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Abuse and other adversities in community-dwelling older adults in Wales: associations with health and well-being

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Summary

Wales is committed to creating an age-friendly society where people of all ages are valued and can live and age well [1]. Protecting older people from abuse and other adversities that harm health and well-being is a core part of this commitment. This report presents findings from a national household survey conducted with residents of Wales aged 60 years and over (February to May 2025). The survey was designed to measure relationships between adversity in later life and physical and mental health. The sample included community-dwelling adults who were cognitively able to participate in a survey; it did not include residents in care homes or other institutional settings.

Using a sample of 1,085 participants, this report focuses on exposure to abuse and four other adverse experiences since the age of 60: having struggled financially; having felt lonely or socially isolated; having been unable to access health or social care; and having felt overwhelmed by caregiving responsibilities. Analyses explore relationships between these experiences and ten poorer health outcomes: self-rated bad health; tobacco smoking; drinking alcohol more than once a week; low mental well-being; high anxiety; having a mental health condition; suicidal thoughts or self-harm; self-neglect; low life satisfaction; and experience of ageism.

Key findings

Since the age of 60:

-  12.5% of participants reported having experienced at least one form of **abuse**. The most common form of abuse reported was verbal abuse (8.4%), followed by physical abuse (4.6%) and financial abuse (2.9%).
-  30.0% of participants reported having been **unable to access health or social care**.
-  20.7% of participants reported having felt **lonely or socially isolated**.
-  19.0% of participants reported having **struggled financially**.
-  12.7% of participants reported having been **overwhelmed by caregiving responsibilities**.

Half (53.6%) of participants reported at least one of these five adverse experiences. Participants that reported one adverse experience were more likely to report others. For example, 42.6% of people that reported having experienced abuse since the age of 60 also reported having felt lonely or socially isolated, compared with 17.6% of those that had not experienced abuse.

-  Participants who had experienced **abuse** were more likely than those who had not to report all poorer health outcomes except high anxiety. Strong independent associations between abuse and most outcomes remained after adjusting for demographics and other adversities, (Figure 1). For example, those who had experienced abuse were **2.5 times more likely to smoke and drink alcohol more than once a week**, and **4.1 times more likely to report suicidal thoughts or self-harm**, compared to those who had not.

 Participants who had been **unable to access health or social care** were more likely than those who had not to report self-rated bad health, low mental well-being, having a mental health condition, suicidal thoughts or self-harm, self-neglect, and low life satisfaction. After adjusting for demographics and other adversities, independent associations only remained for **low life satisfaction (1.7 times more likely)** and **self-neglect (2.0 times more likely)** (Figure 1).

 Participants who had experienced **loneliness or social isolation** were more likely than those who had not to report all poorer health outcomes except alcohol use. After adjusting for demographics and other adversities, strong independent associations remained for all outcomes except smoking (Figure 1). For example, those who had felt lonely or socially isolated were **2.9 times more likely to report ageism experience** and **4.5 times more likely to have low mental well-being** compared to those who had not.

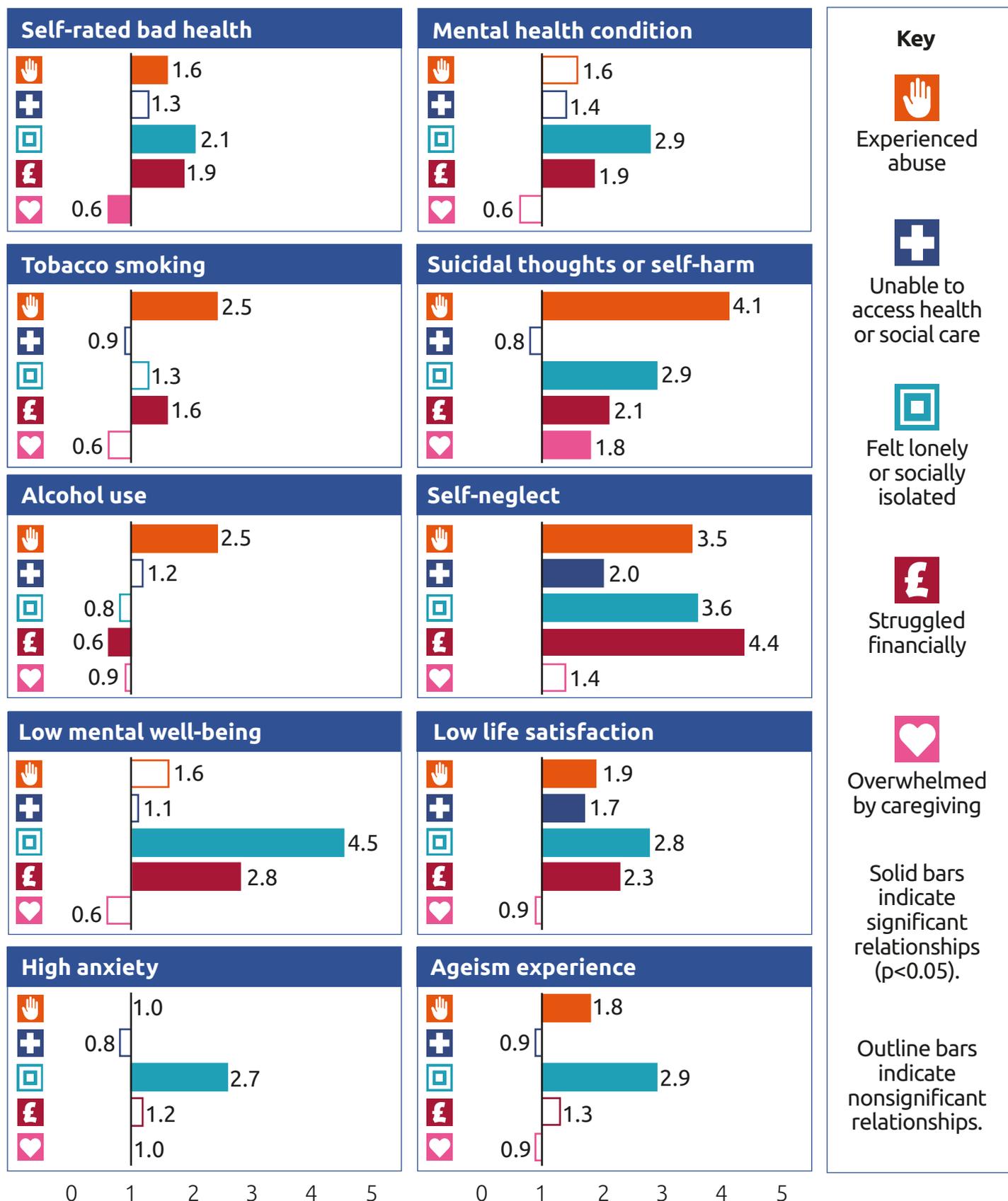
 Participants who had **struggled financially** were more likely than those who had not to report all poorer health outcomes except alcohol use. After adjusting for demographics and other adversities, independent associations remained for all outcomes except high anxiety and ageism (Figure 1). For example, those who had struggled financially were **2.3 times more likely to report low life satisfaction** and **4.4 times more likely to report self-neglect** compared to those who had not. However, they were **less likely to report drinking alcohol more than once a week**.

 Participants who had felt **overwhelmed by caregiving** were more likely than those who had not to report suicidal thoughts or self-harm, self-neglect and low life satisfaction. After adjusting for demographics and other adversities, independent associations only remained for **suicidal thoughts or self-harm (1.8 times more likely)**. Conversely, those who had been overwhelmed by caregiving were **less likely to report self-rated bad health** (Figure 1).

Conclusions

Older people make an essential contribution to Welsh society, and with an ageing population there is increasing reliance on older adults to be well and economically active. However, a substantial proportion of older people in Wales report adverse experiences in later life that can affect their health. Findings here highlight strong, independent associations between abuse, poverty, and loneliness or social isolation and poorer health in later life. Preventing these experiences and supporting those affected by them should be a priority. This will help ensure that residents in Wales live well for longer and strengthen the social and economic value of an increasing older population.

Figure 1: Change in likelihood of poorer health outcomes by exposure to adverse experiences since the age of 60 (adjusted odds ratios, see note)



Note: an adjusted odds ratio [AOR] of 1.0 indicates no change in risk. An AOR above 1.0 shows an increase in risk (e.g. an AOR of 1.6 represents a 60% increase in risk) and an AOR below 1.0 shows a reduction in risk. Models included age, sex, deprivation quintile, ethnicity, and all five adverse experiences. Full data is available in Appendix Tables A3 to A12.

Abuse and other adversities in community-dwelling older adults in Wales: associations with health and well-being

Authorship

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Introduction

Wales is committed to creating an age-friendly society where people of all ages can live and age well, and the benefits of a growing older population can be achieved [1]. Protecting older people from abuse and other adversities that can harm health and well-being is an essential part of this commitment. This report explores how exposure to abuse and other adversities in later life relates to physical and mental health and well-being in older people in Wales.

Preventing abuse of older people has been prioritised by the Older People's Commissioner for Wales through strategic objectives of ensuring older people are treated fairly and feel safe in their homes, communities and relationships [2,3]. Welsh Government has published a National Plan to prevent the abuse of older people [4], which sets out their approach to identifying, addressing and preventing such abuse. Further, the Trauma-informed Wales Framework [5] provides a societal approach to understanding, preventing and supporting those affected by trauma and adversity across the life course, including through older age. Across all this work, however, there is a recognised need for better data and evidence on the abuse of older people to inform policy and practice. To help address this evidence gap, Public Health Wales conducted a national household survey of people aged 60 years and over residing in Wales to measure exposure to abuse and other adversities since the age of 60 and their relationships with health and well-being.

Experiencing abuse at any age can have devastating impacts on individuals' physical, mental and social well-being [6,7]. Globally, however, knowledge on the extent, impacts and prevention of abuse in older people is relatively scarce compared to that for other population groups and specific forms of violence such as intimate partner violence [8]. In Wales, data from health services, police and third sector sources suggest that violence against older people has increased in recent years [9]. Half of all adult safeguarding referrals to social services for abuse (including neglect) are for adults aged 65 and over [10]. However, abuse can often be hidden, and older people can face numerous barriers to disclosing abuse and accessing support [11]. Thus, older people have been found to suffer domestic abuse for longer before seeking help [12] and represent a high proportion of adult family homicide victims [13].

Despite the known under-reporting of abuse, there is a lack of general population data on older people's experience of abuse or how it may affect health and well-being. In 2024/2025, the Crime Survey for England and Wales estimated that 0.4% of people aged 60 to 74 years and 0.3% of people aged 75 years and over experienced violence with or without injury, while 5.3% and 3.4% respectively were estimated to have suffered domestic abuse [14,15]; data are not published separately for Wales. In England, a study found that 2.0% of adults aged 60 years and over had experienced domestic violence, bullying or serious assault in the last year, with experiencing violence found to increase the risk of common mental disorders [16].

Abuse is one of a range of adversities that people can experience in later life. Age Friendly Wales, Welsh Government's strategy for an ageing society [1], prioritises work to address key adversities including poverty, loneliness and social isolation, and poor access to health and social care services. Like abuse, these experiences can have negative impacts on older people's health and well-being and their ability to positively engage in society. They may also be both risk factors for and consequences of abuse.

A further experience that may affect health and well-being in later life is unpaid caregiving [1,17]. Many older people take on valuable caregiving roles, for example, for grandchildren or for partners or relatives who require help with daily living. Data from the 2021 Census indicated that over a third (37.1%) of informal caregivers in Wales are aged 60 and over [18]. Caregiving can be a positive experience that supports well-being, yet for some it can create substantial strain and impose costs on physical, emotional, financial and social well-being [17,19].

In this report, we examine older adults' exposure to abuse and four other adverse experiences since the age of 60: feeling lonely or socially isolated; struggling financially; feeling overwhelmed by caregiving; and being unable to access health or social care. These experiences are prioritised across a range of strategies and policies in Wales (e.g. [1,17,20,21]). They represent different aspects of older people's lives and, like abuse, are preventable. We explore relationships between abuse and these other adverse experiences and a range of health and well-being outcomes, including: self-rated bad health; tobacco smoking; drinking alcohol more than once a week; low mental well-being; high anxiety; having a mental health condition; suicidal thoughts or self-harm; self-neglect; and low life satisfaction (see Appendix 1 for questions asked).

We also explore relationships with ageism using a new tool developed by the World Health Organization (WHO). The WHO Ageism Experiences Scale [22] was designed to measure people's experiences of ageism across multiple dimensions (i.e. stereotypes, prejudice and discrimination) in the past 12 months. We included the 5-item version of the Scale in this survey. While ageism is recognised to be a key risk factor in the abuse of older people, people's self-reported experience of ageism reflects how they have been treated by people and society. Thus, here we explore how exposure to abuse and other adverse experiences since the age of 60 relates to current perceptions of ageism experience.

This report is targeted at policymakers, practitioners and researchers working to prevent abuse and adversity in older people and support healthy ageing in Wales and beyond. While the report focuses on a selection of adversities and health outcomes included in the survey, the questionnaire included a wider range of questions that can support understanding of older people's experiences and health. Overall responses to the full range of questions included in the survey have been provided in Appendix 2.

Methodology

A national survey of adults aged 60 years and over living in households in Wales was undertaken between February and May 2025. The target sample size was 1,000 participants. Stratified quota sampling was used to obtain a nationally representative sample. The sampling units were lower super output areas (LSOAs), stratified by health board area and deprivation quintile (see Appendix 1). Quota targets were set for each LSOA by age and sex. Households in each randomly selected LSOA were randomly approached to take part. Only one resident from each selected household was able to participate. Participants had to be aged 60 years or over and cognitively able to take part. Residents in care homes or other institutional settings were not included in the survey.

A professional market research company was commissioned to undertake sampling and data collection face-to-face at participants' homes. Potential participants were provided with a verbal explanation of the study and a participant information sheet. This detailed the purpose and content of the study, its voluntary nature, the ability to withdraw at any time, how findings would be used and information on privacy, anonymity and data management. The questionnaire was completed by the interviewer on a digital tablet (computer-aided personal interviewing), with participants being able to self-complete questions that were more sensitive. It took an average of 30 minutes to complete. At the end of the survey all participants were provided with a thank you letter containing details on national support services linked to topics included in the survey. Participants were able to complete the survey in either Welsh or English language and all survey materials were provided in both languages. A total of 1,094 surveys were completed, with 45% of eligible households invited to participate taking part.

The questionnaire

The survey questionnaire was developed by the research team at Public Health Wales and Bangor University and used existing and validated questions where possible. It asked about participants' demographics, living situation, social and health-related behaviours, physical and mental health, and use of health and care services. It then asked about exposure to a range of adverse experiences since the age of 60. These included seven forms of abuse: physical abuse, verbal abuse, sexual abuse, financial abuse, controlling behaviour, constraint and medication abuse. Each type of abuse was measured using a single question adapted from existing tools that measure the abuse of older people. Existing tools typically use multiple questions for each abuse type [23] and consequently were too long to be included in this survey. Abuse questions did not specify the setting or perpetrator of each type of abuse and therefore enabled reporting of abuse by any perpetrator in any setting. A separate question was included in the survey asking participants whether they had felt scared of, or threatened by, a range of people since the age of 60 (see Appendix 2).

Other adverse experiences measured since the age of 60 included: struggling financially; feeling lonely or socially isolated; feeling overwhelmed by caregiving; having been unable to access required health or social care; bereavement; having experienced serious injury; and ageism (see Appendix 2 for the full range of questions asked and overall responses).

The questionnaire was piloted with the Age Cymru Consultative Forum and received feedback from key partners and networks.

Adverse experiences and health outcomes analysed in this report

In this report, we focus on exposure to any form of abuse (i.e. at least one of the seven types of abuse measured) and four other adverse experiences since the age of 60. These are: having struggled financially; having felt lonely or socially isolated; having felt overwhelmed by caregiving; and having been unable to access health and/or social care. We selected these experiences as they are modifiable and relate to different aspects of individuals' lives.

The health outcomes explored in this report are: self-rated bad or very bad health (termed self-rated bad health); tobacco smoking; drinking alcohol more than once a week; low mental well-being; high anxiety; having a mental health condition; having had suicidal thoughts or having self-harmed; self-neglect; low life satisfaction; and ageism experience. The time frame for most health outcomes was current. However, suicidal thoughts, self-harm and self-neglect were measured since the age of 60. Ageism was measured over the past 12 months using the WHO's 5-item Ageism Experiences Scale [24]. The survey also included two questions on perceived ageism since age 60 (see Appendix 2).

The questions asked and the responses used to categorise abuse, other adverse experiences and the health and well-being measures included in the study are shown in Appendix 1 (Tables A1 and A2).

Analysis

For this report, we excluded nine participants who had missing data or responded 'prefer not to say' to all questions on abuse and other adverse experiences since the age of 60. Thus, findings are based on an analytical sample of 1,085 participants.

All analyses were conducted using IBM SPSS version 24. Analyses presented in the main report and Appendix 1 use unweighted data. Initial analyses present frequencies of exposure to abuse and other adverse experiences since age 60 and bivariate relationships between these experiences using chi squared analysis. Chi squared analysis is also used to measure relationships between each health outcome and abuse, other adversities and participant demographics. For each health outcome, two multivariate analyses were run using binary logistic regression. The first (model one) included participant demographics and exposure to abuse since age 60. The second (model two) also included exposure to the four other adverse experiences. Results with p-values less than 0.05 were considered statistically significant. The full findings from bivariate and multivariate analyses are provided in Appendix 1 (Tables A3 to A12), with key results presented in the findings section of this report.

In Appendix 2, we provide overall responses to all survey questions using the full sample of 1,094 participants. Frequencies are presented both unweighted and weighted to the demographics of the Welsh national population aged 60 years and over by age group, sex and quintile of residential deprivation (see Appendix 1). It should be noted that the survey only included residents that lived in households and therefore does not represent those living in care homes or other settings. It should also be noted that overall unweighted percentages in Appendix 2 vary slightly from those presented in this report due to the difference in sample size.

Ethical approval

The study was reviewed by the Public Health Wales Research and Development Office and ethical approval was granted by the Schools of Medical and Health Sciences Academic Research Ethics Committee, Bangor University (reference: 0589). All interviewers followed the Market Research Society Code of Conduct.

Sample

Table 1 shows the demographic breakdown of the analytical sample (n=1,085) with a comparison to the demographics of the Welsh population aged 60 years and over. The sample included a smaller proportion of 60 to 69 year olds (38.4% compared with 43.6% nationally) and a greater proportion aged 80 years and over (23.9% compared with 20.3% nationally). The proportion of the sample residing in the most deprived quintile was also slightly higher than in the national population (18.3% compared with 15.1% nationally).

Table 1: Demographics of the analytical sample (n=1,085) and comparison to the Welsh national population aged 60 years and over

	Analytical sample	National population
Age group (years)		
60 to 69	38.4%	43.6%
70 to 79	37.7%	36.1%
80 or over	23.9%	20.3%
Sex		
Female	53.5%	53.3%
Male	46.3%	46.7%
Other	Less than 1.0%	-
Deprivation quintile		
1 (most deprived)	18.3%	15.1%
2	18.8%	18.5%
3	20.3%	21.2%
4	22.2%	22.9%
5 (least deprived)	20.4%	22.3%
Ethnicity		
White	98.4%	98.4%
Other than white	1.6%	1.6%
Health board		
Aneurin Bevan University Health Board	18.7%	18.1%
Betsi Cadwaladr University Health Board	23.1%	24.3%
Cardiff and Vale University Health Board	13.5%	12.5%
Cwm Taf Morgannwg University Health Board	11.8%	13.3%
Hywel Dda University Health Board	15.1%	14.4%
Powys Teaching Health Board	5.6%	5.4%
Swansea Bay University Health Board	12.2%	11.9%

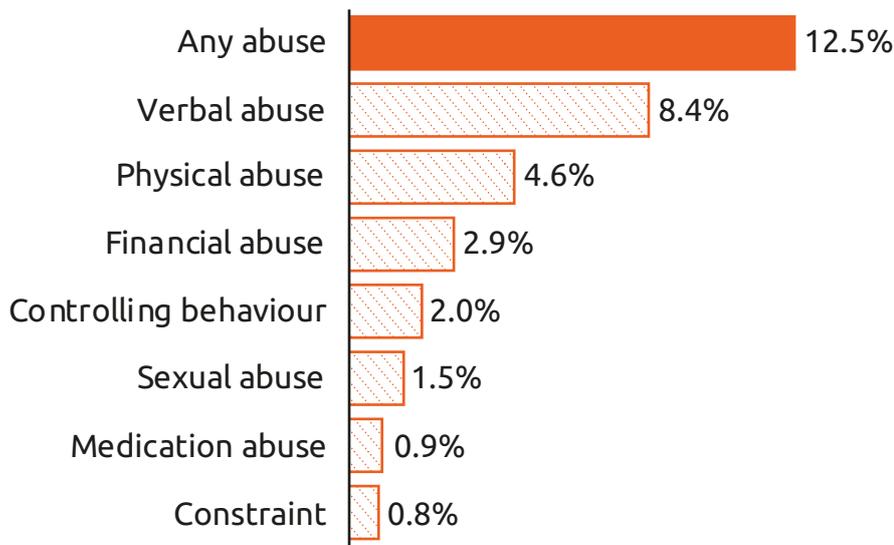
Note: percentages may not add to 100% due to rounding. National population ethnicity figures are calculated from Census 2021 data using counts for individual year of age at local authority level. Counts are rounded to the nearest 5 and counts under 10 are excluded, thus figures are approximate. See: [England and Wales Census 2021 - Ethnic group by age and sex - Ethnic group by age and sex at country level for England and Wales - UK Data Service CKAN](#). For details on weighting see Appendix 1.

Findings

Exposure to abuse since the age of 60

Participants were asked whether they had experienced seven types of abuse since the age of 60 (see Appendix 1, Table A1 for questions used to measure each type of abuse). Overall, 12.5% reported at least one of these abuse types, with the most common being verbal abuse (8.4%) followed by physical abuse (4.6%; Figure 2). Of those that reported abuse, over half (58.8%) reported one type of abuse, 24.3% reported two types and 16.9% reported three or more types.

Figure 2: Proportion of participants reporting abuse since the age of 60



Exposure to other adverse experiences since the age of 60

Participants were also asked how often, if at all, they had faced a range of other adverse experiences since the age of 60, with those responding 'some of the time' or more frequently categorised to having experienced each adversity (Figure 3; see Appendix 1, Table A1 for questions asked). Almost a third (30.0%) reported having been unable to access the health (27.7%) and/or social (14.7%) care they needed. A fifth (20.7%) had felt lonely or socially isolated, 19.0% had struggled financially, and 12.7% had felt overwhelmed by caregiving responsibilities.

Figure 3: Proportion of participants reporting other adverse experiences since the age of 60



Demographic distribution of abuse and other adverse experiences since the age of 60

Table 2 shows the proportion of participants reporting abuse and other adverse experiences since the age of 60 by age group, sex and residential deprivation quintile. Analyses by ethnicity were not undertaken due to low numbers in other than white ethnic groups (see Table 1).

The proportions reporting abuse, having been unable to access health or social care and having struggled financially varied significantly by age group (Table 2). Abuse was reported more by 60 to 69 year olds and 70 to 79 year olds than those aged 80 years and over, while being unable to access health or social care and struggling financially was reported more by 60 to 69 year olds than older age groups. Being overwhelmed by caregiving was the only adverse experience that varied by sex, being reported more by females (16.9%) than males (7.8%). Being unable to access health or social care and having struggled financially were both significantly associated with deprivation, being reported most by participants in the most deprived quintile of residence and least by those in the least deprived quintile. Having felt lonely or socially isolated followed a similar pattern but the variation did not reach significance.

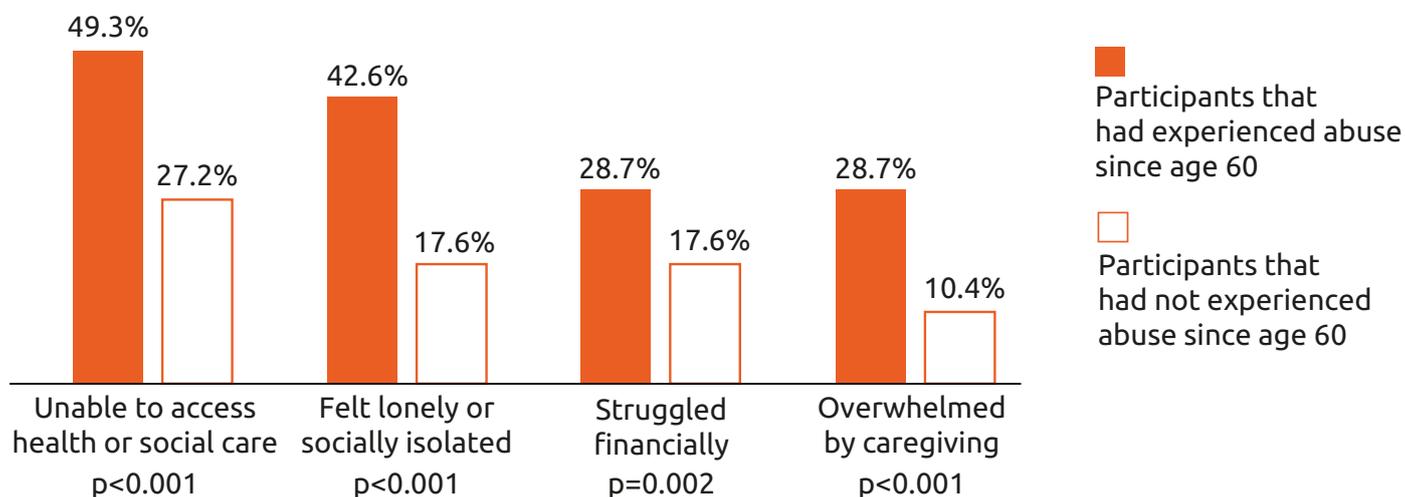
Table 2: Proportion of participants reporting abuse and other adverse experiences since the age of 60, by participant demographics

	 Experienced abuse	 Unable to access health or social care	 Felt lonely or socially isolated	 Struggled financially	 Overwhelmed by caregiving
Age group (years)					
60 to 69	13.7%	36.0%	19.2%	24.7%	15.3%
70 to 79	15.4%	26.7%	20.5%	16.4%	11.0%
80 or over	6.2%	25.5%	23.6%	13.9%	11.2%
χ^2	13.107	11.791	1.870	15.013	4.222
p	0.001	0.003	0.393	<0.001	0.121
Sex					
Female	12.6%	30.7%	22.2%	20.5%	16.9%
Male	12.4%	28.9%	18.9%	17.1%	7.8%
χ^2	0.014	0.419	1.804	2.009	20.273
p	0.907	0.518	0.179	0.156	<0.001
Deprivation quintile					
(most deprived) 1	13.6%	38.7%	27.1%	34.7%	14.6%
2	10.8%	30.4%	19.1%	25.0%	13.7%
3	14.5%	28.2%	23.2%	15.5%	10.9%
4	12.0%	31.1%	18.7%	16.2%	13.3%
(least deprived) 5	11.8%	22.2%	16.3%	5.9%	11.3%
χ^2	1.750	14.127	9.367	64.321	1.913
p	0.782	0.007	0.053	<0.001	0.752

Relationships between abuse and other adverse experiences since the age of 60

Participants who reported abuse since the age of 60 were more likely to also report other adverse experiences (Figure 4). For example, 42.6% of those that reported abuse also reported having felt lonely or socially isolated compared with 17.6% of those not reporting abuse.

Figure 4: Proportion of participants reporting other adverse experiences since the age of 60, by exposure to abuse



Significant associations were also seen between all other combinations of adverse experiences (Table 3). For example, half (51.0%) of those that had struggled financially also reported being unable to access health or social care services, compared with a quarter (25.0%) of those that had not struggled financially. Over a third (37.7%) of those that had been overwhelmed by caregiving reported feeling lonely or socially isolated, compared with 18.3% of those that did not report this experience. Overall, 53.6% of participants reported at least one of the five adverse experiences measured.

Table 3: Proportion of those reporting adverse experiences since the age of 60 that also reported other adverse experiences

Since the age of 60:		Proportion also reporting:				
		Experienced abuse	Unable to access health or social care	Felt lonely or socially isolated	Struggled financially	Overwhelmed by caregiving
Unable to access health or social care	Yes	20.6%	-	33.5%	32.3%	21.5%
	No	9.1%	-	15.3%	13.3%	8.9%
Felt lonely or socially isolated	Yes	25.8%	48.4%	-	37.3%	23.1%
	No	9.1%	25.1%	-	14.2%	10.0%
Struggled financially	Yes	18.9%	51.0%	40.8%	-	24.8%
	No	11.0%	25.0%	16.0%	-	9.9%
Overwhelmed by caregiving	Yes	28.3%	50.7%	37.7%	37.0%	-
	No	10.2%	26.9%	18.3%	16.4%	-

Note: all p values significant at p<0.001, except struggled financially and abuse, p=0.002.

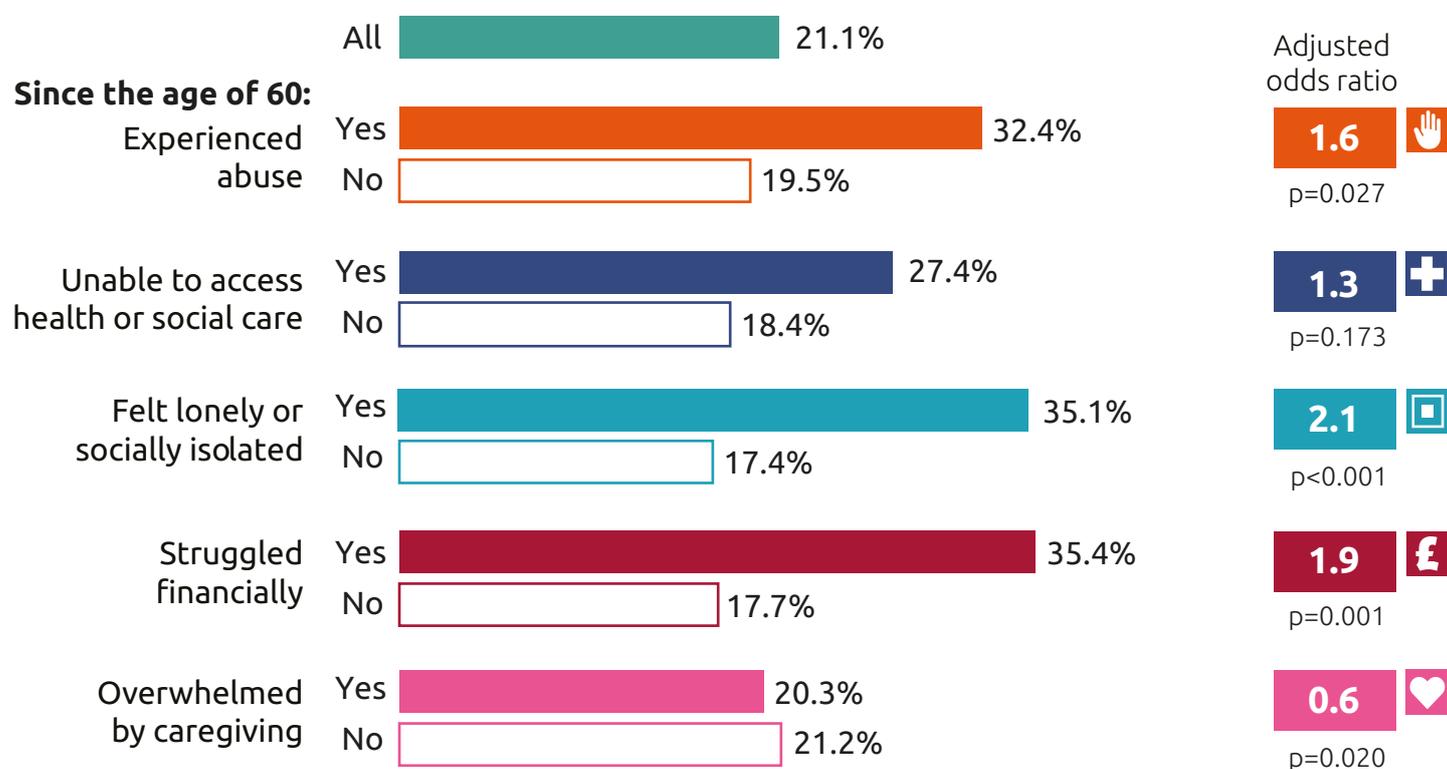
Self-rated bad health

Participants were asked 'How is your health in general?', with response options of very good, good, fair, bad and very bad. A fifth (21.1%) of participants had self-rated bad health (including bad and very bad health). The proportion with self-rated bad health increased with deprivation, from 13.6% in the least deprived quintile to 30.2% in the most deprived quintile (see Appendix 1, Table A3). It was highest in 70 to 79 year-olds (24.7%) and lowest in those aged 80 years and over (17.0%), with no significant difference by sex.

The proportion with self-rated bad health was significantly higher in those that had experienced abuse and all other adverse experiences except for having been overwhelmed by caregiving. Around a third of those experiencing abuse (32.4%), having felt lonely or socially isolated (35.1%) or struggling financially (35.4%) since the age of 60 had self-rated bad health, compared with less than a fifth of those not reporting these experiences (Figure 5).

In multivariate analysis, controlling initially for demographics (model one), abuse was associated with a 2.0 times increased likelihood of self-rated bad health (compared with no abuse, $p=0.001$; Appendix 1, Table A3). An independent relationship between abuse and self-rated bad health remained when other adverse experiences were accounted for (model two; adjusted odds ratio 1.6, $p=0.027$; Figure 5). Having struggled financially and having felt lonely or socially isolated were both independently associated with around a two times greater likelihood of self-rated bad health (compared with those not reporting these experiences; Figure 5). There was no independent association with access to health or social care. However, reporting having been overwhelmed by caregiving was associated with a reduced likelihood of self-rated bad health. A strong independent relationship also remained with deprivation (Appendix 1, Table A3).

Figure 5: Proportion of participants with self-rated bad health, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A3 for full data.

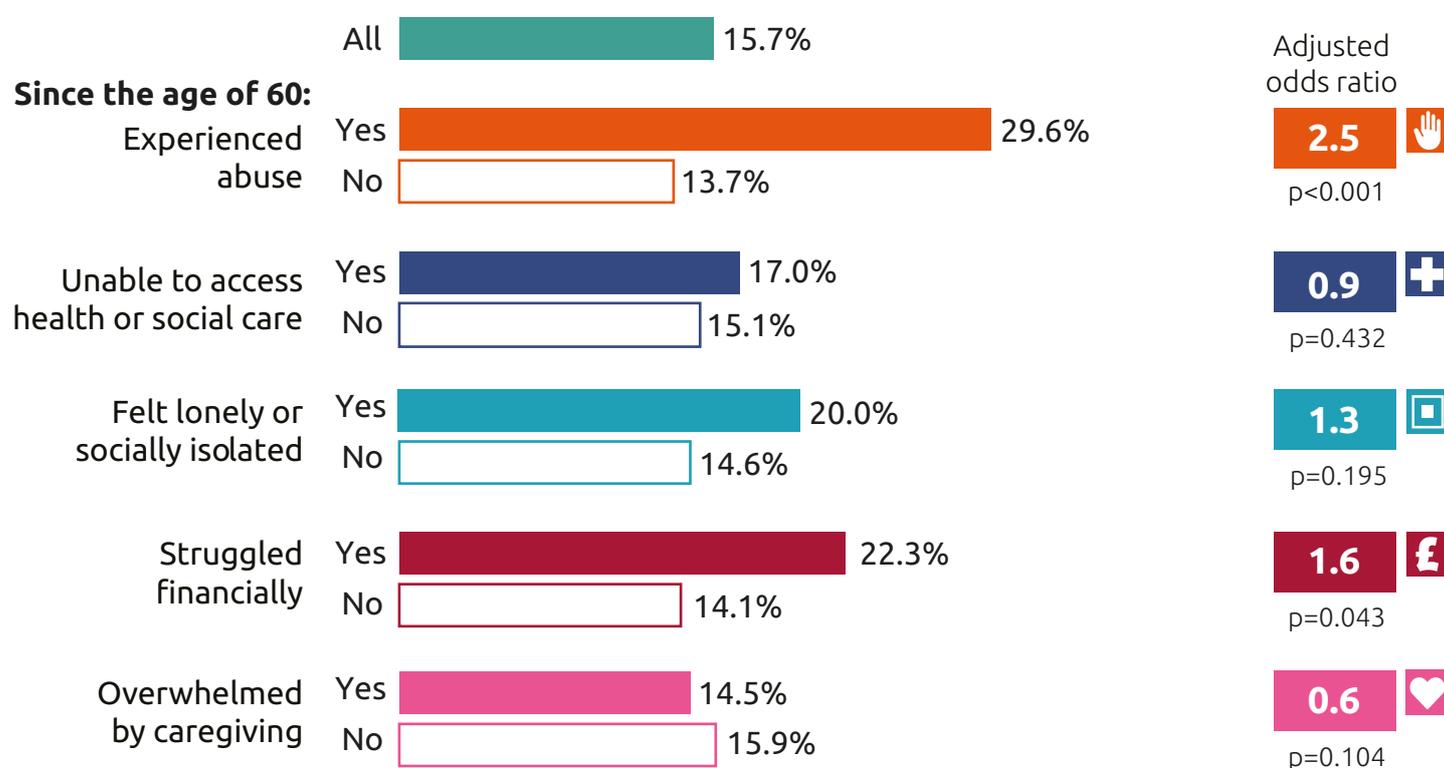
Tobacco smoking

Around one in six participants (15.7%) reported currently smoking tobacco (termed here smoking; see Appendix 1, Table A2 for question asked). The proportion reporting smoking was higher in males (19.6%) than females (12.2%) and reduced with age, from 21.1% in 60 to 69 year olds to 5.4% in those aged 80 years and over. While smoking was more common among those resident in more deprived quintiles, the variation across quintiles was not significant (see Appendix 1, Table A4).

Over a quarter (29.6%) of those who had experienced abuse since the age of 60 reported smoking, compared with 13.7% of those who did not report abuse. Smoking was also more common among those who reported having struggled financially and having felt lonely or socially isolated (Figure 6). However, there was no association between smoking and either being unable to access health or social care or being overwhelmed by caregiving.

Controlling initially for demographics in multivariate analysis (model one), having experienced abuse was associated with a 2.5 times increased likelihood of smoking (compared with no abuse, $p < 0.001$, Appendix 1, Table A4). This strong independent relationship between abuse and smoking remained when other adverse experiences were accounted for (model two; Figure 6). Having struggled financially since the age of 60 was the only other adverse experience that was independently associated with smoking (adjusted odds ratio 1.6, $p = 0.043$; Figure 6). The relationship with loneliness and social isolation was no longer significant. However, relationships between smoking and both male sex and younger age remained (Appendix 1, Table A4).

Figure 6: Proportion of participants reporting current tobacco smoking, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A4, for full data.

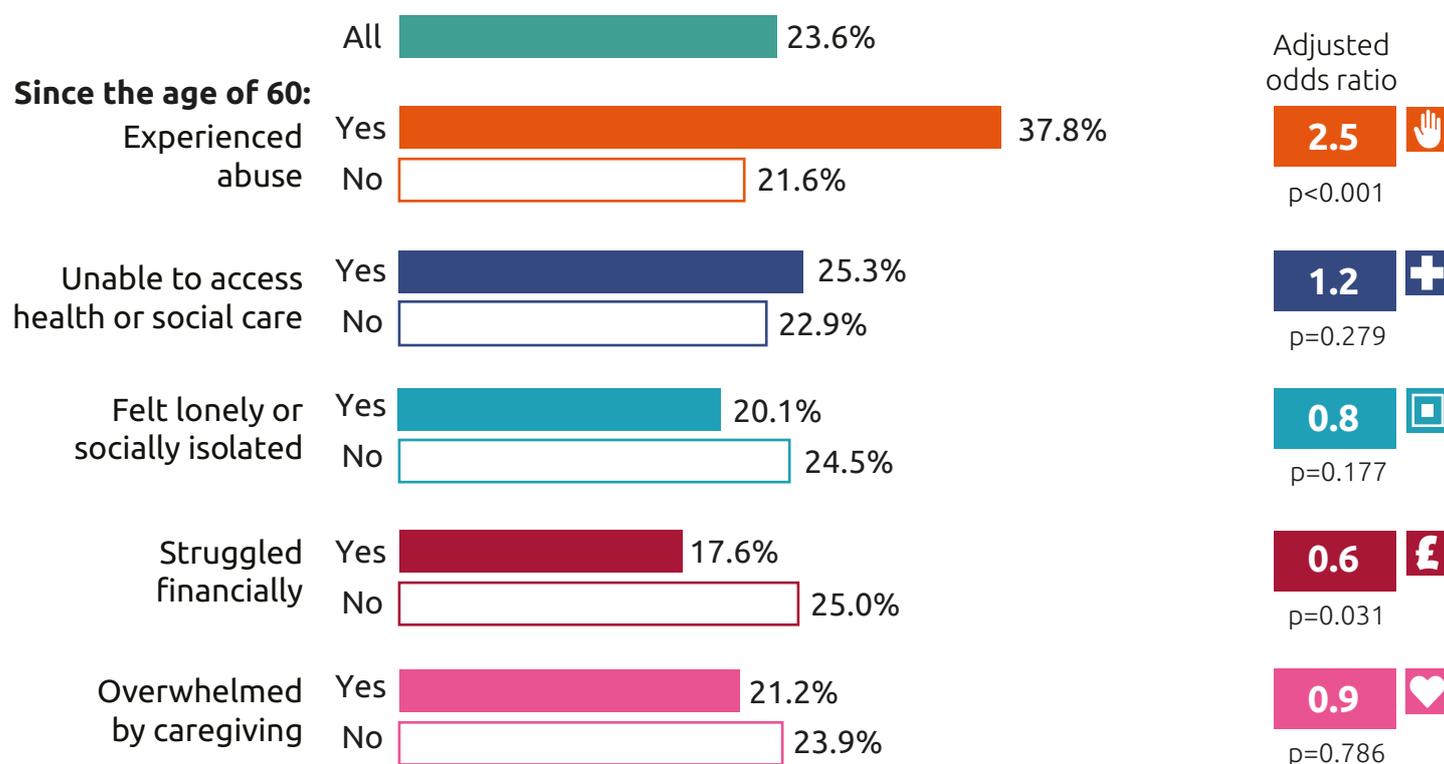
Drinking alcohol more than once a week

Participants were asked how often they had a drink containing alcohol. Almost a quarter (23.6%) reported drinking alcohol more than once a week (31.2% never drank). The proportion reporting drinking more than once a week was substantially higher in males (32.7%) than females (15.9%) and reduced with age, from 28.3% in 60 to 69 year-olds to 18.1% in those aged 80 years and over. There was no significant variation by deprivation (see Appendix 1, Table A5).

Over a third (37.8%) of those who had experienced abuse since the age of 60 reported drinking more than once a week, compared with 21.6% of those not reporting abuse. Drinking more than once a week was less common among those who reported having struggled financially since the age of 60. However, there was no association with the other adverse experiences measured (Figure 7).

In multivariate analysis, controlling initially for demographics, having experienced abuse was associated with a 2.3 times increased likelihood of drinking more than once a week (compared with no abuse, $p < 0.001$; model one; Appendix 1, Table A5). When other adverse experiences were accounted for (model two), adjusted odds associated with abuse rose to 2.5 (Figure 7). Having struggled financially since the age of 60 was associated with a reduced likelihood of drinking more than once a week (adjusted odds ratio 0.6, $p = 0.031$; Figure 7). There were no independent relationships with other adverse experiences. However, relationships between alcohol use and both male sex and younger age remained (Appendix 1, Table A5).

Figure 7: Proportion of participants reporting drinking alcohol more than once a week, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A5 for full data.

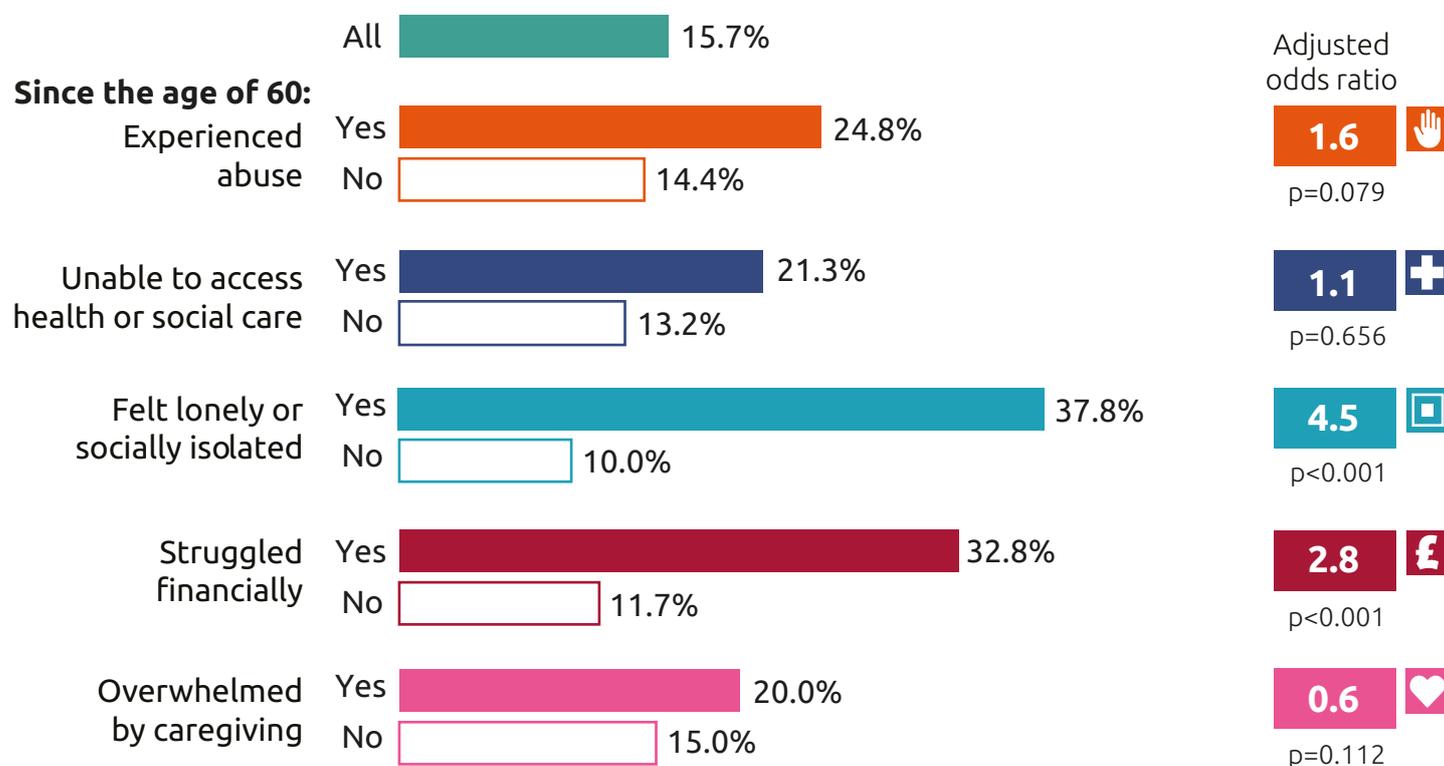
Low mental well-being

Mental well-being was measured using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS [25]). Responses to the seven scale items were summed and converted to metric scores in line with guidance. Participants with scores more than one standard deviation below the mean were categorised as having low mental well-being (15.7%; mean 24.2, standard deviation 4.5; low mental well-being, below 19.7). The proportion with low mental well-being varied significantly by age, sex and deprivation, being highest in the oldest age group (aged 80 years and over, 21.2%), females (18.9%) and participants living in more deprived quintiles (second most deprived, 23.5%; Appendix 1, Table A6).

Low mental well-being was significantly higher in those that had experienced abuse (24.8%, compared with 14.4% of those not reporting abuse) and other adverse experiences except for being overwhelmed by caregiving. Around a third of those who reported feeling lonely or socially isolated (37.8%) or struggling financially (32.8%) since the age of 60 had low mental well-being (Figure 8).

When controlling initially for demographics in multivariate analysis, abuse was associated with a 2.3 times increased likelihood of low mental well-being (compared with no abuse, $p < 0.001$; model one; Appendix 1, Table A6). When other adverse experiences were accounted for, the odds associated with abuse remained elevated but did not reach significance (model 2, Figure 8). Having felt lonely or socially isolated had the strongest association with low mental well-being (adjusted odds ratio 4.5, $p < 0.001$), with odds also substantially increased in those that had struggled financially (Figure 8). There were no independent relationships with access to services or being overwhelmed by caregiving. However, relationships with older age, female sex and living in the second most deprived quintile remained (Appendix 1, Table A6).

Figure 8: Proportion of participants with low mental well-being, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A6 for full data.

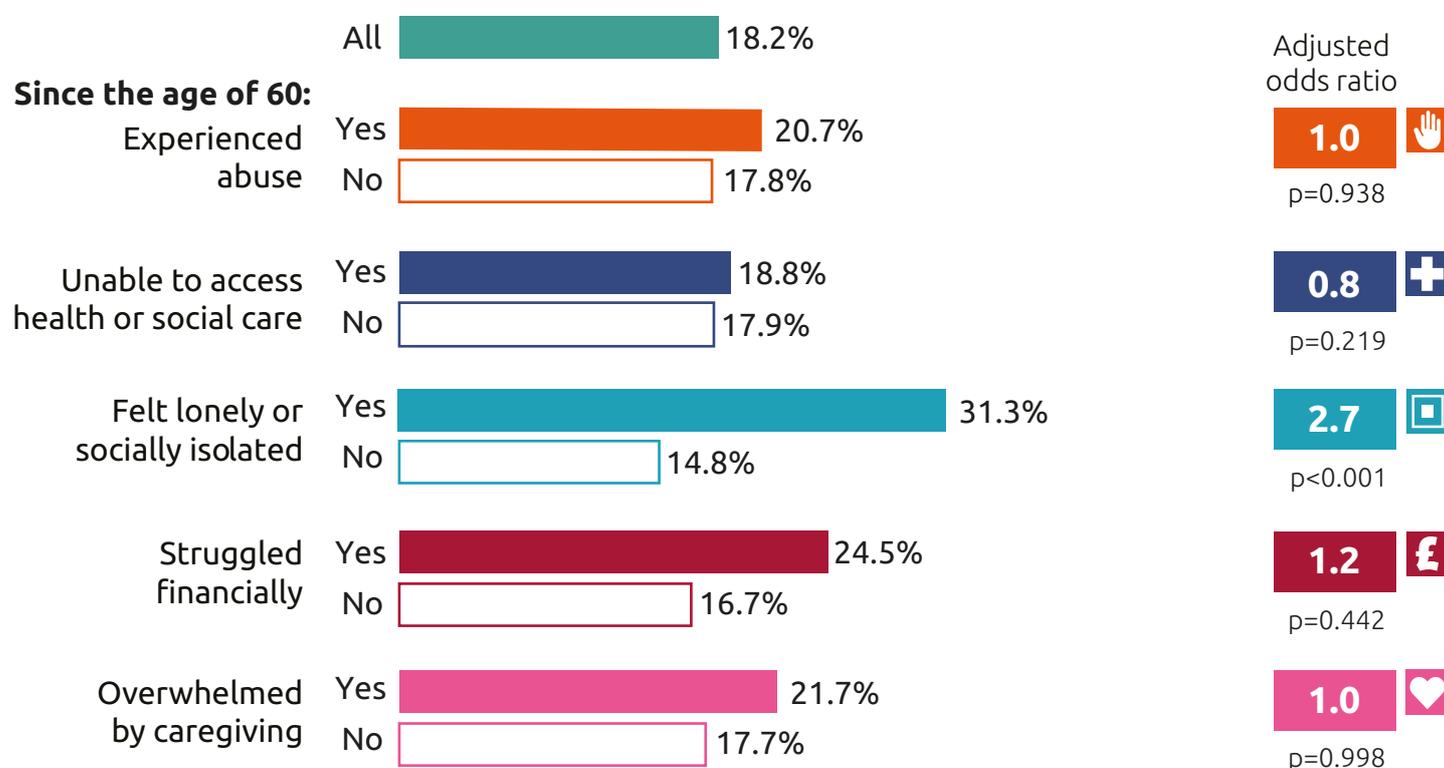
High anxiety

Participants were asked how anxious they had felt on the day before the survey, using a scale where 0 was 'not at all anxious' and 10 was 'completely anxious'. This question is one of four questions used to measure personal well-being by the Office for National Statistics (ONS). In line with ONS categorisations, responses of 6 to 10 were categorised as high anxiety. Overall, 18.2% of participants reported high anxiety (47.8% reported very low anxiety). The proportion reporting high anxiety varied significantly by deprivation, ranging from 25.6% of those living in the second most deprived quintile to 12.3% of those living in the least deprived quintile. There were no significant differences by age group or sex (Appendix 1, Table A7).

Participants that reported having felt lonely or socially isolated, or who had struggled financially, since the age of 60 were significantly more likely to report high anxiety than those that did not report these experiences (Figure 9). However, there was no significant association between high anxiety and reporting abuse or other adverse experiences.

When controlling for demographics in multivariate analysis, exposure to abuse showed no significant association with high anxiety (adjusted odds ratio 1.2, $p=0.359$; model one; Appendix 1, Table A7). When other adverse experiences were included, reporting loneliness and social isolation was found to be associated with a 2.7 times greater likelihood of high anxiety ($p<0.001$; model two; Figure 9). There were no independent relationships with other adverse experiences. The increased likelihood of high anxiety remained substantially elevated in those living in the second most deprived quintile (adjusted odds ratio 2.4, $p=0.001$), compared with those living in the least deprived quintile (Appendix 1, Table A7).

Figure 9: Proportion of participants reporting high anxiety, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A7 for full data.

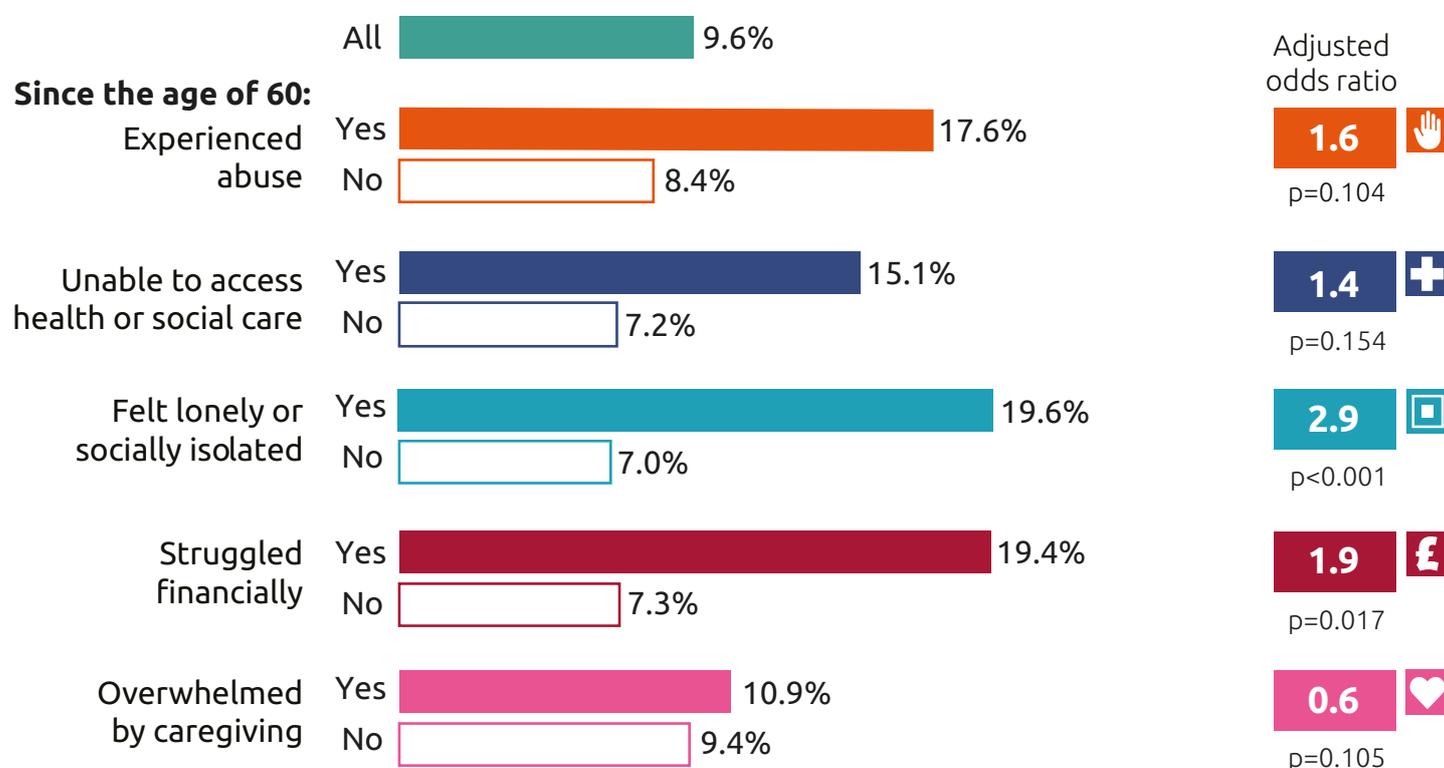
Having a mental health condition

Participants were asked if they had a range of health conditions, including a mental health condition. One in ten (9.6%) participants reported having a mental health condition. This proportion was substantially higher in 60 to 69 year olds than in older age groups (17.7%, falling to 3.1% in those aged 80 years and over). There were no significant differences by sex or deprivation (Appendix 1, Table A8).

The proportion reporting a mental health condition was significantly higher among those that had experienced abuse (17.6%) and all other adverse experiences except for being overwhelmed by caregiving. Around a fifth of those who reported feeling lonely or socially isolated (19.6%) or struggling financially (19.4%) since age 60 reported having a mental health condition (Figure 10).

In multivariate analysis, controlling initially for demographics, abuse was associated with a 2.2 times increased likelihood of having a mental health condition (compared with no abuse, $p=0.004$; model one; Appendix 1, Table A8). When other adverse experiences were accounted for (model two), the odds associated with abuse remained elevated (adjusted odds ratio 1.6, Figure 10) but did not reach significance. Having felt lonely or socially isolated was associated with 2.9 times greater likelihood of having a mental health condition ($p<0.001$), and struggling financially with a 1.9 times greater likelihood, compared with those who did not report these experiences ($p=0.017$; Figure 10). There was no significant relationship with access to care. Being overwhelmed by caregiving showed lower odds of having a mental health condition, although the relationship did not reach significance. Adults aged 60 to 69 years remained significantly more likely to report a mental health condition than those in the older age groups (Appendix 1, Table A8).

Figure 10: Proportion of participants reporting a mental health condition, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A8 for full data.

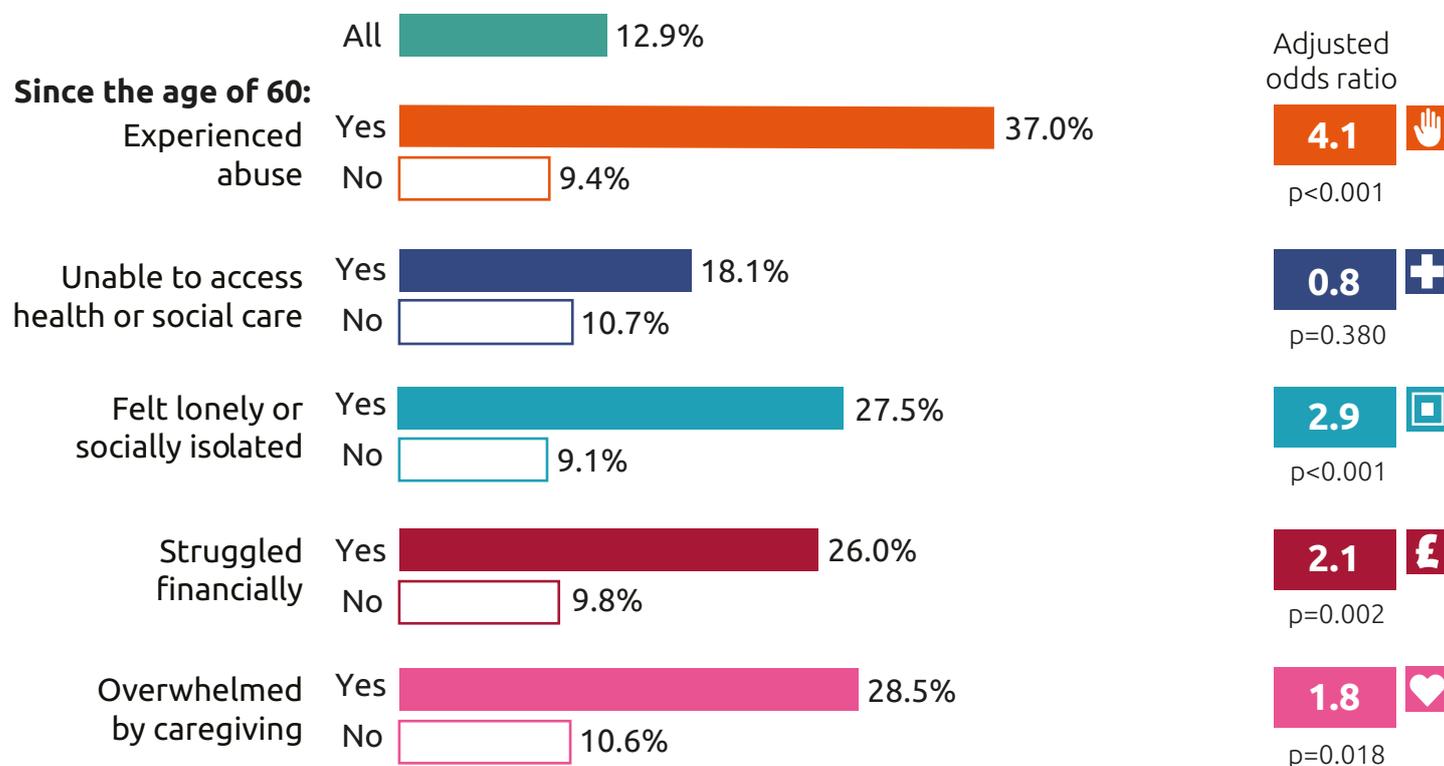
Suicidal thoughts or self-harm

Participants were asked if, since the age of 60, they had ever had thoughts about taking their own life, and if they had ever deliberately harmed themselves in any way but not with the intention of killing themselves (see Appendix 1, Table A2 for full questions). Overall, 12.9% reported having had any suicidal thoughts (12.6%) or having self-harmed (1.0%). While most of those reporting suicidal thoughts said these were not serious thoughts they would ever act upon, around 4% of participants had seriously considered or attempted suicide. The proportion reporting suicidal thoughts or self-harm reduced with age, from 19.5% of 60 to 69 year-olds to 4.7% of those aged 80 years or over. There were no significant differences by sex or deprivation quintile (Appendix 1, Table A9).

Reporting suicidal thoughts or self-harm was significantly higher in those that reported exposure to abuse or other adverse experiences (Figure 11). Over a third (37.0%) of those who had suffered abuse reported suicidal thoughts or self-harm compared with 9.4% of those who had not.

In multivariate analysis, controlling initially for demographics, exposure to abuse was associated with a 5.6 times increased likelihood of suicidal thoughts or self-harm ($p < 0.001$; model one; Appendix 1, Table A9). This strong relationship with abuse remained when other adverse experiences were accounted for (adjusted odds ratio 4.1, $p < 0.001$; model two; Figure 11). Loneliness or social isolation was associated with 2.9 times greater likelihood of suicidal thoughts or self-harm, and struggling financially and having been overwhelmed by caregiving both with around two times greater likelihood, compared with those who did not report these experiences (Figure 11). There was no independent association with being unable to access health or social care. However, relationships with age remained (Appendix 1, Table A9).

Figure 11: Proportion of participants reporting suicidal thoughts or self-harm, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A9 for full data.

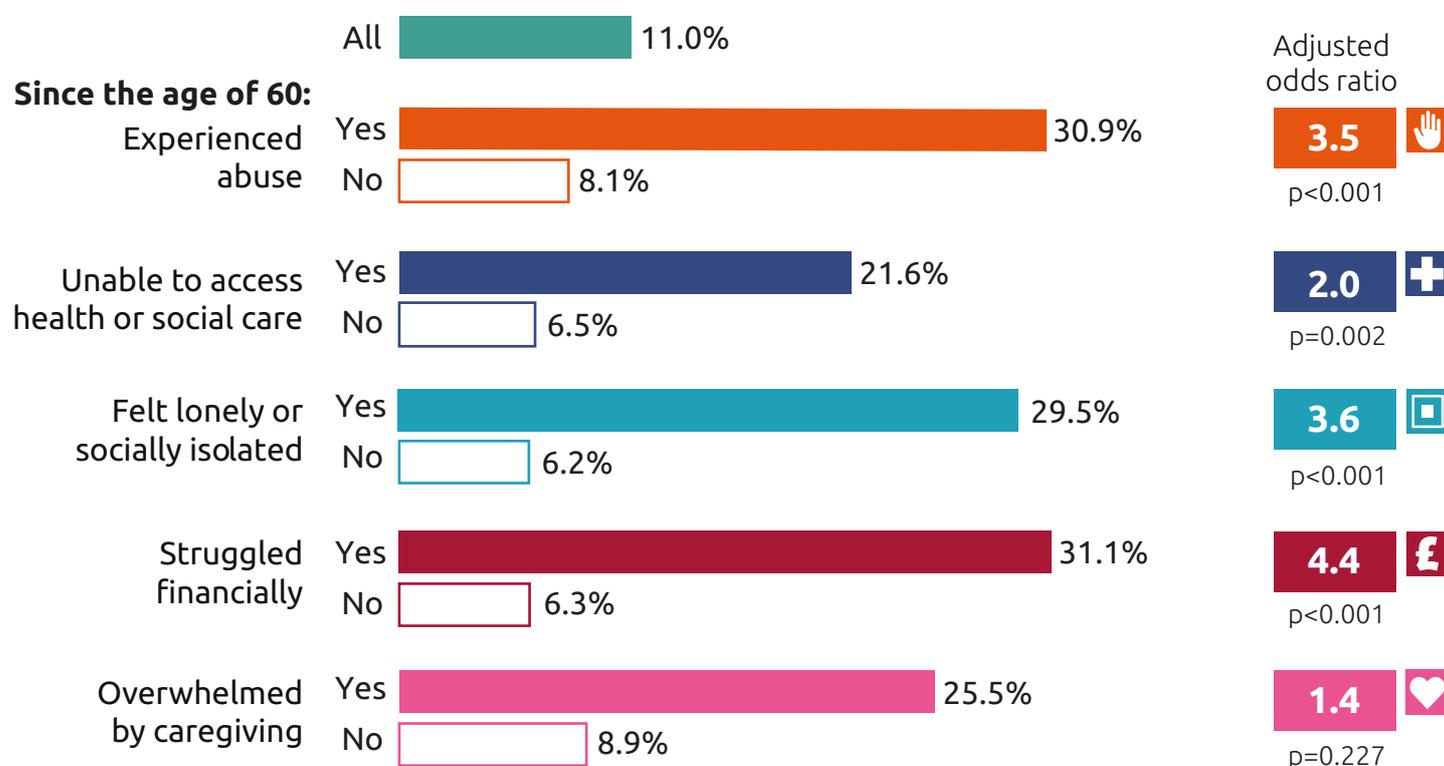
Self-neglect

Participants were asked how often, since the age of 60, they had not taken care of their appearance, their home or their health because they thought it was not worth taking care of. We categorised those responding 'sometimes' or more often as experiencing self-neglect. Overall, 11.0% of participants reported self-neglect. This proportion was higher among 60 to 69 year-olds (14.7%) than older adults. There was no variation by sex. While the proportion reporting self-neglect increased with deprivation (least deprived, 6.8%, most deprived 14.1%), the difference was not significant (see Appendix 1, Table A10).

The proportion reporting self-neglect was significantly higher in those reporting exposure to abuse or other adverse experiences since age 60. For example, almost a third of those reporting abuse (30.9%) or having struggled financially (31.1%) reported self-neglect, compared with 8.1% and 6.3% of those not reporting these experiences respectively (Figure 12).

In multivariate analysis, controlling initially for demographics, exposure to abuse was associated with a 5.4 times increased likelihood of self-neglect ($p < 0.001$, model one; Appendix 1, Table A10). A strong independent relationship between abuse and self-neglect remained when other adverse experiences were accounted for (adjusted odds ratio 3.5, $p < 0.001$; model two; Figure 12). Having felt lonely or socially isolated was independently associated with a similar increased likelihood of self-neglect, while having struggled financially was associated with more than four times increased odds. Being unable to access health or social care also doubled the odds of self-neglect, but there was no significant independent relationship with having been overwhelmed by caregiving. There was also no independent association with age (Appendix 1, Table A10).

Figure 12: Proportion of participants reporting self-neglect, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A10 for full data.

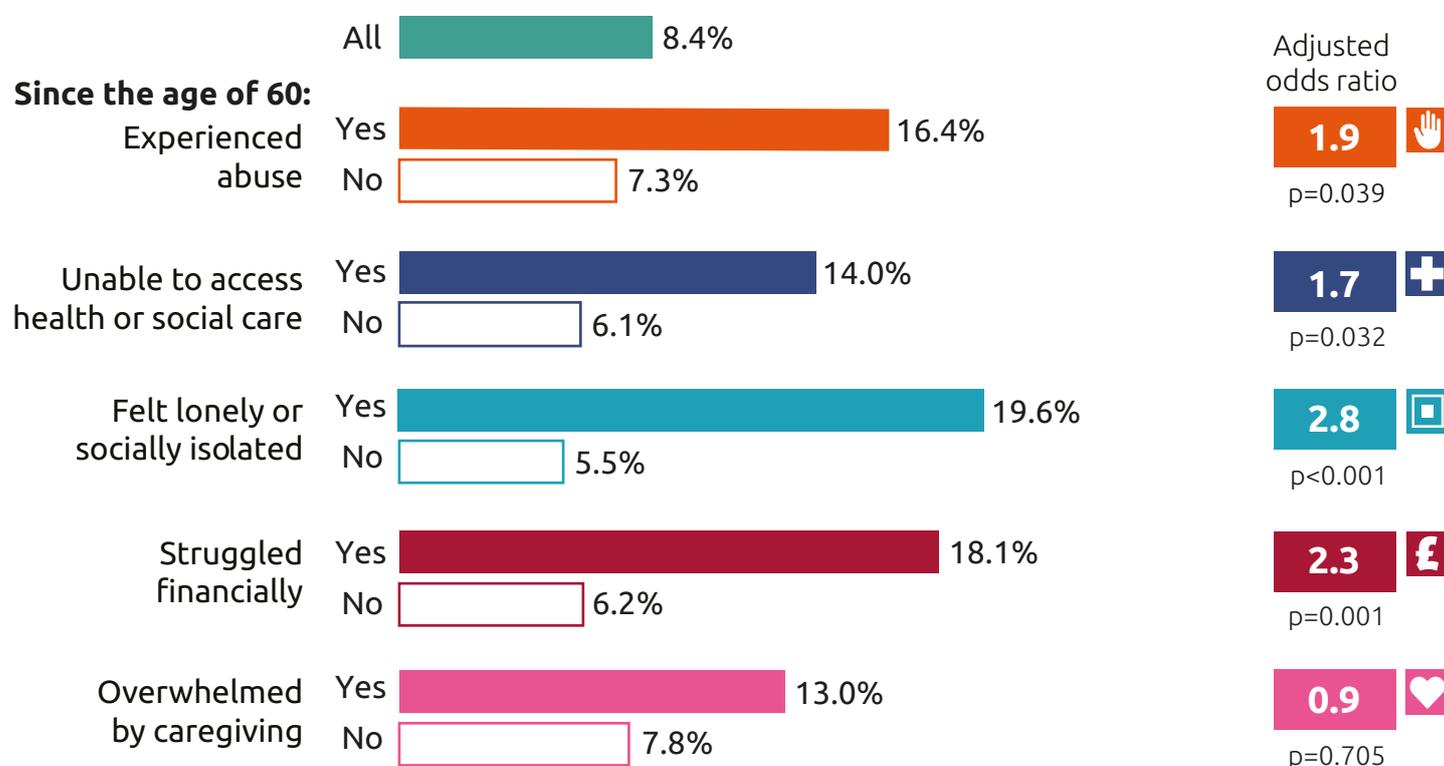
Low life satisfaction

Life satisfaction was measured using the ONS personal well-being question ‘Overall, how satisfied are you with your life nowadays?’, which uses an 11-point response scale from 0 (not at all) to 10 (completely). In line with ONS categorisations, responses of 0 to 4 were categorised as low life satisfaction. Less than one in ten (8.4%) participants reported low life satisfaction. The proportion with low life satisfaction varied by deprivation, being highest in those living in the second most deprived quintile (11.8%). There were no significant differences by sex (see Appendix 1, Table A11).

Low life satisfaction was significantly higher in those reporting exposure to abuse (16.4%, compared with 7.3% with no abuse) and other adverse experiences. Around a fifth who had been lonely or socially isolated (19.6%) or had struggled financially (18.1%) since the age of 60 had low life satisfaction, compared with 5.5% and 6.2% of those without these experiences, respectively (Figure 13).

In multivariate analysis, controlling for demographics, exposure to abuse was associated with a 2.8 times increased likelihood of low life satisfaction ($p < 0.001$; model one; Appendix 1, Table A11). An independent relationship between abuse and low life satisfaction remained when other adverse experiences were accounted for (model two; adjusted odds ratio 1.9; $p = 0.039$; Figure 13). Having felt lonely or socially isolated was associated with the greatest increased odds of low life satisfaction (adjusted odds ratio 2.8, $p < 0.001$), with having struggled financially and having been unable to access health or social care also independently increasing likelihood. There was no significant relationship with having been overwhelmed by caregiving. Associations with living in the second most deprived quintile remained, whilst those aged 80 years and over were twice as likely to report low life satisfaction than 60 to 69 year-olds (Appendix 1, Table A11).

Figure 13: Proportion of participants reporting low life satisfaction, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A11 for full data.

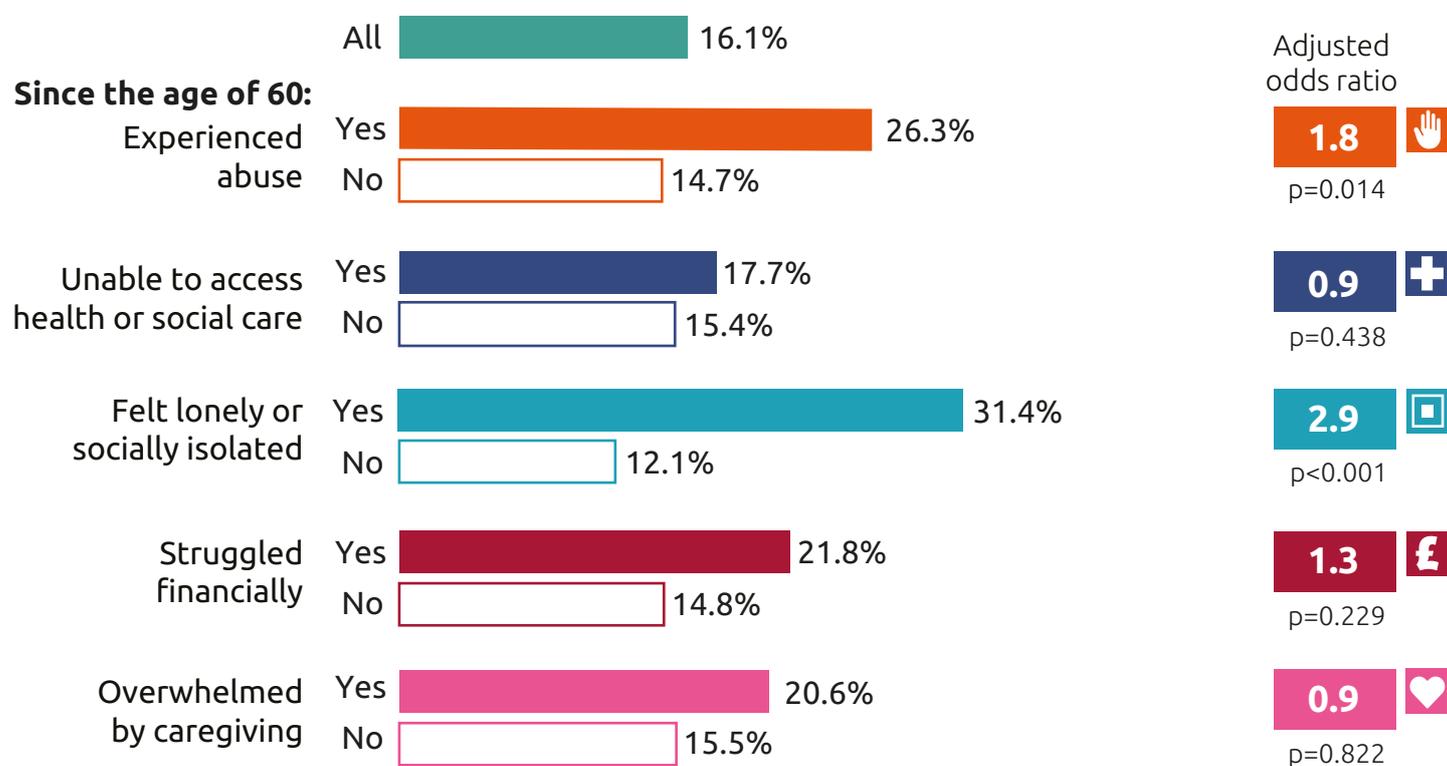
Ageism experience

Experience of ageism in the last 12 months was measured using the brief WHO Ageism Experiences Scale ([24]; see Box 1 and Appendix 2 for scale questions). Participants with scores greater than one standard deviation above the mean were categorised as having greater experience of ageism (16.1%; mean 2.4, standard deviation 0.9, ageism scores above 3.3). The proportion with greater ageism experience increased with age, from 12.9% in 60 to 69 year-olds to 22.0% in those aged 80 years and over. There was no significant difference by sex. Ageism experience was highest amongst participants living in the most deprived quintile (21.3%) and lowest amongst those living in the second least deprived quintile (11.4%), although the variation across quintiles did not reach significance (Appendix 1, Table A12).

Ageism experience was significantly increased in participants who reported exposure to abuse, struggling financially or feeling lonely or socially isolated since the age of 60. For example, greater ageism experience was reported by 31.4% of those that had felt lonely or socially isolated, compared with 12.1% of those that had not (Figure 14).

In multivariate analysis, controlling initially for demographics, abuse was associated with a 2.3 times increased likelihood of greater ageism experience ($p < 0.001$; model one; Appendix 1, Table A12). An independent relationship between abuse and ageism experience remained when other adverse experiences were included in the model (model two; adjusted odds ratio 1.8, Figure 14). Having felt lonely or socially isolated showed the strongest association with greater ageism experience (adjusted odds ratio 2.9), yet there was no independent relationship with having struggled financially, or other experiences. Participants aged 80 years and over were twice as likely to have greater ageism experience as those aged 60 to 69 years (Appendix 1, Table A12).

Figure 14: Proportion of participants reporting greater ageism experience, and adjusted odds ratios, by exposure to abuse and other adverse experiences since the age of 60



Note: adjusted odds ratios from multivariate model two, including age, sex, deprivation quintile, and abuse and other adverse experiences. See Appendix 1, Table A12 for full data.

Box 1: The WHO Ageism Experiences Scale

The WHO Ageism Experiences Scale was developed to measure individuals' experiences of ageism across multiple dimensions (i.e. stereotypes, prejudice and discrimination). The scale is available in 15- and 5-item formats and was launched in 2025. It is not a diagnostic instrument, and its scores have no clinical interpretation. However, the scale enables researchers, policymakers and practitioners to assess experience of ageism. Due to restrictions on survey length, for this study we used the 5-item version of the scale (see Appendix Table A2). We followed guidance to translate the scale into the Welsh language and to score participant responses [24].

As part of its development, a study measured the psychometric robustness of the 5-item WHO Ageism Experiences Scale in a UK sample of 402 adults aged 20 to 60 years [26]. The mean score across the sample was 1.75. Ageism experience varied by age, with scores being highest in young adulthood, decreasing through to the mid-40s then increasing again through older adulthood. Our findings suggest the experience of ageism continues to increase through older age, with mean scores in our sample rising from 2.21 in 60 to 69 year-olds, to 2.41 in 70 to 79 year-olds and 2.55 in those aged 80 years and over.

Further information and resources on the WHO Ageism Scale are available from the Global Campaign to Combat Ageism [22]. Since undertaking this survey, in collaboration with the Older People's Commissioner for Wales, we have completed a Welsh translation of the 15-item version of the WHO Ageism Experiences Scale. This has been used as part of the Public Health Wales Time to Talk Public Health survey ([27]; October 2025 survey) and its wider use across Wales is encouraged.

Discussion

Protecting health and well-being into later life is essential to enable older people to live and age well and to enhance the societal benefits of an increasing older population. Understanding how different experiences in later life relate to health and well-being can inform action to support healthy ageing.

This study explored how older adults' health and well-being relates to their exposure to abuse and four other later life adversities – loneliness or social isolation, struggling financially, poor access to health or social care, and being overwhelmed by caregiving. Half (53.6%) of all participants reported at least one of these five experiences since the age of 60. Those that reported one type were also more likely to report others. For example, 42.6% of those that had experienced abuse had also felt lonely or socially isolated, compared with 17.6% of those that had not experienced abuse.

Abuse

Little previous research has examined exposure to abuse in older adults in the Welsh general population. In this study, one in eight (12.5%) participants reported having experienced at least one form of abuse since the age of 60. The most common form of abuse was verbal abuse (8.4%), followed by physical (4.6%) and financial (2.9%) abuse. Over half (58.8%) of those that had experienced abuse reported more than one type. These figures likely under-represent exposure to abuse in older adults as our study focused on community-dwelling residents who were cognitively able to participate in the survey. It did not include those in care homes, other institutional settings or with cognitive impairment, which may increase vulnerability to abuse [28]. Further, responses may be affected by recall and reporting bias, and individuals who did not want to disclose sensitive information may have chosen not to participate (see Appendix 1 for further study limitations).

Despite these limitations, clear relationships were found between experiencing abuse since the age of 60 and poorer health and well-being. Abuse was associated with increased likelihood of all poorer health outcomes measured apart from high anxiety. For most outcomes, relationships with abuse were still significant when exposure to other adversities was accounted for. Further, abuse showed the strongest associations (of all adversities measured) with smoking, alcohol use and having had suicidal thoughts or self-harming.

One potential explanation for the relationship between abuse and alcohol and tobacco use may be their adoption or continuation as a coping mechanism; however, both can damage health [29]. The relationship between abuse and suicidal thoughts or self-harm mirrors the strong relationships seen between abuse and self-directed violence at other life stages [30,31]. Our study did not explore participants' exposure to violence prior to age 60. However, childhood abuse can increase the risk of violence throughout the life course [6], and for some individuals reporting abuse in later life, this may represent a continuation of abuse experienced throughout adulthood. Further research exploring the relationships between abuse in later life and previous exposure to violence would be beneficial. The Mental Health and Wellbeing Strategy (2025 to 2035) [32] and National Action Plan to Prevent the Abuse of Older People [4] recognise the role that abuse can have in poor mental health. Our findings add weight to the need for targeted services to address mental health challenges for older adults.



Loneliness and social isolation

Loneliness and social isolation can be key challenges for people in later life and their harmful impacts on health are increasingly recognised. The National Survey for Wales found that one in ten older people (aged 65 years and over) are lonely [33]. In our study, one in five participants reported having experienced loneliness or social isolation since the age of 60. This experience was strongly associated with all outcomes except alcohol and tobacco use. Further, of all adversities measured, it had the strongest associations with self-rated bad health, low mental well-being, high anxiety, having a mental health condition, low life satisfaction and ageism experience. These findings support the critical need for action to strengthen social connection in later life.

The WHO Commission on Social Connection is aiming to ensure loneliness and social isolation are recognised and resourced as global public health priorities. Its flagship report, published in 2025 [34], set out evidence for prevention and recommendations for action. To support this agenda, Public Health Wales has developed a national report summarising what is known about social connection in Wales [35]. This outlines the wide range of work already underway to improve social connection, including through Welsh Government's Connected Communities strategy for tackling loneliness and social isolation and building stronger social connections [21].



Struggling financially

The links between poverty and poorer health are well established, and one in six older people in Wales live in poverty [36]. In our study, 19.0% of participants reported having struggled financially since the age of 60. This experience was associated with all poorer health outcomes except high anxiety, ageism experience and alcohol use. For alcohol use, struggling financially actually reduced the likelihood of drinking more than once a week. However, there is a known 'alcohol harm paradox' whereby individuals in lower income groups are less likely to drink alcohol than those with higher income yet experience more alcohol-related harm [37].

Independent relationships between struggling financially and poorer health outcomes were seen even after accounting for residential deprivation; emphasising the importance of personal finances. The rapid rise in the cost of living seen following the COVID-19 pandemic placed financial pressure on people across Wales, with the greatest burden on those already living in poverty [38]. Older people can have limited opportunity to increase their finances and be particularly vulnerable to rising costs. Ensuring people have sufficient resources to access nutritious food, maintain warm homes and socially connect, for example, is critical to supporting their health and well-being. Specific recommendations for addressing poverty in older people in Wales have been set out by the Older People's Commissioner for Wales [36].



Being unable to access health or social care

Almost a third of participants said, since the age of 60, they had been unable to access health or social care services they needed. Access to services may be affected due to ongoing high waiting lists which have not recovered since the COVID-19 pandemic [39]. Despite links with several outcomes, being unable to access health or social care services was only independently related to self-neglect and low life satisfaction. Thus, experiences such as abuse, poverty, and loneliness and social isolation may be more important in driving poor health and likely contribute to difficulty accessing services. Stigma and lower trust in services associated with adversities such as abuse may also act as a barrier [40,41]. To increase engagement with services it is important people feel they are connected and safe, and that barriers are reduced. The Trauma-informed Wales framework

[5] is designed to help organisations and sectors in Wales support people affected by trauma. It underscores the need to recognise that adversity can happen at any age and supports sustained engagement to improve health outcomes for those affected.

The Primary Care Model for Wales [42] offers a whole-system approach to sustainable, accessible, place-based care, delivered through multi-professional teams. Public Health Wales' Prevention Based Health and Care Framework [43] complements this model, highlighting the need for prevention in health and social care systems. Along with meeting care and treatment needs, supporting access to services creates opportunities for professionals to identify adversities such as abuse and provide support (e.g. in line with 'ask and act' duties; see [44]). It also provides opportunities for referral to other services, including through social prescribing, which connects people to community assets that could benefit their health and well-being. Social prescribing can play a vital role in improving social connection, reducing isolation and providing pathways to a variety of support. A national framework for social prescribing was published by Welsh Government in 2024 [45].

Being overwhelmed by caregiving responsibilities

Unpaid caregivers are a critical source of support within families and communities and many older people provide this essential care. While caregiving experience per se was not examined in this study, a third of survey participants had been a main caregiver for someone with a long-term physical or mental health condition, or problems with daily living since age 60, and a quarter had had regular childcare responsibilities (Appendix 2). Around one in eight (12.7%) participants said they had been overwhelmed or burdened by caregiving responsibilities since age 60. In bivariate analyses, this experience was related to suicidal thoughts or self-harm, self-neglect and low life satisfaction. However, when other adversities were accounted for, associations only remained for suicidal thoughts and self-harm. Conversely, being overwhelmed by caregiving was associated with lower likelihood of self-rated bad health.

Being able to take on a caregiving role may necessitate better health, and caregiving can have benefits for the caregiver. For example, it may increase people's sense of purpose, strengthen their bonds with care recipients and prevent anxiety or guilt over the well-being of loved ones. However, for some it can impose substantial strain and costs. A British study found that caring for primary kin (particularly a spouse), living with the care recipient and greater caregiving intensity was related to lower psychological well-being [19]. We did not ask for details on the caregiving relationship that had left participants feeling overwhelmed. However, a future study could explore differences between caregivers who did and did not feel overwhelmed or burdened by this role.

Demographic differences

A greater proportion of females reported having been overwhelmed by caregiving than males, yet there were no sex differences for the other adversities measured, including abuse (Table 2). Gender norms may make it particularly hard for older males to disclose abuse, and it is important they are not overlooked in action to prevent abuse and support those affected by it.

The proportion reporting abuse, struggling financially and being unable to access health or social care tended to reduce with age. With abuse and poverty strongly linked to poorer health, this may reflect reduced healthy life expectancy and longevity in people that suffer these adversities (i.e. with earlier illness and death removing them from household survey samples). By the same effect, smoking, alcohol use, mental illness and suicidal thoughts or self-harm were all more likely in younger participants. Differences in language and stigma around mental health in older generations may also

affect their reporting. Conversely, older participants were more likely than younger participants to report ageism experience, low mental well-being and low life satisfaction.

Struggling financially and being unable to access health or social care were reported more by participants living in more deprived communities. Residential deprivation was also associated with self-rated bad health, low mental well-being and high anxiety, with these associations remaining after accounting for the five adversities.

Conclusions and recommendations for further research

The Age Friendly Wales strategy [1] aims to ensure that services and systems support older people to remain independent at home, stay connected to their communities and actively engage in society. Older people make substantial economic and social contributions to Wales through, for example, employment, unpaid care, volunteering, civic engagement, knowledge, skills, and spending and investment. In 2016, their contribution was estimated to have an annual economic value of £2.2 billion, with a projected increase to £3.5 billion by 2030 [46]. As our population ages, there is increasing reliance on older adults to be well and economically active. Our study shows that abuse, poverty, and loneliness and social isolation in later life all have strong, independent associations with poorer health. Preventing these experiences and supporting those affected by them should help to ensure that residents in Wales are able to live well for longer. Moreover, greater recognition of the roles played by older people in the economy, caregiving, community and family life is an important feature in creating a culture that is positive towards older people and consequently protective against their abuse, isolation and destitution.

While this study has provided an initial examination of the relationships between abuse, other adversities and health in later life, recommendations for further research include:

- Exploring the prevalence of abuse and other later life adversities at a population level, including older adults living in care homes and who may not be able to cognitively participate in a survey.
- Examining the nature of abuse (e.g. settings, perpetrators) experienced by older adults in the general population in Wales, along with risk and protective factors.
- Examining factors that increase adults' resilience to adversity in later life.
- Exploring the cumulative impact of adversities in later life in Wales on health and well-being, particularly abuse, poverty and loneliness and social isolation.
- Examining how abuse and other adversity across the life course relates to abuse and adversity in later life, to inform a life course approach to healthy ageing.
- Collating evidence on effective approaches to preventing abuse, poverty and loneliness and social isolation in later life to identify common approaches and components of approaches that offer benefits across multiple types of adversity.
- Building evidence on the effectiveness of responses to abuse and other adversity in Wales.

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Competing interests

Authors have no competing interests.

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Appendix 1: Additional methodology and data tables

Sampling: Stratified quota sampling was used to obtain a nationally representative sample, stratified by Health Board and deprivation quintile (based on the Welsh Index of Multiple Deprivation; WIMD [47]). The sampling unit was Lower Super Output Areas (LSOA; geographical areas with approximately 1,500 residents) with a target of six interviews per sampled LSOA. LSOAs in each Health Board were ranked by WIMD score and categorised into quintiles, then a random selection was drawn from each deprivation quintile in each Health Board to achieve a sample proportionate to population size. Households in each selected LSOA were randomly approached to take part. Quota targets were set for each Health Board by age, sex, ethnicity and deprivation quintile.

Data collection: Training was provided to survey interviewers from the procured professional market research company (DJS Research Ltd) to ensure interviews were conducted sensitively and objectively. A researcher observed a selection of interviews for quality control. Opt-in informed consent to participate was collected by interviewers as part of the survey script. No personal identifiable details were collected from the individual at any stage during the recruitment process or interview. Household visits were made on all days of the week between 10am and 8pm. Potential participants were also given the option for the interviewers to call back at a date or time more suitable to them. Addresses were visited up to five times before being removed from the sample and a record of contact was retained.

Data weighting: Data in Appendix 2 are weighted to the demographics of the Welsh national population aged 60 years and over by age group, sex and quintile of residential deprivation using mid-2020 population estimates for LSOAs by sex, age group [48] and deprivation quintile (WIMD; [47]). Due to small numbers in Wales reporting other than white ethnicity (see Table 1), weighting could not include ethnicity.

Limitations: There are several limitations that should be considered when interpreting findings from this study. The study only included residents of households that were cognitively able to participate in the survey and therefore does not represent older adults residing in care homes, in hospital or other residential settings, or those with cognitive impairment. Participation in the survey was voluntary, and it is not possible to identify or exclude bias created by refusal to participate. Data were self-reported, and some measures were retrospective (e.g. since the age of 60), and may be vulnerable to recall capacity, subjectivity, under-reporting of sensitive issues and individual reporting tendencies. However, participants were able to answer sensitive questions in the survey privately using computer assisted self-interviewing.

Some survey questions were developed by the research team or adapted from existing scales. However, questions were reviewed by subject experts and assessed by the Age Cymru Consultative Forum for understanding and accessibility. There were some differences between the national sample and demographics of the Welsh population (see Table 1), however estimates weighted to the Welsh population are provided in Appendix 2. Finally, causality between outcomes cannot be established due to the cross-sectional and retrospective survey methodology.

Appendix Table A1. Questions and qualifying responses measuring abuse and other adverse experiences

	Question	Qualifying responses (other response options)	PNTS, prefer not to say
Experienced abuse	All questions were preceded by the statement <i>"Since the age of 60, has anyone done any of the following to you..."</i>		
Physical abuse	Tried to hurt or harm you physically (e.g. by slapping, hitting, kicking or shoving you) Yes, once; yes, more than once (no; PNTS)		
Verbal abuse	Insulted you, humiliated you, belittled you, yelled at you or verbally threatened you Yes, more than once (no; yes, once; PNTS) <i>In line with other research measuring verbal abuse, our measure of more than once recognises that a single incident, while harmful, may not have the same effect as repeated exposure to verbal abuse</i>		
Sexual abuse	Sexually harassed or abused you, either verbally or physically (e.g. by talking to you in a sexual way that made you feel uncomfortable, touching you sexually against your will or forcing you to have sex) Yes, once; yes, more than once (no; PNTS)		
Financial abuse	Spent your money without your permission, prevented you from accessing money that should be yours, or taken money or property from you against your will (e.g. through stealing, or forcing or misleading you into giving it to them) Yes, once; yes, more than once (no; PNTS)		
Controlling behaviour	Isolated you from family or friends or been controlling of your behaviour (e.g. controlled who you see or speak to or what you do with your time against your wishes) Yes, once; yes, more than once (no; PNTS)		
Constraint	Physically restrained you in any way against your will (e.g. locked you in your room or house so you cannot leave, tied you in a chair) Yes, once; yes, more than once (no; PNTS)		
Medication abuse	Forced you to take medication against your will, or prevented you from taking medication or accessing health care when you needed it Yes, once; yes, more than once (no; PNTS)		
Any abuse	A qualifying response to any of the above questions		
Other adversities	All questions were preceded by the statement <i>"Since the age of 60, has anyone done any of the following to you..."</i>		
Struggled financially	Had too little money to pay for your household's essential needs (e.g. food, electricity, heating)? Some of the time; a lot of the time; almost all of the time (never; rarely; PNTS)		
Overwhelmed by caregiving	Felt overwhelmed or burdened by caregiving responsibilities? Some of the time; a lot of the time; almost all of the time (never; rarely; PNTS)		
Unable to access health or social care	<i>A qualifying response to either of the following questions:</i> Been unable to access the health care services you need? Been unable to access the social care services you need? Some of the time; a lot of the time; almost all of the time (never; rarely; PNTS)		
Felt lonely or socially isolated	Felt lonely or socially isolated? Some of the time; a lot of the time; almost all of the time (never; rarely; PNTS)		

Note: participants that responded 'prefer not to say' to all abuse questions were excluded.

Appendix Table A2. Questions and qualifying responses for outcome measures

	Question Qualifying responses (other response options categorised to 'no' [see note])
Self-rated bad health	How is your health in general? Bad; very bad (very good; good; fair)
Tobacco smoking	Do you currently smoke tobacco or use e-cigarettes/vapes? Yes, I smoke tobacco (yes, I use e-cigarettes/vapes; no, I used to smoke tobacco or use e-cigarettes/vapes but I do not anymore; no, I have never smoked tobacco or used e-cigarettes/vapes)
Drink more than once a week	How often do you have a drink containing alcohol? 2 to 4 times a week; 5 or more times a week (never; monthly or less; 2 to 3 times a month; once a week)
Low mental well-being	Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS®). Using SWEMWBS guidelines, scores for individual questions were summed and transformed into metric scores. Scores less than one standard deviation below the mean (mean 24.18; standard deviation 4.52)
High anxiety	On a scale where 0 is “not at all anxious” and 10 is “completely anxious”, overall, how anxious did you feel yesterday? Scores of 6 to 10 (scores of 0 to 5)
Mental health condition	Do you have any of the following conditions? Please tell me all that apply even if the condition is being managed with medication... A mental health condition Yes (not ticked) <i>See Appendix 2 for other conditions measured in the survey</i>
Suicidal thoughts or self-harm	Qualifying response to either question: Since the age of 60, have you ever had thoughts about taking your own life? Yes, but never serious thoughts I would ever act upon; Yes, seriously considered suicide but didn't act on those thoughts; Yes, seriously considered suicide and even planned how I would do it, but didn't actually make a suicide attempt; Yes, and have made a suicide attempt (no, never) Since the age of 60, have you ever deliberately harmed yourself in any way but not with the intention of killing yourself? Yes (no)
Self-neglect	Since the age of 60, how often have you... Not taken care of your appearance, your home or your health because you thought it was not worth taking care of? Some of the time; a lot of the time; almost all of the time (never; rarely)
Low life satisfaction	On a scale of 0 to 10, where 0 is “not at all” and 10 is “completely... overall, how satisfied are you with your life nowadays? Scores of 0 to 4 (scores of 5 to 10)
Ageism experience	WHO Ageism Experiences Scale 5-item version (see Appendix 2 for questions). Scores were summed according to guidelines. Scores less than one standard deviation below the mean (mean 2.37; standard deviation 0.86)

Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

Note: participants who responded prefer not to say or chose not to answer a question were classed as having missing data for each outcome (See Appendix 2 for n values).

Appendix Table A3: Self-rated bad health: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Self-rated bad health (including responses of bad and very bad)								
		%	Proportion		AOR	Model 1		AOR	Model 2	
			χ^2	p		95% CIs	p		95% CIs	p
Age group (years)	60 to 69	20.1%			Ref		0.061	Ref		0.032
	70 to 79	24.7%			1.37	0.98-1.92	0.068	1.46	1.03-2.07	0.034
	80 or over	17.0%	6.032	0.049	0.89	0.59-1.34	0.573	0.91	0.59-1.40	0.670
Sex	Female	21.6%			1.08	0.80-1.46	0.612	1.07	0.78-1.46	0.676
	Male	20.7%	0.112	0.737	Ref			Ref		
Deprivation quintile	(most deprived) 1	30.2%			2.84	1.73-4.66	<0.001	2.14	1.28-3.59	0.004
	2	28.9%			2.71	1.65-4.45	<0.001	2.36	1.42-3.93	<0.001
	3	18.2%			1.43	0.85-2.41	0.175	1.25	0.73-2.12	0.411
	4	16.6%			1.28	0.77-2.15	0.343	1.13	0.67-1.92	0.639
	(least deprived) 5	13.6%	28.860	<0.001	Ref		<0.001	Ref		<0.001
Experienced abuse	Yes	32.4%			1.95	1.30-2.93	0.001	1.63	1.06-2.52	0.027
	No	19.5%	11.812	0.001	Ref			Ref		
Unable to access health or social care	Yes	27.4%						1.27	0.90-1.78	0.173
	No	18.4%	10.984	<0.001				Ref		
Felt lonely or socially isolated	Yes	35.1%						2.12	1.48-3.04	<0.001
	No	17.4%	33.438	<0.001				Ref		
Struggled financially	Yes	35.4%						1.87	1.28-2.72	0.001
	No	17.7%	31.362	<0.001				Ref		
Overwhelmed by caregiving	Yes	20.3%						0.55	0.33-0.91	0.020
	No	21.2%	0.063	0.801				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A4: Tobacco smoking: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Tobacco smoking								
		Proportion			Model 1			Model 2		
		%	χ^2	p	AOR	95% CIs	p	AOR	95% CIs	p
Age group (years)	60 to 69	21.1%			Ref		<0.001	Ref		<0.001
	70 to 79	16.7%			0.77	0.54-1.11	0.164	0.77	0.54-1.11	0.165
	80 or over	5.4%	30.252	<0.001	0.25	0.14-0.44	<0.001	0.24	0.13-0.44	<0.001
Sex	Female	12.2%			0.61	0.43-0.86	0.005	0.61	0.43-0.87	0.006
	Male	19.6%	10.919	0.001	Ref			Ref		
Deprivation quintile	(most deprived) 1	18.1%			1.49	0.85-2.60	0.164	1.31	0.73-2.34	0.367
	2	17.2%			1.40	0.80-2.45	0.236	1.30	0.74-2.30	0.364
	3	18.2%			1.50	0.87-2.59	0.141	1.41	0.82-2.45	0.217
	4	13.3%			1.09	0.62-1.92	0.758	1.03	0.58-1.82	0.912
	(least deprived) 5	12.2%	5.256	0.262	Ref		0.458	Ref		0.655
Experienced abuse	Yes	29.6%			2.47	1.62-3.78	<0.001	2.48	1.58-3.90	<0.001
	No	13.7%	22.684	<0.001	Ref			Ref		
Unable to access health or social care	Yes	17.0%						0.85	0.57-1.27	0.432
	No	15.1%	0.584	0.445				Ref		
Felt lonely or socially isolated	Yes	20.0%						1.33	0.86-2.04	0.195
	No	14.6%	4.002	0.045				Ref		
Struggled financially	Yes	22.3%						1.56	1.01-2.41	0.043
	No	14.1%	8.499	0.004				Ref		
Overwhelmed by caregiving	Yes	14.5%						0.62	0.35-1.10	0.104
	No	15.9%	0.169	0.681				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A5: Drinking alcohol more than once a week: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Drinking alcohol more than once a week								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	28.3%			Ref		0.049	Ref		0.044
	70 to 79	22.3%			0.73	0.52-1.01	0.056	0.71	0.51-1.00	0.047
	80 or over	18.1%	9.643	0.008	0.65	0.44-0.96	0.032	0.64	0.43-0.96	0.030
Sex	Female	15.9%			0.39	0.29-0.52	<0.001	0.40	0.29-0.54	<0.001
	Male	32.7%	41.766	<0.001	Ref			Ref		
Deprivation quintile	(most deprived) 1	20.6%			0.69	0.43-1.12	0.132	0.78	0.48-1.28	0.333
	2	24.6%			0.90	0.57-1.43	0.663	0.97	0.61-1.54	0.895
	3	23.6%			0.82	0.52-1.29	0.392	0.86	0.54-1.35	0.504
	4	23.8%			0.89	0.57-1.39	0.615	0.92	0.59-1.44	0.730
	(least deprived) 5	25.1%	1.393	0.845	Ref		0.646	Ref		0.871
Experienced abuse	Yes	37.8%			2.31	1.55-3.44	<0.001	2.55	1.67-3.88	<0.001
	No	21.6%	17.230	<0.001	Ref			Ref		
Unable to access health or social care	Yes	25.3%						1.20	0.86-1.67	0.279
	No	22.9%	0.759	0.384				Ref		
Felt lonely or socially isolated	Yes	20.1%						0.76	0.51-1.13	0.177
	No	24.5%	1.920	0.166				Ref		
Struggled financially	Yes	17.6%						0.62	0.40-0.96	0.031
	No	25.0%	5.100	0.024				Ref		
Overwhelmed by caregiving	Yes	21.2%						0.94	0.58-1.51	0.786
	No	23.9%	0.510	0.475				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A6: Low mental well-being: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Low mental well-being								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	14.3%			Ref		0.008	Ref		0.006
	70 to 79	13.5%			0.93	0.62-1.40	0.729	1.02	0.65-1.59	0.930
	80 or over	21.2%	7.821	0.020	1.74	1.14-2.67	0.010	1.95	1.22-3.11	0.005
Sex	Female	18.9%			1.71	1.20-2.43	0.003	1.68	1.15-2.44	0.007
	Male	12.0%	9.423	0.002	Ref			Ref		
Deprivation quintile	(most deprived) 1	21.0%			2.22	1.27-3.88	0.005	1.33	0.72-2.45	0.356
	2	23.5%			2.67	1.54-4.61	<0.001	2.23	1.24-3.99	0.007
	3	14.0%			1.32	0.73-2.36	0.356	1.09	0.59-2.01	0.793
	4	10.2%			0.92	0.50-1.68	0.778	0.73	0.38-1.39	0.340
	(least deprived) 5	11.1%	22.658	<0.001	Ref		<0.001	Ref		0.002
Experienced abuse	Yes	24.8%			2.25	1.42-3.57	<0.001	1.59	0.95-2.66	0.079
	No	14.4%	9.302	0.002	Ref			Ref		
Unable to access health or social care	Yes	21.3%						1.10	0.73-1.64	0.656
	No	13.2%	11.053	<0.001				Ref		
Felt lonely or socially isolated	Yes	37.8%						4.47	3.01-6.64	<0.001
	No	10.0%	101.152	<0.001				Ref		
Struggled financially	Yes	32.8%						2.81	1.84-4.29	<0.001
	No	11.7%	54.333	<0.001				Ref		
Overwhelmed by caregiving	Yes	20.0%						0.64	0.37-1.11	0.112
	No	15.0%	2.206	0.137				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A7: High anxiety: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		High anxiety								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	19.0%			Ref		0.853	Ref		0.817
	70 to 79	17.2%			0.91	0.64-1.31	0.611	0.89	0.61-1.28	0.528
	80 or over	18.5%	0.468	0.792	1.00	0.67-1.50	0.999	0.93	0.61-1.41	0.732
Sex	Female	20.2%			1.35	0.98-1.85	0.065	1.31	0.95-1.81	0.105
	Male	16.0%	3.081	0.079	Ref			Ref		
Deprivation quintile	(most deprived) 1	20.6%			1.87	1.10-3.18	0.021	1.67	0.96-2.90	0.069
	2	25.6%			2.47	1.48-4.13	0.001	2.40	1.42-4.06	0.001
	3	16.8%			1.46	0.85-2.50	0.168	1.37	0.79-2.36	0.264
	4	16.7%			1.42	0.84-2.40	0.195	1.39	0.82-2.38	0.225
	(least deprived) 5	12.3%	14.119	0.007	Ref		0.008	Ref		0.016
Experienced abuse	Yes	20.7%			1.24	0.78-1.95	0.359	0.98	0.60-1.59	0.938
	No	17.8%	0.665	0.415	Ref			Ref		
Unable to access health or social care	Yes	18.8%						0.79	0.55-1.15	0.219
	No	17.9%	0.119	0.730				Ref		
Felt lonely or socially isolated	Yes	31.3%						2.66	1.83-3.86	<0.001
	No	14.8%	32.269	<0.001				Ref		
Struggled financially	Yes	24.5%						1.17	0.78-1.76	0.442
	No	16.7%	6.706	0.010				Ref		
Overwhelmed by caregiving	Yes	21.7%						1.00	0.62-1.61	0.998
	No	17.7%	1.325	0.250				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A8: Having a mental health condition: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Having a mental health condition								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	17.7%			Ref		<0.001	Ref		<0.001
	70 to 79	5.4%			0.26	0.16-0.43	<0.001	0.26	0.16-0.44	<0.001
	80 or over	3.1%	52.750	<0.001	0.16	0.08-0.34	<0.001	0.15	0.07-0.33	<0.001
Sex	Female	9.2%			1.04	0.68-1.58	0.870	0.94	0.60-1.45	0.769
	Male	10.0%	0.213	0.645	Ref			Ref		
Deprivation quintile	(most deprived) 1	11.1%			1.18	0.61-2.31	0.620	0.78	0.38-1.60	0.496
	2	11.8%			1.19	0.62-2.29	0.606	0.95	0.48-1.88	0.883
	3	9.5%			0.92	0.46-1.81	0.803	0.72	0.35-1.46	0.359
	4	7.5%			0.77	0.39-1.54	0.462	0.64	0.31-1.31	0.221
	(least deprived) 5	8.6%	3.042	0.551	Ref		0.682	Ref		0.695
Experienced abuse	Yes	17.6%			2.19	1.29-3.70	0.004	1.60	0.91-2.84	0.104
	No	8.4%	11.593	0.001	Ref			Ref		
Unable to access health or social care	Yes	15.1%						1.41	0.88-2.27	0.154
	No	7.2%	16.230	<0.001				Ref		
Felt lonely or socially isolated	Yes	19.6%						2.88	1.76-4.71	<0.001
	No	7.0%	32.407	<0.001				Ref		
Struggled financially	Yes	19.4%						1.86	1.12-3.10	0.017
	No	7.3%	28.228	<0.001				Ref		
Overwhelmed by caregiving	Yes	10.9%						0.58	0.29-1.12	0.105
	No	9.4%	0.292	0.589				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A9: Suicidal thoughts or self-harm: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Suicidal thoughts or self-harm								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	19.5%			Ref		<0.001	Ref		<0.001
	70 to 79	11.3%			0.48	0.32-0.73	0.001	0.49	0.32-0.76	0.001
	80 or over	4.7%	32.635	<0.001	0.22	0.12-0.42	<0.001	0.21	0.11-0.41	<0.001
Sex	Female	13.0%			1.16	0.79-1.69	0.457	0.99	0.66-1.48	0.972
	Male	12.6%	0.042	0.837	Ref			Ref		
Deprivation quintile	(most deprived) 1	15.1%			1.34	0.73-2.47	0.342	0.94	0.49-1.83	0.865
	2	13.4%			1.18	0.64-2.19	0.595	0.95	0.50-1.81	0.873
	3	13.2%			1.10	0.59-2.03	0.770	0.95	0.50-1.80	0.871
	4	12.1%			1.07	0.58-1.96	0.830	0.94	0.50-1.77	0.848
	(least deprived) 5	11.0%	1.779	0.776	Ref		0.896	Ref		1.000
Experienced abuse	Yes	37.0%			5.61	3.66-8.60	<0.001	4.06	2.55-6.45	<0.001
	No	9.4%	80.221	<0.001	Ref			Ref		
Unable to access health or social care	Yes	18.1%						0.82	0.52-1.28	0.380
	No	10.7%	10.951	0.001				Ref		
Felt lonely or socially isolated	Yes	27.5%						2.89	1.86-4.49	<0.001
	No	9.1%	53.053	<0.001				Ref		
Struggled financially	Yes	26.0%						2.05	1.29-3.26	0.002
	No	9.8%	38.456	<0.001				Ref		
Overwhelmed by caregiving	Yes	28.5%						1.84	1.11-3.05	0.018
	No	10.6%	33.962	<0.001				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A10: Self-neglect: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Self-neglect								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	14.7%			Ref		0.014	Ref		0.149
	70 to 79	8.4%			0.50	0.32-0.80	0.004	0.61	0.36-1.02	0.059
	80 or over	9.3%	9.410	0.009	0.71	0.42-1.20	0.202	0.92	0.52-1.65	0.789
Sex	Female	11.2%			1.13	0.76-1.70	0.539	0.92	0.59-1.44	0.719
	Male	10.6%	0.108	0.742	Ref			Ref		
Deprivation quintile	(most deprived) 1	14.1%			2.08	1.05-4.13	0.036	0.88	0.40-1.92	0.745
	2	12.3%			1.93	0.97-3.86	0.062	1.25	0.58-2.67	0.568
	3	12.3%			1.78	0.90-3.53	0.100	1.38	0.66-2.89	0.398
	4	10.0%			1.49	0.74-2.98	0.261	1.06	0.49-2.25	0.889
	(least deprived) 5	6.8%	6.916	0.140	Ref		0.259	Ref		0.717
Experienced abuse	Yes	30.9%			5.41	3.46-8.46	<0.001	3.48	2.07-5.84	<0.001
	No	8.1%	62.831	<0.001	Ref			Ref		
Unable to access health or social care	Yes	21.6%						2.05	1.30-3.23	0.002
	No	6.5%	53.156	<0.001				Ref		
Felt lonely or socially isolated	Yes	29.5%						3.57	2.27-5.63	<0.001
	No	6.2%	98.406	<0.001				Ref		
Struggled financially	Yes	31.1%						4.38	2.72-7.04	<0.001
	No	6.3%	104.703	<0.001				Ref		
Overwhelmed by caregiving	Yes	25.5%						1.41	0.81-2.47	0.227
	No	8.9%	33.922	<0.001				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A11: Low life satisfaction: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Low life satisfaction								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	7.5%			Ref		0.041	Ref		0.016
	70 to 79	7.4%			1.00	0.59-1.70	0.998	1.21	0.69-2.11	0.504
	80 or over	11.6%	4.456	0.108	1.85	1.07-3.19	0.027	2.27	1.27-4.07	0.006
Sex	Female	9.7%			1.39	0.89-2.18	0.149	1.33	0.84-2.12	0.228
	Male	7.1%	2.302	0.129	Ref			Ref		
Deprivation quintile	(most deprived) 1	11.6%			2.80	1.29-6.10	0.010	1.71	0.75-3.89	0.199
	2	11.8%			3.04	1.40-6.59	0.005	2.49	1.12-5.54	0.025
	3	8.6%			1.99	0.90-4.42	0.090	1.71	0.76-3.88	0.197
	4	6.3%			1.42	0.62-3.26	0.402	1.20	0.51-2.81	0.669
	(least deprived) 5	4.6%	11.260	0.024	Ref		0.020	Ref		0.148
Experienced abuse	Yes	16.4%			2.80	1.64-4.79	<0.001	1.85	1.03-3.32	0.039
	No	7.3%	12.596	<0.001	Ref			Ref		
Unable to access health or social care	Yes	14.0%						1.70	1.05-2.76	0.032
	No	6.1%	18.191	<0.001				Ref		
Felt lonely or socially isolated	Yes	19.6%						2.78	1.72-4.51	<0.001
	No	5.5%	45.901	<0.001				Ref		
Struggled financially	Yes	18.1%						2.30	1.38-3.85	0.001
	No	6.2%	30.604	<0.001				Ref		
Overwhelmed by caregiving	Yes	13.0%						0.89	0.47-1.66	0.705
	No	7.8%	4.336	0.037				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix Table A12: Ageism experience: bivariate and multivariate relationships with demographics, abuse and other adverse experiences since the age of 60.

		Ageism experience								
		%	Proportion χ^2	p	AOR	Model 1 95% CIs	p	AOR	Model 2 95% CIs	p
Age group (years)	60 to 69	12.9%			Ref		0.003	Ref		0.008
	70 to 79	15.6%			1.26	0.84-1.88	0.265	1.25	0.82-1.89	0.295
	80 or over	22.0%	9.838	0.007	2.09	1.36-3.20	<0.001	1.98	1.27-3.09	0.002
Sex	Female	17.1%			1.13	0.81-1.58	0.481	1.09	0.77-1.55	0.610
	Male	14.9%	0.955	0.328	Ref			Ref		
Deprivation quintile	(most deprived) 1	21.3%			1.35	0.81-2.23	0.248	1.12	0.66-1.91	0.674
	2	15.5%			0.99	0.58-1.68	0.963	0.91	0.53-1.58	0.746
	3	16.6%			1.01	0.60-1.68	0.979	0.92	0.55-1.56	0.767
	4	11.4%			0.66	0.38-1.13	0.127	0.62	0.35-1.07	0.087
	(least deprived) 5	16.5%	7.884	0.096	Ref		0.138	Ref		0.289
Experienced abuse	Yes	26.3%			2.29	1.48-3.56	<0.001	1.81	1.13-2.89	0.014
	No	14.7%	11.723	<0.001	Ref			Ref		
Unable to access health or social care	Yes	17.7%						0.86	0.58-1.27	0.438
	No	15.4%	0.870	0.351				Ref		
Felt lonely or socially isolated	Yes	31.4%						2.90	1.98-4.26	<0.001
	No	12.1%	47.747	<0.001				Ref		
Struggled financially	Yes	21.8%						1.31	0.84-2.03	0.229
	No	14.8%	5.943	0.015				Ref		
Overwhelmed by caregiving	Yes	20.6%						0.94	0.57-1.57	0.822
	No	15.5%	2.319	0.128				Ref		

Note: AOR, adjusted odds ratio; CI, confidence interval; Ref, reference category.

Appendix 2: Full sample responses to survey questions

The following tables present overall responses to all survey questions using the full sample of 1,094 participants.

Unweighted figures may vary from those presented in the report due to a smaller sample size (n=1,085) being used in the analytical sample (see methods).

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Full sample demographics

		Full sample (unweighted)		Full sample (weighted)	National population
		n	%	%	%
All		1094		1097	
Sex	Female	584	53.4%	53.1%	53.3%
	Male	507	46.3%	46.6%	46.7%
	Other	3	0.3%	0.3%	-
Age group	60 to 69 years	421	38.5%	43.7%	43.6%
	70 to 79 years	412	37.7%	36.1%	36.1%
	80 years or over	261	23.9%	20.2%	20.3%
Deprivation quintile	1 (most deprived)	200	18.3%	15.1%	15.1%
	2	207	18.9%	18.4%	18.5%
	3	220	20.1%	21.3%	21.2%
	4	246	22.5%	22.8%	22.9%
	5 (least deprived)	221	20.2%	22.3%	22.3%
Ethnicity	White	1077	98.4%	98.5%	98.4%
	Other than white	17	1.6%	1.5%	1.6%
Health Board	Aneurin Bevan UHB	203	18.6%	18.4%	18.1%
	Betsi Cadwaladr UHB	255	23.3%	23.4%	24.3%
	Cardiff and Vale UHB	146	13.3%	13.3%	12.5%
	Cwm Taf Morgannwg UHB	129	11.8%	11.6%	13.3%
	Hywel Dda UHB	166	15.2%	15.4%	14.4%
	Powys Teaching HB	63	5.8%	6.0%	5.4%
	Swansea Bay UHB	132	12.1%	11.9%	11.9%

Note: UHB, University Health Board. Percentages may not add to 100% due to rounding. National population ethnicity figures are calculated from Census 2021 data using counts for individual year of age at local authority level. Counts are rounded to the nearest 5 and counts under 10 are excluded, thus figures are approximate. See: [England and Wales Census 2021 - Ethnic group by age and sex at country level for England and Wales - UK Data Service CKAN](#). For details on weighting see Appendix 1.

All n values in the following tables show unweighted sample sizes.

Employment, relationship status and household occupancy

Which of the following best describes your current employment status? (respondents were able to select all that apply)

Response options	n	Unweighted	Weighted
Retired	887	81.1%	79.0%
Employed or self-employed full-time (paid; 35 or more hours per week)	58	5.3%	5.9%
Employed or self-employed part-time (paid; under 35 hours per week)	87	8.0%	8.7%
Volunteer	29	2.7%	2.9%
Long-term sick or disabled	70	6.4%	7.0%
Unpaid carer	18	1.6%	1.7%
Other/missing	12	1.1%	1.1%

What is your current relationship status?

Response options	n	Unweighted	Weighted
Single (including never married, separated, divorced or widowed)	610	55.8%	54.4%
Married, in a civil partnership or in a long-term relationship	482	44.1%	45.4%
Other/missing	2	0.2%	0.2%

Number of people living in the household (including respondent)

Response options	n	Unweighted	Weighted
1	535	48.9%	47.9%
2	467	42.7%	43.5%
3 or more	92	8.4%	8.6%

Caregiving responsibilities

Since the age of 60, have you been a main caregiver for someone who has a long-term physical or mental health condition or problems with daily living?

Response options	n	Unweighted	Weighted
No	741	67.7%	68.2%
Yes, but not currently	255	23.3%	22.7%
Yes, currently	97	8.9%	9.1%
Missing	1	0.1%	0.1%

Since the age of 60, have you had regular childcare responsibilities (e.g. for a grandchild)?

Response options	n	Unweighted	Weighted
No	812	74.2%	74.0%
Yes, but not currently	173	15.8%	15.7%
Yes, currently	109	10.0%	10.3%
Missing	0	0.0%	0.0%

Social connection

In general, how connected do you feel to people? [49]

Response options	n	Unweighted	Weighted
Very connected	450	41.1%	41.4%
Fairly connected	475	43.4%	43.4%
A little connected	130	11.9%	11.8%
Not at all connected	38	3.5%	3.3%
Missing	1	0.1%	0.1%

How often do you visit friends or family or have them visit you? [50]

Response options	n	Unweighted	Weighted
Almost daily	301	27.5%	27.1%
2-4 times a week	308	28.2%	28.2%
About once a week	215	19.7%	20.2%
Once or twice a month	132	12.1%	12.3%
Once every few months	81	7.4%	7.3%
Never or almost never	44	4.0%	3.7%
No friends or family outside household	12	1.1%	1.1%
Missing	1	0.1%	0.1%

Apart from meeting people face to face, which other ways do you keep in touch with family and friends? (respondents were able to select all that apply)

Response options	n	Unweighted	Weighted
Letters	27	2.5%	2.5%
Telephone	964	88.1%	87.9%
Videocall (e.g. Facetime, Zoom)	250	22.9%	23.7%
Text or WhatsApp messaging	512	46.8%	48.5%
Email	213	19.5%	20.3%
Social media (e.g. Facebook)	268	24.5%	26.2%
Do not keep in touch with family or friends	43	3.9%	3.8%
Missing	5	0.5%	0.5%

Which of the following leisure or social activities do you engage in once a week or more often? (respondents were able to select all that apply) (adapted from [50])

Response options	n	Unweighted	Weighted
Sports club, gym or exercise group	148	13.5%	14.1%
Pub or social club	221	20.2%	21.3%
Religious group/church	153	14.0%	14.1%
Adult education class	22	2.0%	2.2%
Community group/centre	194	17.7%	17.9%
Volunteering activity	93	8.5%	8.8%
Other group activity	246	22.5%	22.1%
None of the above	445	40.7%	39.6%
Missing	0	0.0%	0.0%

Feelings of safety

How safe or unsafe do you feel: (adapted from [51])

	Response options	n	Unweighted	Weighted
At home during the day	Very safe	918	83.9%	84.7%
	Fairly safe	156	14.3%	13.6%
	A bit unsafe	9	0.8%	0.8%
	Very unsafe	11	1.0%	0.9%
	Missing	0	0.0%	0.0%
At home after dark	Very safe	824	75.3%	76.1%
	Fairly safe	208	19.0%	18.5%
	A bit unsafe	37	3.4%	3.4%
	Very unsafe	20	1.8%	1.6%
	Missing	5	0.5%	0.4%
In your local area during the day	Very safe	813	74.3%	75.2%
	Fairly safe	228	20.8%	20.4%
	A bit unsafe	26	2.4%	2.3%
	Very unsafe	16	1.5%	1.3%
	Missing	11	1.0%	0.9%
Walking alone in your area after dark	Very safe	441	40.3%	40.8%
	Fairly safe	237	21.7%	22.2%
	A bit unsafe	152	13.9%	14.2%
	Very unsafe	72	6.6%	6.1%
	Missing	19	1.7%	1.7%
	Not applicable (do not go out)	173	15.8%	15.0%

Housing

How would you rate the overall condition of your home (e.g. state of repair, insulation, heating, security, damp, mould)?

	Response options	n	Unweighted	Weighted
	Very good	474	43.3%	43.2%
	Good	422	38.6%	38.9%
	Fair	159	14.5%	14.2%
	Poor	30	2.7%	2.9%
	Very poor	7	0.6%	0.5%
	Missing	2	0.2%	0.2%

General health

How is your health in general? [52]

	Response options	n	Unweighted	Weighted
	Very good	142	13.0%	13.3%
	Good	354	32.4%	33.1%
	Fair	364	33.3%	32.6%
	Bad	190	17.4%	16.9%
	Very bad	44	4.0%	4.0%
	Missing	0	0.0%	0.0%

EQ-5D-5L [53]

	Response options	n	Unweighted	Weighted
Mobility	No problems	464	42.4%	43.8%
	Slight problems	237	21.7%	21.4%
	Moderate problems	202	18.5%	17.9%
	Severe problems	160	14.6%	14.1%
	Unable to	24	2.2%	2.2%
	Missing	7	0.6%	0.6%
Self-care	No problems	774	70.7%	71.3%
	Slight problems	176	16.1%	15.9%
	Moderate problems	90	8.2%	7.9%
	Severe problems	27	2.5%	2.4%
	Unable to	9	0.8%	0.9%
	Missing	18	1.6%	1.6%
Usual activities	No problems	559	51.1%	51.9%
	Slight problems	266	24.3%	23.9%
	Moderate problems	182	16.6%	16.4%
	Severe problems	63	5.8%	5.8%
	Unable to	16	1.5%	1.4%
	Missing	8	0.7%	0.7%
Pain/discomfort	No pain	287	26.2%	27.4%
	Slight pain	325	29.7%	29.3%
	Moderate pain	315	28.8%	28.2%
	Severe pain	124	11.3%	11.1%
	Extreme pain	33	3.0%	3.0%
	Missing	10	0.9%	0.9%
Anxiety/depression	Not anxious	608	55.6%	55.4%
	Slightly anxious	280	25.6%	25.9%
	Moderately anxious	137	12.5%	12.6%
	Severely anxious	39	3.6%	3.7%
	Extremely anxious	14	1.3%	1.2%
	Missing	16	1.5%	1.3%

Health conditions

Do you have any of the following conditions? (respondents were able to select all that apply)

Response options	n	Unweighted	Weighted
High blood pressure	545	49.8%	49.2%
High cholesterol	343	31.4%	31.0%
Diabetes	208	19.0%	19.1%
A mental health condition	106	9.7%	10.5%
Arthritis (including osteoarthritis or rheumatism)	523	47.8%	46.7%
Osteoporosis (or thin or brittle bones)	124	11.3%	10.8%
Cardiovascular disease (i.e. a heart condition)	257	23.5%	22.5%
Cancer or a malignant tumour	86	7.9%	7.5%
Chronic lung disease (e.g. COPD, chronic bronchitis, emphysema)	145	13.3%	13.5%
Parkinson's disease	13	1.2%	1.2%
Dementia (including Alzheimer's disease)	21	1.9%	1.8%
None of these	139	12.7%	13.7%
Missing	2	0.2%	0.2%

Asked to participants that reported at least one of the above health conditions (n=953):
Overall, do you feel that you are getting the health care you need to manage your condition(s) adequately?

Response options	n	Unweighted
Yes	724	76.0%
No	218	22.9%
Missing	11	1.2%

Falls

Since the age of 60, how many times, if at all, have you fallen and injured yourself?

Response options	n	Unweighted	Weighted
0	632	57.8%	58.7%
1	160	14.6%	14.4%
2	116	10.6%	10.3%
3 or more	181	16.5%	16.1%
Missing	5	0.5%	0.5%

Have you fallen in the last year (with or without injury)?

Response options	n	Unweighted	Weighted
Yes	363	33.2%	32.6%
No	731	66.8%	67.4%
Missing	0	0.0%	0.0%

In general, how much do you worry about falling?

Response options	n	Unweighted	Weighted
Not at all	515	47.1%	48.2%
A little	385	35.2%	34.7%
A lot	193	17.6%	17.0%
Missing	1	0.1%	0.1%

Health service use

In the last 12 months, excluding for vaccinations, approximately how many times have you:

	Response options	n	Unweighted	Weighted
Had a GP appointment (in person, by phone or online)	0	229	20.9%	21.3%
	1	226	20.7%	20.9%
	2	205	18.7%	19.2%
	3 or more	424	38.8%	37.7%
	Missing	10	0.9%	1.0%
Had a community nurse appointment (in person, by phone or online)	0	494	45.2%	44.8%
	1	211	19.3%	19.5%
	2	159	14.5%	14.8%
	3 or more	220	20.1%	19.9%
	Missing	10	0.9%	1.0%
Had an appointment with another health professional from your GP practice who was not a doctor or nurse (e.g. physio or speech and language therapist)	0	859	78.5%	78.5%
	1	105	9.6%	9.7%
	2	54	4.9%	4.8%
	3 or more	66	6.0%	6.0%
	Missing	10	0.9%	1.0%
Attended a hospital appointment (daytime, as an outpatient)	0	534	48.8%	49.5%
	1	207	18.9%	19.0%
	2	130	11.9%	11.8%
	3 or more	213	19.5%	18.8%
	Missing	10	0.9%	1.0%
Attended Accident and Emergency (as a patient)	0	891	81.4%	81.6%
	1	146	13.3%	13.3%
	2	24	2.2%	2.1%
	3 or more	23	2.1%	2.0%
	Missing	10	0.9%	1.0%
Had a consultation with a pharmacist (excluding for vaccination)	0	863	78.9%	78.8%
	1	167	15.3%	15.3%
	2	32	2.9%	3.0%
	3 or more	22	2.0%	2.0%
	Missing	10	0.9%	1.0%
In the last 12 months, how many nights in total have you spent in hospital as a patient?	0	925	84.6%	85.2%
	1	38	3.5%	3.4%
	2	32	2.9%	2.8%
	3 or more	98	9.0%	8.5%
	Missing	1	0.1%	0.1%

Vaccinations

Since September 2024, have you had either of the following vaccinations?

	Response options	n	Unweighted	Weighted
Flu	Yes	898	82.1%	81.5%
	No, I would have liked one but could not get one	21	1.9%	1.8%
	No – other reason	169	15.4%	16.1%
	Don't know	5	0.5%	0.5%
	Missing	1	0.1%	0.1%
COVID-19	Yes	820	75.0%	74.4%
	No, I would have liked one but could not get one	22	2.0%	2.1%
	No – other reason	241	22.0%	22.5%
	Don't know	10	0.9%	0.9%
	Missing	1	0.1%	0.1%

Note: examples were provided for the response “No - I would have liked one but could not get one (e.g. couldn't get an appointment, couldn't get out to get one)”

Personal care

If you were injured or ill, for any reason, would you have someone who could help you while you recovered (e.g. with meals, shopping and personal care)?

	Response options	n	Unweighted	Weighted
	Yes	876	80.1%	80.2%
	No	194	17.7%	17.5%
	Missing	24	2.2%	2.3%

In the past 12 months, have you regularly needed help with any of the following activities? (respondents were able to select all that apply)

	Response options	n	Unweighted	Weighted
	Shopping for groceries	372	34.0%	32.8%
	Preparing or eating meals	150	13.7%	13.2%
	Travel or transport	323	29.5%	28.8%
	Getting in and out of bed	84	7.7%	7.7%
	Washing, bathing or using the toilet	104	9.5%	9.3%
	Dressing or undressing	107	9.8%	9.6%
	Managing and taking medication	79	7.2%	6.8%
	None of these	625	57.1%	58.5%
	Missing	0	0.0%	0.0%

Asked of those reporting needing help with any of the above activities (n=469)

In general, have you received the help you need with these activities most of the time?

Response options	n	Unweighted
Yes	426	90.8%
No	42	9.0%
Missing	1	0.2%

Asked of those reporting needing help with any of the above activities (n=469)

How many times in the last 12 months have you not received the help you needed from someone you were relying on? (adapted from [54])

Response options	n	Unweighted
Never	385	82.1%
Once	32	6.8%
2-9 times	40	8.5%
10 or more times	7	1.5%
Missing	5	1.1%

Thinking about what your future care and support needs might be, how confident are you that they will be met? (all participants)

Response options	n	Unweighted	Weighted
Very confident	301	27.5%	27.4%
Somewhat confident	468	42.8%	42.4%
Not confident at all	207	18.9%	19.2%
Don't know	117	10.7%	10.9%
Missing	1	0.1%	0.1%

Experience of ageism

WHO Ageism Scale 5-item version [24]: The following statements are designed to measure your experiences with different age groups. Use the response options below to tell us how much you agree with each statement. When answering, think about whether the statement applies in relation to the past 12 months.

	Response options	n	Unweighted	Weighted
Due to my age, I limit my participation in discussions even when they are about things that affect me	Strongly agree	31	2.8%	2.7%
	Agree	181	16.5%	16.1%
	Neither agree nor disagree	105	9.6%	9.4%
	Disagree	309	28.2%	28.4%
	Strongly disagree	446	40.8%	41.4%
	Don't know or not applicable	17	1.6%	1.5%
	Missing	5	0.5%	0.5%
Others think that I have nothing valuable to contribute to society because of my age	Strongly agree	18	1.6%	1.6%
	Agree	137	12.5%	12.2%
	Neither agree nor disagree	143	13.1%	13.2%
	Disagree	334	30.5%	30.3%
	Strongly disagree	407	37.2%	37.5%
	Don't know or not applicable	48	4.4%	4.5%
	Missing	7	0.6%	0.6%
Others feel frustrated with me due to my age	Strongly agree	17	1.6%	1.5%
	Agree	119	10.9%	10.7%
	Neither agree nor disagree	165	15.1%	14.9%
	Disagree	331	30.3%	30.2%
	Strongly disagree	415	37.9%	38.2%
	Don't know or not applicable	38	3.5%	3.6%
	Missing	9	0.8%	0.9%
Others make decisions for me because of my age	Strongly agree	25	2.3%	2.2%
	Agree	134	12.2%	12.0%
	Neither agree nor disagree	86	7.9%	7.5%
	Disagree	298	27.2%	26.8%
	Strongly disagree	525	48.0%	49.1%
	Don't know or not applicable	22	2.0%	2.2%
	Missing	4	0.4%	0.4%
Policies made by the government (e.g. on housing, social security, healthcare) do not meet the needs of people my age	Strongly agree	365	33.4%	34.2%
	Agree	288	26.3%	26.3%
	Neither agree nor disagree	210	19.2%	19.0%
	Disagree	105	9.6%	9.3%
	Strongly disagree	68	6.2%	6.1%
	Don't know or not applicable	38	3.5%	3.5%
	Missing	20	1.8%	1.8%

Since the age of 60, how often have you: (adapted from [55])

	Response options	n	Unweighted	Weighted
Felt that people have shown prejudice against you or treated you unfairly because of your age?	Never	838	76.6%	76.1%
	Rarely	129	11.8%	12.1%
	Some of the time	78	7.1%	7.2%
	A lot of the time	25	2.3%	2.3%
	Almost all of the time	13	1.2%	1.2%
	Prefer not to say/missing	11	1.0%	1.0%
Felt that people have shown you a lack of respect because of your age, for instance by ignoring or patronising you?	Never	808	73.9%	73.2%
	Rarely	129	11.8%	12.2%
	Some of the time	103	9.4%	9.6%
	A lot of the time	26	2.4%	2.4%
	Almost all of the time	16	1.5%	1.5%
	Prefer not to say/missing	12	1.1%	1.1%

Abuse

Since the age of 60, have you felt scared of, or threatened by, any of the following people?

	Response options	n	Unweighted	Weighted
A spouse or partner	Yes	32	2.9%	3.0%
	No	1049	95.9%	95.8%
	Prefer not to say/missing	13	1.2%	1.2%
An adult family member	Yes	17	1.6%	1.4%
	No	1066	97.4%	97.6%
	Prefer not to say/missing	11	1.0%	1.0%
A friend	Yes	24	2.2%	2.3%
	No	1059	96.8%	96.7%
	Prefer not to say/missing	11	1.0%	1.0%
A caregiver	Yes	9	0.8%	0.8%
	No	1068	97.6%	97.7%
	Prefer not to say/missing	17	1.6%	1.5%

Since the age of 60, has anyone done any of the following to you: (Questions developed by reviewing and adapting items in existing tools and surveys, including [16,54,56–62])

	Response options	n	Unweighted	Weighted
Tried to hurt or harm you physically (e.g. by slapping, hitting, kicking or shoving you)	No	1031	94.2%	94.2%
	Yes, once	26	2.4%	2.4%
	Yes, more than once	24	2.2%	2.2%
	Prefer not to say/Missing	13	1.2%	1.2%
Insulted you, humiliated you, belittled you, yelled at you or verbally threatened you	No	921	84.2%	83.5%
	Yes, once	67	6.1%	6.4%
	Yes, more than once	91	8.3%	8.7%
	Prefer not to say/Missing	15	1.4%	1.3%
Sexually harassed or abused you, either verbally or physically (e.g. by talking to you in a sexual way that made you feel uncomfortable, touching you sexually against your will or forcing you to have sex)	No	1066	97.4%	97.4%
	Yes, once	6	0.5%	0.6%
	Yes, more than once	10	0.9%	1.0%
	Prefer not to say/ Missing	12	1.1%	1.1%
Spent your money without your permission, prevented you from accessing money that should be yours, or taken money or property from you against your will (e.g. through stealing, or forcing or misleading you into giving it to them)	No	1049	95.9%	95.9%
	Yes, once	17	1.6%	1.7%
	Yes, more than once	15	1.4%	1.3%
	Prefer not to say/ Missing	13	1.2%	1.2%
Isolated you from family or friends or been controlling of your behaviour (e.g. controlled who you see or speak to or what you do with your time against your wishes)	No	1059	96.8%	96.9%
	Yes, once	11	1.0%	1.1%
	Yes, more than once	11	1.0%	0.9%
	Prefer not to say/ Missing	13	1.2%	1.1%
Physically restrained you in any way against your will (e.g. locked you in your room or house so you cannot leave, tied you in a chair)	No	1073	98.1%	98.2%
	Yes, once / Yes, more than once [see note]	9	0.8%	0.8%
	Prefer not to say/ Missing	12	1.1%	1.1%
Forced you to take medication against your will, or prevented you from taking medication or accessing health care when you needed it	No	1072	98.0%	98.0%
	Yes, once	5	0.5%	0.5%
	Yes, more than once	5	0.5%	0.5%
	Prefer not to say/ Missing	12	1.1%	1.1%

Note: responses combined due to low numbers.

Other adverse experiences

Since the age of 60, how often have you:

	Response options	n	Unweighted	Weighted
Had too little money to pay for your household's essential needs (e.g. food, electricity, heating)	Never	719	65.7%	65.9%
	Rarely	155	14.2%	14.3%
	Some of the time	146	13.3%	13.4%
	A lot of the time	33	3.0%	2.9%
	Almost all of the time	27	2.5%	2.3%
	Prefer not to say/missing	14	1.3%	1.2%
Felt overwhelmed or burdened by caregiving responsibilities?	Never	842	77.0%	76.9%
	Rarely	99	9.0%	8.9%
	Some of the time	105	9.6%	9.9%
	A lot of the time	17	1.6%	1.5%
	Almost all of the time	16	1.5%	1.3%
	Prefer not to say/missing	15	1.4%	1.4%
Been unable to access the health care services you need?	Never	591	54.0%	53.5%
	Rarely	186	17.0%	17.2%
	Some of the time	190	17.4%	17.9%
	A lot of the time	67	6.1%	6.0%
	Almost all of the time	44	4.0%	3.9%
	Prefer not to say/missing	16	1.5%	1.5%
Been unable to access the social care services you need?	Never	797	72.9%	72.6%
	Rarely	89	8.1%	8.1%
	Some of the time	95	8.7%	8.7%
	A lot of the time	40	3.7%	3.7%
	Almost all of the time	25	2.3%	2.2%
	Prefer not to say/missing	48	4.4%	4.7%
Felt lonely or socially isolated?	Never	675	61.7%	61.8%
	Rarely	183	16.7%	17.1%
	Some of the time	160	14.6%	14.2%
	A lot of the time	41	3.7%	3.8%
	Almost all of the time	24	2.2%	2.1%
	Prefer not to say/missing	11	1.0%	1.0%

Since the age of 60, have you experienced any of the following? (respondents were able to select all that apply)

Response options	n	Unweighted	Weighted
Serious injury other than a fall	70	6.4%	6.4%
Death of a spouse or partner	241	22.0%	20.0%
Death of a child	45	4.1%	3.6%
Death of a close relative or friend	624	57.0%	56.3%
Marital separation/divorce	49	4.5%	4.4%
None of these	305	27.9%	29.4%
Prefer not to say/missing	15	1.4%	1.1%

Self-neglect, self-harm and suicidal thoughts

Since the age of 60, how often have you: (adapted from [63])

	Response options	n	Unweighted	Weighted
Not taken care of your appearance, your home or your health because you thought it was not worth taking care of?	Never	829	75.8%	75.0%
	Rarely	134	12.2%	12.8%
	Some of the time	95	8.7%	9.0%
	A lot of the time	17	1.6%	1.5%
	Almost all of the time	7	0.6%	0.6%
	Prefer not to say/missing	12	1.1%	1.1%

Since the age of 60, have you ever had thoughts about taking your own life? (adapted from [64])

	Response options	n	Unweighted	Weighted
	No, never	942	86.1%	85.4%
	Yes, but never serious thoughts I would ever act upon	92	8.4%	9.0%
	Yes, seriously considered suicide but didn't act on those thoughts	23	2.1%	2.1%
	Yes, seriously considered suicide and even planned how I would do it, but didn't actually make a suicide attempt	9	0.8%	0.8%
	Yes, and have made a suicide attempt	13	1.2%	1.2%
	Prefer not to say/missing	15	1.4%	1.3%

Since the age of 60, have you ever deliberately harmed yourself in any way but not with the intention of killing yourself? [65]

	Response options	n	Unweighted	Weighted
	No	1069	97.7%	97.7%
	Yes	11	1.0%	1.1%
	Prefer not to say/missing	14	1.3%	1.3%

Smoking

Do you currently smoke tobacco or use e-cigarettes/vapes? (respondents were able to select all that apply)

Response options	n	Unweighted	Weighted
Yes, I smoke tobacco	172	15.7%	16.0%
Yes, I use e-cigarettes/vapes	42	3.8%	3.9%
No, I used to smoke tobacco or use e-cigarettes/vapes but I do not any more	396	36.2%	36.0%
No, I have never smoked tobacco or used e-cigarettes/vapes	489	44.7%	44.5%
Missing	1	0.1%	0.1%

Alcohol use

How often do you have a drink containing alcohol? [66]

Response options	n	Unweighted	Weighted
Never	341	31.2%	30.1%
Monthly or less	224	20.5%	20.5%
2-3 times a month	103	9.4%	9.6%
Once a week	162	14.8%	15.3%
2-4 times a week	189	17.3%	17.6%
5 or more times a week	71	6.5%	6.5%
Missing	4	0.4%	0.4%

Asked of those that reported consuming alcohol (n=749)

What are your main reasons for drinking alcohol? (respondents were able to select all that apply)

Response options	n	Unweighted
To socialise	466	62.6%
To relax	246	33.0%
To relieve stress	53	7.1%
For enjoyment	233	31.3%
To cope (e.g. with anxiety, depression, loneliness)	21	2.8%
To help me sleep	39	5.2%
Because I like the feeling	57	7.7%
I think it's good for my health	22	3.0%
Other (please specify)	13	1.7%
Missing	4	0.5%

Fruit and vegetable consumption

On a normal day, how many portions of fruit and vegetables (excluding potatoes) would you usually eat (one portion is roughly one handful or a full piece of fruit such as an apple)? [67]

Response options	n	Unweighted	Weighted
0	43	3.9%	3.7%
1	99	9.0%	8.8%
2	230	21.0%	20.8%
3	330	30.2%	30.3%
4	169	15.4%	15.2%
5+	219	20.0%	20.8%
Missing	4	0.4%	0.4%

Weight

Given your age and height, how would you assess your current weight? [68]

Response options	n	Unweighted	Weighted
I am quite a lot lighter than I think I should be	25	2.3%	2.2%
I am slightly lighter than I think I should be	66	6.0%	6.1%
I think I am about the right weight	506	46.3%	45.6%
I am slightly heavier than I think I should be	363	33.2%	33.4%
I am quite a bit heavier than I think I should be	130	11.9%	12.4%
Missing	4	0.4%	0.3%

Compared with one year ago, has your weight changed? [69]

Response options	n	Unweighted	Weighted
Yes - lost weight	217	19.8%	19.6%
No - weigh about the same	652	59.6%	59.8%
Yes - gained weight	200	18.3%	18.6%
Do not know	23	2.1%	1.9%
Missing	2	0.2%	0.2%

Physical activity and physical ability

How often do you do the following: (adapted from [69])

	Response options	n	Unweighted	Weighted
Physical activity (e.g. walking, cycling, swimming, running, team sports, heavy housework or gardening)	Never	327	29.9%	29.0%
	Less than once a week	102	9.3%	8.8%
	Once a week	117	10.7%	11.0%
	2-3 times a week	225	20.6%	20.6%
	4-6 times a week	127	11.6%	12.1%
	Every day	194	17.7%	18.4%
	Missing	2	0.2%	0.2%
Muscle strengthening activity (e.g. yoga, tai chi, going to the gym, exercises using weights or resistance bands, carrying shopping bags)	Never	634	58.0%	57.2%
	Less than once a week	93	8.5%	8.6%
	Once a week	136	12.4%	12.8%
	2-3 times a week	125	11.4%	11.5%
	4-6 times a week	45	4.1%	4.3%
	Every day	60	5.5%	5.5%
	Missing	1	0.1%	0.1%

How would you describe your usual walking pace? [69]

	Response options	n	Unweighted	Weighted
	Slow pace	523	47.8%	46.3%
	Steady average pace	437	39.9%	40.7%
	Brisk pace	125	11.4%	12.1%
	Missing	9	0.8%	0.9%

Do you have any difficulty lifting or carrying weights over 10 pounds, like a heavy bag of groceries? [68]

	Response options	n	Unweighted	Weighted
	Yes	521	47.6%	46.3%
	No	568	51.9%	53.2%
	Missing	5	0.5%	0.4%

Over the last 2 weeks, how often have you felt tired or had little energy? [69]

	Response options	n	Unweighted	Weighted
	Not at all	323	29.5%	30.5%
	Several days	378	34.6%	34.6%
	More than half the days	112	10.2%	9.9%
	Nearly every day	274	25.0%	24.5%
	Missing	7	0.6%	0.6%

Memory

How would you rate your memory at the present time? Would you say it is: [68]

Response options	n	Unweighted	Weighted
Excellent	143	13.1%	13.3%
Very good	362	33.1%	33.2%
Good	359	32.8%	32.9%
Fair	183	16.7%	16.5%
Poor	45	4.1%	4.0%
Missing	2	0.2%	0.1%

Personal well-being

On a scale of 0 to 10, where 0 is *not at all* and 10 is *completely*: [70]

	Response options	n	Unweighted	Weighted
Overall, how satisfied are you with your life nowadays?	Low life satisfaction (0-4)	91	8.3%	7.9%
	Medium life satisfaction (5-6)	216	19.7%	19.7%
	High life satisfaction (7-8)	447	40.9%	41.0%
	Very high life satisfaction (9-10)	333	30.4%	30.7%
	Missing	7	0.6%	0.7%
Overall, to what extent do you feel the things you do in your life are worthwhile?	Low worthwhile (0-4)	86	7.9%	7.6%
	Medium worthwhile (5-6)	235	21.5%	20.8%
	High worthwhile (7-8)	394	36.0%	36.3%
	Very high worthwhile (9-10)	362	33.1%	33.8%
	Missing	17	1.6%	1.5%
Overall, how happy did you feel yesterday?	Low happiness (0-4)	116	10.6%	10.1%
	Medium happiness (5-6)	208	19.0%	18.8%
	High happiness (7-8)	405	37.0%	37.5%
	Very high happiness (9-10)	359	32.8%	33.0%
	Missing	6	0.5%	0.6%

On a scale where 0 is *not at all anxious* and 10 is *completely anxious*:

	Response options	n	Unweighted	Weighted
Overall, how anxious did you feel yesterday?	Very low anxiety (0-1)	519	47.4%	47.9%
	Low anxiety (2-3)	227	20.7%	21.1%
	Medium anxiety (4-5)	142	13.0%	12.5%
	High anxiety (6-10)	203	18.6%	18.3%
	Missing	3	0.3%	0.3%

Childhood happiness

Thinking back to your childhood, on a scale of 0 to 10, where 0 is not at all and 10 is completely: (adapted from [71])

	Response options	n	Unweighted	Weighted
Overall, how happy would you say your childhood was?	Low happiness (0-4)	92	8.4%	8.3%
	Medium happiness (5-6)	177	16.2%	16.3%
	High happiness (7-8)	311	28.4%	28.8%
	Very high happiness (9-10)	507	46.3%	45.9%
	Missing	7	0.6%	0.7%

Mental well-being

(SWEMWBS; [25]): Over the last two weeks:

	Response options	n	Unweighted	Weighted
I've been feeling optimistic (positive) about the future	None of the time	35	3.2%	3.1%
	Rarely	146	13.3%	13.0%
	Some of the time	410	37.5%	37.2%
	Often	389	35.6%	35.9%
	All of the time	107	9.8%	10.2%
	Missing	7	0.6%	0.6%
I've been feeling useful	None of the time	32	2.9%	2.8%
	Rarely	146	13.3%	12.9%
	Some of the time	313	28.6%	27.9%
	Often	396	36.2%	36.5%
	All of the time	201	18.4%	19.4%
	Missing	6	0.5%	0.5%
I've been feeling relaxed	None of the time	31	2.8%	2.8%
	Rarely	113	10.3%	10.0%
	Some of the time	361	33.0%	33.1%
	Often	439	40.1%	40.4%
	All of the time	148	13.5%	13.5%
	Missing	2	0.2%	0.2%
I've been dealing with problems well	None of the time	16	1.5%	1.4%
	Rarely	60	5.5%	5.3%
	Some of the time	259	23.7%	23.3%
	Often	471	43.1%	42.9%
	All of the time	279	25.5%	26.2%
	Missing	9	0.8%	0.9%
I've been thinking clearly	None of the time	12	1.1%	1.1%
	Rarely	56	5.1%	4.9%
	Some of the time	249	22.8%	22.0%
	Often	448	41.0%	41.2%
	All of the time	326	29.8%	30.5%
	Missing	3	0.3%	0.3%
I've been feeling close to other people	None of the time	15	1.4%	1.4%
	Rarely	68	6.2%	6.1%
	Some of the time	245	22.4%	22.0%
	Often	433	39.6%	39.6%
	All of the time	330	30.2%	30.6%
	Missing	3	0.3%	0.3%
I've been able to make up my own mind about things	None of the time	10	0.9%	0.9%
	Rarely	24	2.2%	2.1%
	Some of the time	125	11.4%	10.9%
	Often	373	34.1%	33.5%
	All of the time	557	50.9%	52.1%
	Missing	5	0.5%	0.4%



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