house bound, poor appetite and nutrition, all of which could lead to physical deterioration, a loss of motivation, unwillingness to engage, and increased loneliness. The following quotes highlight this complex interaction:

"I think that loneliness and depression are very, very strongly linked as well. I think sometimes people have too much thinking time when they're by themselves and perhaps when they become housebound. Perhaps when they, functionally, they become more dependent on other people. I think perhaps becoming low in mood and loneliness go hand in hand" [5 OT]

"Somebody's loneliness impacts on their mood and that, in itself, impacts on their physical health" [8 Physio]

Identifying and referring loneliness is a professional priority but managing it is not

All study participants stated that loneliness was a significant concern for ICT clients and most felt that it was right that ICT professionals should play a role in detecting loneliness in their clients. There were differing opinions regarding the extent to which ICT professionals felt they should be involved in managing loneliness. Some felt it was their responsibility to provide holistic care, and addressing loneliness was central to providing such care, others felt that their responsibility was to refer patients to appropriate services.

"I don't think that we should pass it on, in the sense that it should be right up there. If we're saying that we are holistic and we look at people, then loneliness is pretty central to how a person responds to you...So I think it should be addressed with everything else in kind of an equal way." [7 Nurse]

"I think that we should identify it and refer it on. Just because, you know, we are a busy team. We have got an awful lot of other pressures on us and I think it might be too big an issue to address. But I think that it should certainly be addressed and sign-posted on to the right team." [1 Physio]

It was clear that loneliness could be viewed either as a health or social care problem and this led to confusion about which service should be responsible for managing loneliness.

"It goes back to the fact that we are a health service, we are here to help patients with medical conditions and ill health at that particular time. Is this a health issue or is this a social issue?" [5 OT]

"…and we have nobody to pass that, really, onto, because we are the health service and loneliness is that a health need? It's a bit of both isn't it? Social and health" [3 OT]

Barriers to referring loneliness to other services

Whilst some interviewees reported that they had gained confidence over time in referring lonely clients to social and independent sector services, others described frustration at complex and ineffective referral systems that required them to "jump through hoops" in order to justify a patient's eligibility, or systems that 'fell through" when patients were admitted to hospital mid-application, thus wasting the time and effort that the professional had put in making the referral.

> *"You really had to jump through many, many hoops to prove that somebody was really lonely or that there was carer strain in order for someone to qualify for one day a week out because everything is costed."* [3 OT]

> *"You'll see referral closed, because they are in hospital; and that never gets done again because the hospital will send them home and so the spiral goes again; and all that hard work you have done on a previous period when they have been with us has gone out of the window."* [2 Nurse]

Perceived attitude of the ICT service towards loneliness:

Loneliness is a low priority for the ICT service

Despite recognising the significant impact that loneliness could have on physical and mental health, loneliness was largely viewed as a low priority for ICT services, which were described as being predominantly medically focussed. Participants explained that ICT professionals are required to assess the physical and functional rehabilitation of clients as this tends to be the main factor that allows someone to stay at home. Once clients demonstrate the ability to manage their activities of daily living, professionals feel under pressure to discharge them in order to make way for those in greater need of the service:

> *"Its [loneliness is] low down because we are task-orientated. The minute somebody can do for themselves from a rehab point of view, they can put their bra on or take their meal out of the microwave, we pull out and, because somebody else is waiting in the wings and are needing the service."[3 OT]*

There was a strong sense of feeling that the scope of service provided to clients was limited by funding restrictions that limited resources and increased work-load. Participants typically felt there was not enough time to review complex or long-term issues with their clients:

"From the organisation perspective, I think they have made it harder because budgets have been cut. So yes, you know you're trying to do more work, for things that you want to offer people" [7 Nurse]

"I think a lot of it comes with working through what patients' goals are. And, that again, is a challenge in the short period of time that we have with patients, so we don't always achieve. We do the functional short-term goals. We don't necessarily think about the other goals of getting somebody back into society as a whole. That's very limited and part of the constraints of what we can offer somebody." [8 Physio]

ICT funded to meet commissioners requirement

Many professionals felt that their work roles were dictated by the need to achieve specific standards that were audited by commissioners who were responsible for funding ICT services. It was felt that such audits monitored service performance, which did not always align with meetings clients' needs related to loneliness.

"Our service has evolved to meet the requests of the people who are commissioning it; and the people who are auditing and measuring our performance. The commissioners are paying us to patch people up and move on to the next one." [3 OT]

The perceived difficulty in objectively measuring loneliness was cited as one reason why loneliness might not be monitored as part of service performance.

"I don't think it [loneliness] is something that you can quantify and you can look at measures to say well it's an issue, it's so much of an issue this year, compared to next years."[8 Physio]

Despite these beliefs, others recalled that loneliness used to be routinely screened for on patient assessment documents but these questions no longer appeared in the paperwork:

"I'm sure there used to be a question that we use to ask that said 'have you ever felt lonely and have you ever felt scared?'. Wasn't there those questions on one of the assessment documents that we used to use?"[4 Nurse]

Perceived behavioural control:

A conflict between personal and service attitudes towards loneliness in ICT clients

Whilst loneliness was perceived as a significant problem for ICT clients, it was felt to be less of a priority in cases where there were serious health-related issues present. Participants felt that professionals within ICT work according to a medical model that prioritises the assessment of symptoms and functions. This was felt to be in conflict with ICT professionals' beliefs, as they felt that loneliness could exacerbate other health-related issues that would affect a patient's ability to manage functional tasks, such as maintaining adequate dietary intake.

> *"In one sense it's not a medical condition, however I think it has a direct impact on every medical condition and health related issue they have. We've talked about the link to depression; we've talked about its link to other health related issues in exacerbating the problems they have got through how they are feeling and through their mood."[5 OT]*

ICT professionals felt their role was to provide holistic patient care and some expressed sadness that this was in conflict with the perceived medical focus of the service more generally.

> *"I think that we make it [loneliness] a priority for individuals, I wouldn't say that the trust, I don't think it's targeted as a part of loneliness. I think we think, unfortunately, quite medically. We are a quite medical model still, and that is quite sad as we tend to be trained holistically so we look at social aspects and what links are out there"* [2 Nurse]

Patient-barriers to managing loneliness

In addition to service-level barriers, interviewees identified patient-level barriers to addressing loneliness, such as negative attitudes and behaviours. ICT professionals explained that resolving issues of loneliness could be challenging as sometimes the services available did not suit what a patient required or was willing to consent to; patients may not want to go out and meet strangers, additionally they may not consent to strangers coming in to their homes.

> *"we talk about people going out to day centres and things but I know lots of people who we've suggested that to but who were outraged by it because they don't have, they don't want to go and spend time with strangers."* [7 Nurse]

> *"I think that the only barrier that we do struggle with often is the consent. It's that the person themselves, they are often lonely and you know that they need help but they often are unwilling to consent to somebody externally coming in."* [2 Nurse]

Patients who are anxious or depressed were reportedly difficult to engage with and it was felt this affected their ability to rehabilitate and led to further issues.

> *"There are huge impacts on somebody's remaining health and rehab, you can't rehab somebody that's depressed and lonely and tearful, because they are not wanting to engage."* [2 Nurse]

Ideas for overcoming barriers to detection and management of loneliness

In the previous sections, it is apparent that all interviewees believed loneliness was an important issue for ICT clients. However, many barriers to identifying and managing loneliness were cited. In the following section, we focus on some solutions that were proposed during the interviews. For example, it was suggested that ICT professionals should be encouraged to identify issues of loneliness but due to variability in professionals' knowledge and skills that training was needed to explain methods of detecting loneliness and to clarify local referral pathways.

> *"I don't think everyone's awareness of these services out there, I don't. I think that the home from hospital service is new. I didn't have the awareness of that service in its entirety until yesterday, so no I don't think the awareness is out there… it would be helpful to know far more about what's out there."[5 OT]*

> *"I don't think we have had enough training or enough information given. You get given little snippets from like voluntary agencies in this area and how to refer in and things, but not necessarily what I would class as well informed."* [4 Nurse]

It was acknowledged that successful management of loneliness would require longer-term care strategies, which were often beyond the remit of ICT services to deliver alone and which would require closer and longer-term working with social care and independent sector services:

> *"When we are involved we need to look at the implications that it has for us as health care workers, in terms of their physical and mental health. But then equally, you know when people are passed to social services, you can't just say right it stops there."* [7 Nurse]

> *"Building those links up [with social and independent sector services], so that it, so that they got, you know, that relationship there with them already and so they can access the resources a bit easier."* [6 OT]

Participants suggested there was a window of opportunity to address loneliness before it exacerbated other health issues. There was consensus that health and social care professionals needed to take timely action against loneliness.

> *"But addressing these issues before they exacerbate to a point where you feel you actually can't, with all those services out there, you can't move the individual on to the next stage. Yeah, I think that there is definitely a window of opportunity."[5 OT]*

Discussion

This study explored the attitudes of ICT professionals towards loneliness and examined factors that may influence their behaviour regarding identifying and managing loneliness in their clients. Participants in this study demonstrated an in-depth and compassionate understanding of loneliness, which was related to an individual's perception of the quality of their social relationships with others. They described loneliness as being an important issue for ICT clients but acknowledged that loneliness was complex and cyclical in nature. They described how loneliness could be caused by or lead to declining mental wellbeing or physical functioning. There was a keen awareness that ICT clients living alone were at higher risk of developing poor health outcomes, which aligns with current research evidence (Lillyman and Land, 2007; Buchman et al., 2010; La Grow et al., 2011; Bekhet and Zauszniewski, 2012). Despite this, study participants failed to identify progressive mental and physical health deterioration, which can contribute to the development of loneliness (Hagan Hennessy and Walker, 2004). This finding is likely to be related to the short-term nature of ICT involvement in individual care and rehabilitation, which deals predominantly with acute illness episodes.

Study participants felt it was the responsibility of all professionals working in healthcare, social care, or independent sector services to detect loneliness in their clients. A notable exception was for clients presenting with serious health problems where it was acknowledged that in these circumstances that detecting loneliness would be a lower priority. There was some variability in opinion about whether loneliness should then be managed within ICT or referred to independent and social care services. Some participants, particularly nurses, felt it was their responsibility to provide holistic care, which included managing loneliness. Others felt that their professional priority was the physical rehabilitation of clients to enable them to be independent in their own homes. These professionals would, therefore, refer clients who were lonely to other services. The Department Of Health (2006) guidance on healthy aging recommends a joint working approach, whereby social care and independent sector services work

alongside the NHS to tackle issue such as loneliness. It argues that joint working should improve overall patient health and social care outcomes because social and independent sector services are well placed to promote social interaction and independence in the community. As such, the guidance recommends that all healthcare professionals familiarise themselves with relevant local services that are in a position to support the complex social care needs of NHS patients.

Whilst the participants in this study felt it was appropriate to work with independent and social care services to manage loneliness, many felt that engaging with these services can be difficult in practice. Some participants reported that they had developed good skills in making successful referrals, but the majority felt that referral processes were overly bureaucratic, time consuming, and unreliable. Many also reported it was common for clients to refuse referrals as they perceived the referral would not meet their needs or did not align with their preferences. Many ICT professionals felt that improving day-to-day working relationships with social and independent sector services and giving patients time to become familiar with providers of these services could help to improve referral processes and patient uptake of support.

Whilst all participants felt it was important to take steps to tackle loneliness early to prevent the escalation of physical and mental health problems, some participants explained that due to large caseloads and time pressures it was very likely that lonely clients were not being identified by ICT professionals. A conflict between professional role, focusing on patients' holistic care, and the medical focus of ICT services was also described. Many felt that loneliness was a low priority to ICT services, which prioritised physical rehabilitation for functional independence. It was felt that the priorities of ICT were influenced by care commissioners who set service performance markers by which ICT is assessed. A number of participants came to the conclusion that loneliness was difficult to measure objectively, therefore it could not be assessed through service performance, therefore, it was not a priority to the service.

The finding that individual professionals vary in their skills and confidence in detecting and managing loneliness reflects similar findings by Murphy (2006) who reported that health care professionals vary in their knowledge and capability to identify and address loneliness. Professionals in the current study identified a training need regarding loneliness. They wished to gain confidence in accurately identifying lonely clients and improve skills to make timely and effective referrals. In addition, professionals wanted improved consistency in communication about locally available services so that they were kept up to date about what was available with clarity regarding criteria and processes for

referral. Tackling such communication barriers between ICT and social and independent sector services may lead to a shared understanding of the pressures of each organisation, improve working relationships, and ultimately increase the likelihood that patients experiencing loneliness receive appropriate and timely care.

There are a number of limiting factors to this research. The first is that although the sample was representative of healthcare roles in ICT, the sample was fairly small and was from a single healthcare trust. These factors may have implications for generalising the findings of this study beyond the current setting. Secondly, the views represented in this study are likely to be from those professionals with experience of an interest in loneliness in their clients. Those unmotivated by the research topic who did not participate may have different views to those expressed in this study (Bowers et al. 2006). Further research in this field is warranted and the investigation of experiences of staff working in social and independent sector services to provide care for lonely clients would provide an interesting counterpoint to the data presented here.

Conclusion

High work-load and time pressures, unsatisfactory referral systems, and lack of close working with social-care and independent sector services are often barriers to detecting and managing loneliness. Improved staff training about detecting loneliness and improving working relationships with social care and independent sector services were highlighted as key strategies that could improve the detection and management of loneliness for ICT clients.

References

Aebischer, J. 2008. Loneliness among homebound older adults: implications for home healthcare clinicians. *Home Healthc Nurse.* **26**(9), pp.521-4.

Ajzen, I. 1991. Theory of planned behavior. *Organizational behavior and human decision processes.* **50**, pp.179-211.

Beaumont, J. 2013. *Measuring National Well-being - Older people and loneliness.* Office for National Statistics.

Bekhet, A.K. and Zauszniewski, J.A. 2012. Mental health of elders in retirement communities: is loneliness a key factor? *Arch Psychiatr Nurs.* **26**(3), pp.214-24.

Buchman, A.S. et al. 2010. Loneliness and the rate of motor decline in old age: the Rush Memory and Aging Project, a community-based cohort study. *BMC Geriatr.* **10**, p77.

Davidson, S. and Rossall, P. 2015. *Evidence Review: Loneliness in Later Life.* Age UK.

Department of Health, O. 2006. *A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People.* London.

Ebersole, P. 2002. Loneliness, compassion, and nursing. *Geriatr Nurs.* **23**(5), pp.236-7.

Hagan Hennessy, H. and Walker, A. 2004. *Growing Older: Quality of Life in Old Age.* London: Open University Press.

Hawkley, L.C. et al. 2010. Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. *Psychol Aging.* **25**(1), pp.132-41.

La Grow, S. et al. 2011. Loneliness and self-reported health among older persons in New Zealand. *Australasian Journal on Ageing.* **31**(2), pp.121-123.

Lillyman, S. and Land, L. 2007. Fear of social isolation: results of a survey of older adults in Gloucestershire. *Nurs Older People.* **19**(10), pp.26-8.

Luo, Y. et al. 2012. Loneliness, health, and mortality in old age: a national longitudinal study. *Soc Sci Med.* **74**(6), pp.907-14.

Meakins, E. and Gorman, J. 2004. *How to cope with loneliness.* London: Mind (National Association for Mental Health).

Murphy, F. 2006. Loneliness: a challenge for nurses caring for older people. *Nurs Older People.* **18**(5), pp.22-5.

National Health Service. 2013. *NHS Choices: Loneliness in older people.* [Online]. [Accessed 03/02/2016]. Available from: http://www.nhs.uk/Livewell/women60-plus/Pages/Loneliness-in-older-people.aspx

Owen, T. 2006. Working with socially isolated older people. *British Journal of Community Nursing.* **12**(2), pp.115-116.

Perlman, D. and Peplau, L.A. 1984. Loneliness Research: A survey of empiricle findings. In: Peplau, L.A. and Goldston, S. eds. *Preventing the harmful consequences of severe and persistent loneliness.* U.S Government Printing Office, pp.13-46.

Ritchie, J. and Spencer, L. 1994. Qualitative data analysis for applied policy research. In: Bryman, A. and Burgess, R. eds. *Analyzing Qualitative Data.* London: Routledge.

Shankar, A. et al. 2013. Social isolation and loneliness: relationships with cognitive function during 4 years of follow-up in the English Longitudinal Study of Ageing. *Psychosom Med.* **75**(2), pp.161-70.

Smith, J.M. 2012. Portraits of loneliness: emerging themes among community-dwelling older adults. *J Psychosoc Nurs Ment Health Serv.* **50**(4), pp.34-9.

Valtora, N. and Hanratty, B. 2012. Loneliness, isolation and the health of older adults: do we need a new research agenda? *Journal of the Royal Society of Medicine.* **105**, pp.518-522.

Victor, C. et al. 2000. Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology.* **10**(04), pp.407-417.

Victor, C. et al. 2003. *Loneliness, Social Isolation and Living Alone in Later Life.* Sheffield: ESRC Growing Older Programme.

Windle, K. et al. 2011. *SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes.* Social Care Institute for Excellence.