Collaboration for Leadership in Applied Health Research and Care, North West Coast

NHS National Institute for Health Research

CLAHRC BITE BRIEFING

Brokering Innovation Through Evidence

A summary of CLAHRC NWC research **FEBRUARY 2017**

Social Isolation and Loneliness – A review of the evidence

What is Social Isolation and Loneliness?

'images: www.freeimages.co.uk'

The literature suggests that social isolation is not simply a condition that leads to health co-morbidities, but it also forms part of a cascade of complex psycho-social factors that interact together to cause negative health outcomes, particularly among older adults (Nicholson, 2012).

Burchardt et al. (2002) identified four dimensions of social isolation/loneliness:

1. "***Consumption*** - the capacity to purchase goods and services, i.e. income;
2. ***Production*** - participation in economically or socially valuable activities such as employment, child-rearing or voluntary work;
3. ***Political activity*** - involvement in local or national decision making through voting or membership of a campaigning organisation;
4. ***Social engagement*** - with family, friends, and community" (cited in McConkey, 2007).

Other understandings of social isolation/loneliness found in the literature are:

- The **Threshold Effect**, that is regardless of perceptions, a minimal level of companionship & social activity are key elements in maintaining a person's sense of well-being (Thompson & Heller, 1990).
- The effects of living alone, declining cognition & difficulty undertaking routine daily activities of everyday life.
- Different people have different feelings about what represents social isolation/loneliness, e.g. Thompson & Heller (1990: 541) found that: 'family support was very important to our sample of elderly women… Among women who had weak ties with family members … companionship & social activity with friends appeared to be an effective substitute…'
- **Physical factors**, in conjunction with **subjective factors**, such as a lack of sense of belonging & feeling deficient in the quality of social relationships, are important attributes of social isolation (Nicholson, 2012).
- Having no friends from outside their place of abode, having no personal visitors to their home in the past month, not being known to their neighbours or knowing their neighbours (McConkey, 2007).

What we did?

In 2015 the CLAHRC NWC Public Health Theme conducted an evidence review on topic of social isolation & loneliness.

The review had a dual purpose: to *contribute to local decision-making* about the design of the Neighbourhood Resilience Programme we are developing in 10 relatively disadvantaged neighbourhoods across the North West Coast area; & to *support a programme of capacity building in research* for our local authority partners' staff.

We extensively searched the Web of Science databases & utilised Google Scholar & other search engines to identify literature sources relevant to our subject area. Our approach to the evidence review was pragmatic: we were not aiming at a comprehensive review due to time constraints & limited staffing resources. Instead we aimed to be systematic in the sense of being transparent about what we did & how we did it.

The evidence review extracted a range of academic & 'grey' policy literature on the social isolation/loneliness theme.

Risk Factors

Conjugal bereavement - can lead to an increased risk of deteriorating physical & emotional health in older people (Stewart, 2001).

A large literature exists on the benefits of marriage. A spouse can be seen as a special type of social network member who is invaluable to a partner's overall well-being (Nicholson, 2012).

Being widowed - loneliness among widowed females may be more prevalent if they fail to meet their social needs despite their stereotypical advantage in forming meaningful social relationships (Masi et al, 2010).

Economic constraints/low income - both factors are associated with social isolation along with inadequate personal resources (Nicholson, 2012). Lack of income can be a constraint on participating in clubs & activities that are often necessary to form & maintain friendship networks.

Linked to this, socio-economic status of an individual is a potential risk factor for social isolation (Nicholson, 2012).

Gender - being male! Females tend to be more self-reliant than males in finding & maintaining 'meaningful' social relations.

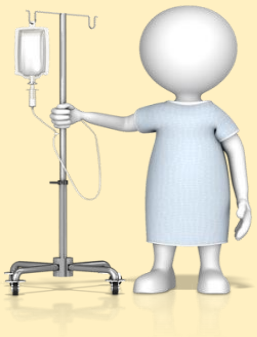
Level of education - one study found that older adults with less than 12 years of education were 1.6 times more likely to become socially isolated than those with 12 or more years of education (Nicholson, 2012).

Crime/fear of crime - neighbourhoods where safety is a concern may contribute to an increased risk of becoming socially isolated, particular among older adults (Nicholson, 2012).

Homelessness - social integration is an area in which homeless adults, even when housed, show little improvement (Tsai et al., 2012).

Poor health & other contributory factors of social isolation: having a physical health condition(s) or mental ill-health can inhibit social interaction. Being a carer, geographic location, communication & transport difficulties also contribute to social isolation & loneliness (Edelbrock et al., 2001; Gardner et al., 1999; Hall & Havens, 1999; Russell & Schofield, 1999).

Many of these factors [above] are often beyond the socially isolated person's control & are therefore 'not obviously susceptible to amelioration' (Wenger et al., 1996: 345-6). Thus, designing effective interventions to address social isolation & loneliness is a challenging task (Findlay, 2003).



Health Impacts of Social Isolation & Loneliness

Social isolation & loneliness impact on a range of moderate & severe health conditions, in particular (McLeod, Baker & Black, 2006):

- Heart disease/cancer
- Elevated blood pressure
- Sleeplessness
- Depression
- Cognitive decline
- Dementia
- Suicidal thoughts
- Resistance to the common cold

Social isolation also impacts the psychological & cognitive well-being of older adults. Those who have poor social connections & do not participate in social activities are at an increased risk of experiencing cognitive decline (Nicholson, 2012; Tilvis et al., 2004).

Lonely people are more likely to suffer Alzheimer's disease (Wilson et al., 2007).

Less socially connected men are at a significantly increased risk of death from suicide, as well as from other causes (Nicholson, 2012).

Conversely, older adults who have extensive social networks are more protected against dementia (Nicholson, 2012).

Social isolation can influence the pathways through which physiological mechanisms cause disease (Grant et al., 2009). For example, social isolation can inhibit the body's ability to recover from physiological responses to stress.

Types of intervention

Support groups - 'in-person' group support activities were found to decrease social isolation among over 65s (Medical Advisory Secretariat, 2008).

Befriending schemes - it was found that schemes where an individual befriender provides social support have a *modest effect* on depression across range of population groups (Mead et al, 2010).

Exercise programmes - community based exercise programmes were shown to reduce loneliness among physically inactive elders (Medical Advisory Secretariat, 2008). The Aging Well & Healthily programme for over-65's, consisting of health education by peers & low-intensity exercise was found to have a positive effect on reducing loneliness (Hopman-Rock & Westhoff, 2002).

Interactive, educational sessions - these aimed to educate older participants about the brain & memory, & focused on creating new memories & engaging in activities requiring relatively high levels of attention. These activities were designed to facilitate social interactions & develop social support networks (Winningham & Pike, 2007).

Art gallery intervention - *Viewing & making together*: *a multi-session art-gallery-based intervention for people with dementia & their carers* (Camic et al., 2014). Despite the lack of significance from standardised measures the interventions helped foster social inclusion & social engagement & enhanced the quality of life for the person with dementia.

Using creative activity - the *Upstream* model addressed social isolation in older people. It promoted active social contact, which encouraged creativity (e.g. crafts, creative writing, cookery, reading by school children & gentle exercise etc), along with the use of mentoring. Interventions of this kind are more likely to positively affect health & well-being (Greaves & Farbus, 2006).

Design factors contributing to positive outcomes

Group interventions & targeting - educational & social activity group interventions targeted at specific groups (women, carers, the widowed, the physically inactive or those with serious mental ill-health) can alleviate social isolation & loneliness (Cattan et al., 2005).

User group involvement - enabling some level of participant and/or facilitator control or consultation with the target group before the intervention (Cattan et al., 2005). For instance, interventions in which older people are active participants appeared more likely to be effective (Dickens et al., 2011).

Effectiveness of group-based activities - these appear more successful across a wider range of outcome domains than those offered on a one-to-one basis (Dickens et al., 2011).

Building on what exists - interventions have a greater chance of success if they utilise existing community resources & build on community capacity (Findlay, 2003).

Interventions are best directed to address specific support deficiencies - e.g. interventions for people who are quantitatively isolated but who view their existing social ties as supportive, may best be directed toward removing constraints that limit opportunities for interaction (Thompson & Heller, 1990).

'Invisible support' - i.e. support which the recipient is unaware, has detectable effects on wellbeing, partly because it does not entail the psychological cost to competence that comes from more transparent acts of assistance (Bolger, Zuckerman & Kessler, 2000 cited in Schnittker, 2007).

Teams models - which challenge inequities of power distribution in adult-adolescent relationships & institutional racism. Shared governance of groups between youth & adults, across social class, culture & ethnicity can address social inclusion & empowerment issues among youth people (McDonald et al., 2009).

Gaps in the research literature

There is an absence of research and literature beyond the level of the individual (Bigby, 2012).

Little research has been directed at identifying effective interventions that influence the social isolation & other burdens imposed upon caregivers (Medical Advisory Secretariat, 2008).

Research must move beyond an approach that tends to equate social inclusion with simple counts of how many times a person goes out their front door to visit the community (Bigby, 2012).

There is scarce evidence that public health professionals are assessing social isolation in older persons, despite their unique access to very socially isolated, homebound older adults (Nicholson, 2012).

The small body of research about the social inclusion of people with challenging behaviour means there is a dearth of evidence on which to base decisions about specific psychosocial, behavioural & clinical interventions or the organisation of programmes to support social inclusion (Bigby, 2012).

REFERENCES

Bigby, C. (2008). Known well by no-one: Trends in the informal social networks of middle-aged & older people with intellectual disability five years after moving to the community. Journal of Intellectual & Developmental Disability 33(2): 148-157.

Burchardt, T. et al. (2002). Degrees of exclusion: developing a dynamic, multidimensional measure.In Understanding Social Exclusion (eds J. Hills, J. Le Grand & D. Piachaud): 30 -43.

Campbell, C. & McLean, C. (2002). Ethnic identities, social capital & health inequalities: factors shaping African-Caribbean participation in local community networks in the UK. Social Science & Medicine, 55(4): 643-657.

Camic, P. M., et al. (2014). Viewing & making together: a multi-session art-gallery-based intervention for people with dementia & their cares. Aging & Mental Health 18(2): 161-168.

Cattan, M. et al. (2005). Preventing social isolation & loneliness among older people: a systematic review of health promotion interventions. Ageing & Society 25: 41-67.

Chinman, M.J. et al. (2001). Chronicity reconsidered: Improving person-environment fit through a consumer-run service. Community Mental Health Journal 37(3): 215-229.

Dickens, A. P. et al. (2011). Interventions targeting social isolation in older people: a systematic review. BMC Public Health 11.

Edelbrock, D. et al. (2001). Social support, social networks & social isolation: The Sydney older persons' study. Australasian Journal on Ageing, 20, 4, 173-8.

Findlay, R.A. (2003). Interventions to reduce social isolation amongst older people: where is the evidence? Ageing & Society, 23(05), 647-58.

Gardner, I., et al. (1999). Improving Social Networks, a Research Report: Improving Health & Social Isolation in the Australian Veteran Community. Lincoln Gerontology Centre, La Trobe University, Melbourne.

Grant et al. (2009). Social isolation & stress related cardiovascular, lipid & cortisol responses. Ann Behay Med. 37(1): 29-37.

Greaves, C. J. & L. Farbus (2006). Effects of creative & social activity on the health & well-being of socially isolated older people: outcomes from a multi-method observational study. Journal of the Royal Society for the Promotion of Health 126(3): 134-142.

Hall, M. & Havens, B. (1999). Ageing in Manitoba Study. Dept. of Community Health Sciences, University of Manitoba, Winnipeg.

Hopman-Rock, M. (2002). Development & Evaluation of Aging Well & Healthily: A Health-Education & Exercise Program for Community-Living Older Adult. Journal of Aging & Physical Activity,10, 364-38.

Masi, C.M. et al. (2010). A meta-analysis of interventions to reduce loneliness. Personality & Social Psychology Review.

McConkey, R. (2007). Variations in the social inclusion of people with intellectual disabilities in supported living schemes & residential settings. Journal of Intellectual Disability Research, 51: 207-217.

Mccorkle, B.H. et al. (2009). Compeer friends: A qualitative study of a volunteer friendship programme for people with serious mental illness. International Journal of Social Psychiatry 55(4): 291-305.

McDonald, L., et al. (2009). An evaluation of a groupwork intervention for teenage mothers & their families. Child & Family Social Work, 14(1): 45-57.

McLeod A, Baker D & Black M. (2006) Investigating the nature of formal social support provision for young mothers in a city in the North West of England Health. Social Care in the Community, 14 (6), 453-464.

Mead, N. et al. (2010) Effects of befriending on depressive symptoms & distress: Systematic review & meta-analysis. British Journal of Psychiatry, 196: 96-100.

Medical Advisory Secretariat, (2008). Social isolation in community-dwelling seniors: an evidence-based analysis. Ontario Health Technology Assessment Series; 8(5).

Nicholson, N. R. (2012). A Review of Social Isolation: An Important but Under assessed Condition in Older Adults. Journal of Primary Prevention, 33(2-3): 137-152.

Routasalo et al. (2009). Effects of psychosocial group rehabilitation on social functioning, loneliness & well-being of lonely, older people: randomized controlled trial. Journal of Advanced Nursing, 65(2): 297-305.

Russell, C. & Schofield, T. (1999). Social isolation in old age: a qualitative exploration of service providers' perceptions. Ageing & Society, 19: 1, 69-91.

Schnittker, J. (2007). Look (closely) at all the lonely people - Age & the social psychology of social support. Journal of Aging & Health 19(4): 659-682.

Stewart, M. et al. (2001). Promoting positive affect & diminishing loneliness of widowed seniors through a support intervention. Public Health Nursing 18(1): 54-63

Thompson, M. G. & K. Heller (1990). Facets of support related to well-being - quantitative social-isolation & perceived family support in a sample of elderly women. Psychology & Aging, 5(4): 535-544.

Tsai, J., et al. (2012). Does Housing Chronically Homeless Adults Lead to Social Integration?" Psychiatric Services, 63(5): 427-434.

Tilvis RS, et al. (2004). Predictors of cognitive decline & mortality of aged people over a 10-Year period. The Journals of Gerontology Series A, Biological Sciences & Medical Sciences, 59(3): 268-274.

Wenger, C., et al. (1996). Social isolation & loneliness in old age: review & model refinement. Ageing & Society, 16, 3, 333-58.

Wilson RS, et al. (2007). Loneliness & risk of Alzheimer disease. Archives of General Psychiatry, 64:234-240.

Winningham, R. G. & N. L. Pike. (2007). A cognitive intervention to enhance institutionalized older adults' social support networks & decrease loneliness. Aging & Mental Health 11(6): 716-721.

How will the review be used?

The review has contributed to broadening the evidence base on the subject of social isolation & loneliness.

It has provided information to CLAHRC NWC partners, especially those who are considering developing interventions or responses to social isolation & loneliness.

The review has identified a significant gap in the academic literature on social isolation & loneliness, which the CLARHC NWC Public Health Theme will seek to address by producing publications.

The findings of the review will be available to inform the development of systems resilience changes that will take place in CLARHC NWC's 10 *Neighbourhoods for Learning*.

What is the CLAHRC NWC?

The Collaboration for Leadership in Applied Health Research & Care, North West Coast is a partnership between universities, NHS, councils & other stakeholders & public.

Our mission is to undertake applied research to improve public health, well-being, quality of care & reduce health inequalities across the North West Coast region.

CLAHRC NWC is funded by the National Institute for Health Research.

Any comments/feedback contact: glenn.simpson@liverpool.ac.uk.