Loneliness or isolation: is there a difference & does it matter?

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www.gbhi.org

Educational goals

- The meaning of loneliness and isolation
- The evidence that loneliness and isolation can impact on health
- The differential effects of loneliness and isolation on mortality and aspects of health
- Implications for interventions

The neglect of social relationships & health

- Little in psychological, psychiatric or gerontological literature
- Not covered in medical school curriculum
- Despite the effects on health, no public health policy or funding support

What is loneliness?

"……exceedingly unpleasant and driving experience connected with inadequate discharge of the need for human intimacy, for interpersonal intimacy" Harry Stack Sullivan (1953)

"Loneliness appears to be such a frightening and painful experience that people will do practically everything to avoid it"….. "real loneliness plays an essential role in the genesis of mental disorder" (Fromm- Reichmann 1959)

"Loneliness is a proximity-promoting mechanism necessary for the survival of the species (Bowlby, 1973)

"Vulnerability to loneliness may be part of our evolutionary heritage"(Weiss 1973); "loneliness is the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively" (Perlman & Peplau, 1981)

"Loneliness is felt as social pain which motivates human beings to form relationships" (Cacioppo & Patrick, 2009)

Loneliness may be part of our innate biology

- Social connection is vital for the survival of social species
- Social isolation, social exclusion, or feelings of social disconnection can lead to the 'painful' state of loneliness
- The negative aversive state of isolation & loneliness triggers desire to seek out social interaction in both humans and rodents (mice)

"Of Mice and Men"

"A guy needs somebody to be near him. A guy goes nuts if he ain't got nobody. Don't make no difference who the guy is, long's he's with you. I tell ya, a guy gets lonely an' he gets sick."

John Steinbeck 1937

Of mice (not men)

*Dorsal Raphe Dopamine Neurons May Represent the **Experience** of Social Isolation*

Gillian A. Matthews, Edward H. Nieh, Caitlin M. Vander Weele, Sarah A. Halbert, Roma V. Pradhan, Ariella S. Yosafat, Gordon F. Glober, Ehsan M. Izadmehr, Rain E. Thomas, Gabrielle D. Lacy, Craig P. Wildes, Mark A. Ungless, Kay M. Tye

DRN DOPAMINE neurons represent a neural substrate for the subjective experience of social isolation and serve to promote a response to alleviate this aversive state

Cell PRESS
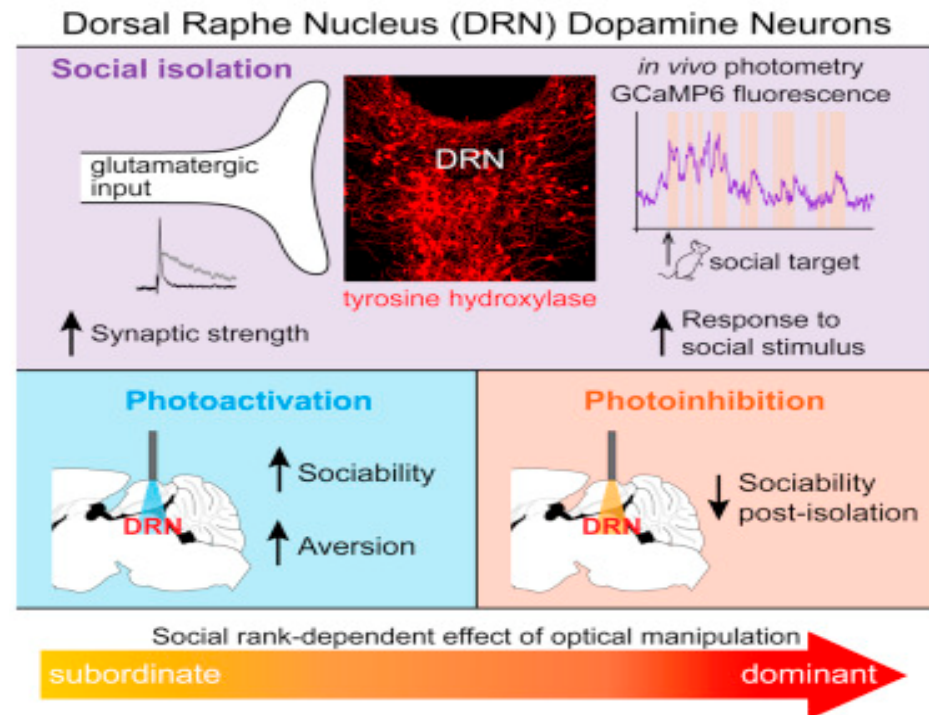
The psychopathology of loneliness

- A poorly conceptualized psychological phenomena
- A response to 'relational deficit' that is uniformly distressing
- Different from depression which cannot be 'reached' by relationships but is a risk for and close to depression
- Different to grief but is often a component of grief and persists if no new relationship develops
- Loneliness is not caused by being alone and is not necessarily cured by ending 'aloneness'

Types of loneliness

Weiss RS 1973 Typology of Loneliness
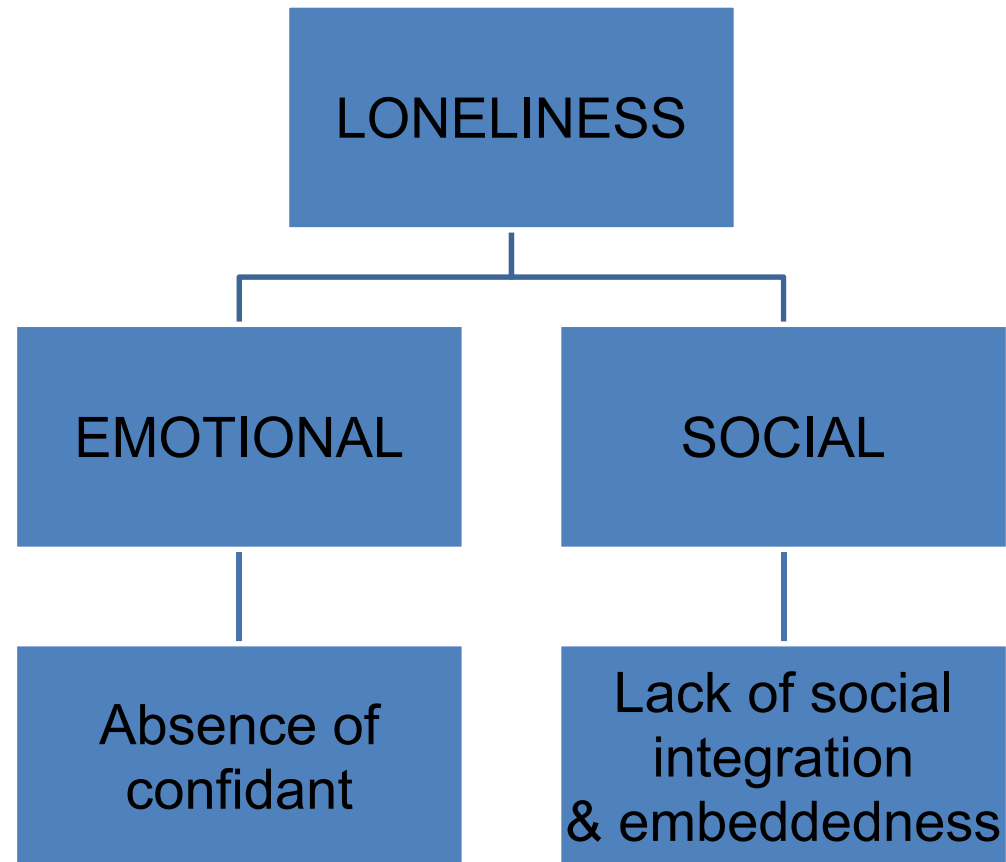
Descriptive phenomenology of loneliness

- Emotional loneliness: similar to re-experiencing the anxiety of a childhood separation-**anxiety, hyper-vigilance, overly sensitive, prone to misinterpret, searching for a confidant**

- Social loneliness :experienced more like **feelings of marginalization, boredom, sense of exclusion, poor concentration**-searching for activities and a network with **fewer feelings of anxiety**

What is isolation?

Isolation is more **objective** and reflects frequency or number of **social contacts, social network, marital status, living alone**

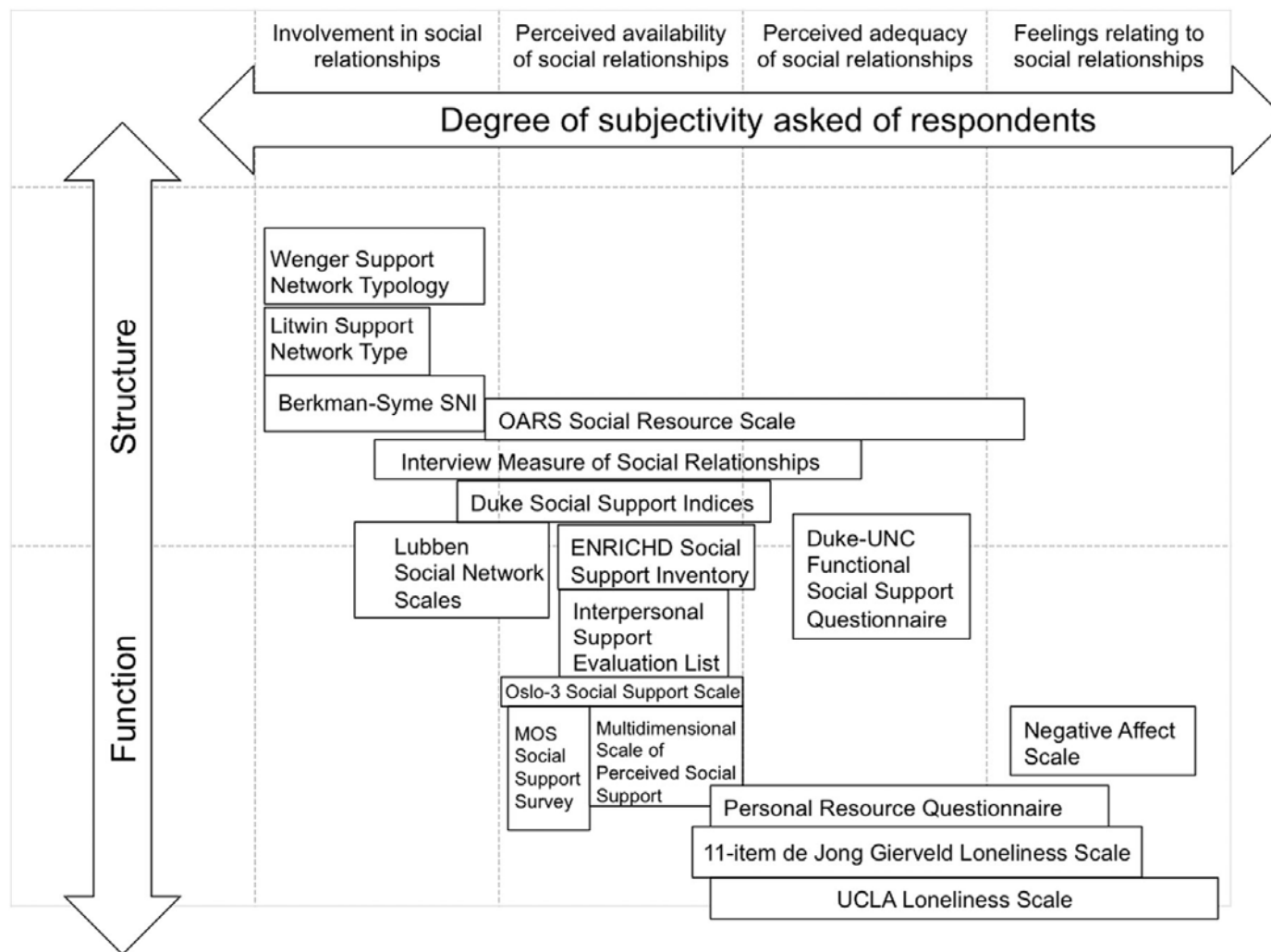Isolation is frequently but not always associated with loneliness

Isolation and loneliness are often poorly correlated

Loneliness & isolation

- Often blurred by definition
- Commonly co-occur
- Significant overlap in what is measured
- Risks to health not necessarily interchangeable

Comparing multi-item questionnaires using a two-dimensional diagram

Nicole K Valtorta et al. BMJ Open 2016;6:e010799

BMJ Open

Prevalence & risk factors for loneliness

- 35% report **feeling lonely**
- 6-9% have **significant level of loneliness**
- Risk factors include being widowed, **living alone**, having physical disability and a **poor social network**

Golden et al. In J Geriatr Psychiatry 2009

Loneliness & isolation are associated with…..

- Increased risk of premature death
- Sleep problems
- Hypertension
- Stroke
- Heart attack
- Depression and increased risk of depression
- Poor quality of life
- Frailty
- Cognitive impairment & dementia

How loneliness & isolation kill
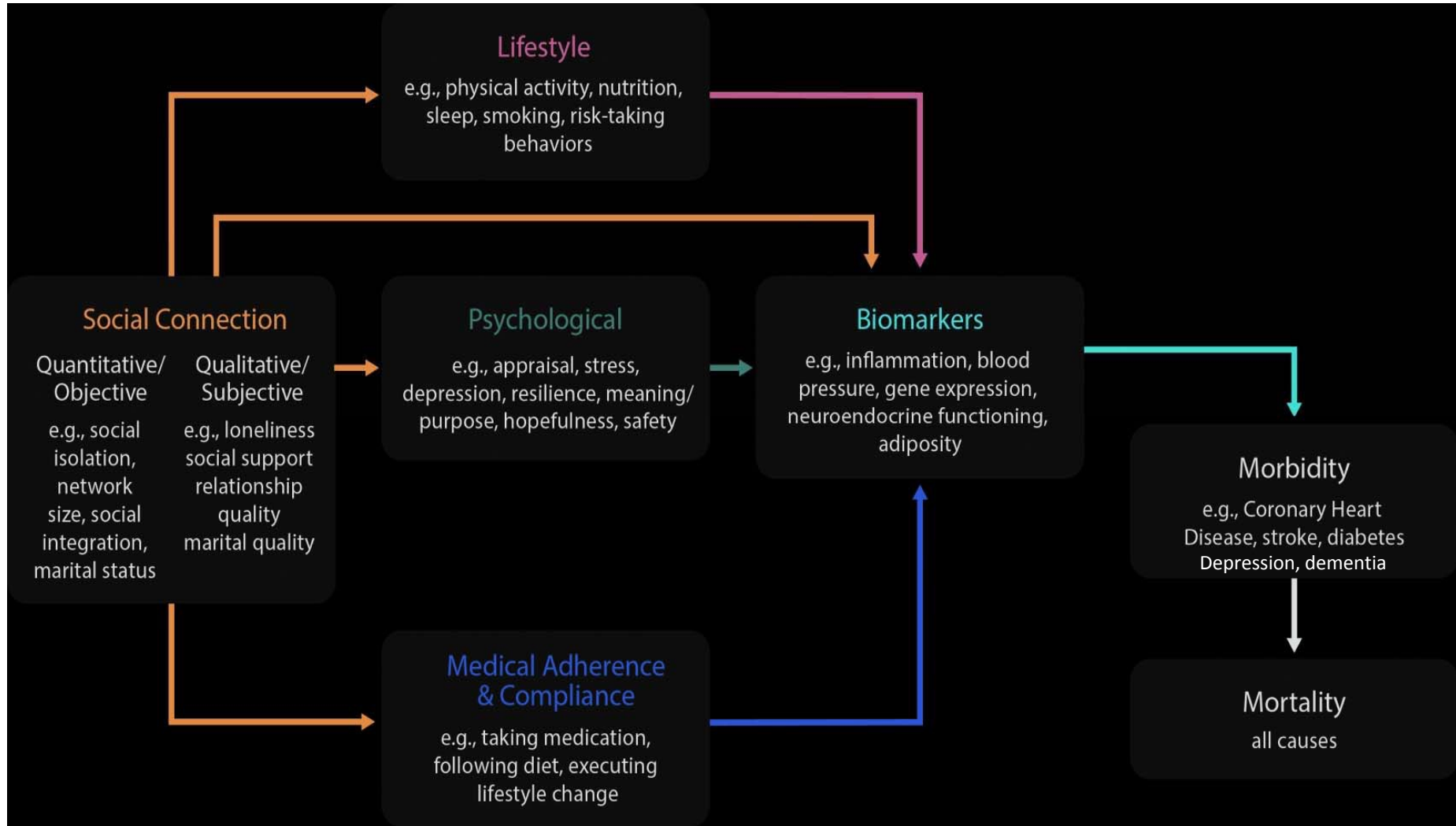
Modified from Holt –Lunstad & Smith 2016

Loneliness, isolation and mortality

'...the overall odds for mortality was 1.50, similar to the risk from light smoking and exceeding the risks conferred by hypertension and obesity '

Holt-Lunstad et al.2010

Differential effects of loneliness & isolation: mortality

- Some suggestion that loneliness is what matters in terms of increasing mortality at 10 years in men only (Howerda et al. 2012); increased mortality in lonely but not for isolation (Chan et al. 2015)

- Isolation but not loneliness has significant effect on mortality and reducing isolation may be more important (Steptoe et al. 2013)

- Holt-Lundstad et al. meta-analysis (2015) found no difference between objective isolation & subjective isolation (29% vs 26%) on increased risk of mortality

Heart attack & stroke

- Meta-analysis showed 30% increased risk due to **poor social relationships** (Valtorta et al. 2016)

- Difficult to tease apart whether this is due to loneliness, isolation or a mixture of the two

- Most studies measured isolation and not loneliness for CHD; for stroke, no study measured the effect of loneliness

Social engagement & risk of dementia

Social relationship factors that represent a **lack of social interaction** are associated with incident dementia

Low social participation (**RR: 1.41** (95% CI: 1.13–1.75)

Less social contact (**RR: 1.57** (95% CI: 1.32–1.85)

Loneliness (**RR: 1.58** (95% CI: 1.19–2.09))

The strength of the associations between poor social interaction and incident dementia is comparable to **low education attainment, physical inactivity, and late-life depression**

Kuiper et al. Ageing Research Reviews 2015

Dementia

- Feeling lonely but not isolation associated with risk of dementia at 3 years (Howerda et al. 2015)

- High loneliness score increased risk of AD compared to low score and no effect of isolation (Wilson et al. 2007)

Interactive Impacts of **Loneliness** & **Social Isolation** on Incident Dementia in the English Longitudinal Study of Ageing (ELSA)

JE McHugh[1,2], BA Lawlor[2], A Steptoe[3] & F Kee[1]

1: Centre for Public Health, Queen's University Belfast, BT12 6BJ, United Kingdom; 2: Institute of Neuroscience, Trinity College, Dublin 2, Ireland; 3: Department of Epidemiology and Public Health, University College London, London WC1E 6BT.

Introduction

With 46 million people worldwide currently living with dementia, and a figure of 131.5 million expected by 2050[1], a search for modifiable risk factors is imperative.
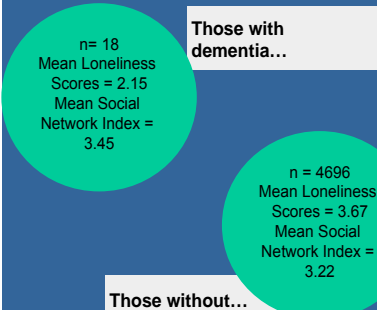
Social isolation has been shown to relate to increased dementia risk[2].

Holwerda and colleagues attribute the causality to **Loneliness** rather than social isolation in the etiology of dementia[3].

While Holwerda and colleagues examined loneliness in relation to dementia among socially isolated subgroups of participants, they did not directly explore the potential for an interaction between loneliness and social isolation in predicting incident dementia.

Research Question: Is the effect of loneliness on incident dementia different at different levels of social isolation?

Methods

Study Design

✐The English Longitudinal Study of Ageing (ELSA) is a population-based representative observational cohort study of older adults.

Participants

✐For our analyses, we included data from 4717 participants aged over 50 who partook in waves 3, 4, 5, and 6 of ELSA and who lived independently in the community without dementia at wave 3.

Measures

✐Outcome: Incident dementia: that is, dementia diagnosis between waves 5 & 6 (but not before wave 5).

✐Predictors: Loneliness (scores on the UCLA modified loneliness scale[4]) and Social Isolation (scores on the Berkman Syme Social Network Index[5]).**Lower scores on the index indicate higher levels of social isolation.**

✐Covariates: age, gender, education level, deprivation index, depressive symptoms, cognitive status, self-reported chronic illnesses.

Data Analysis

- Multiple imputation was used to respond to missing data in the dataset. Logistic regression analysis with moderation effects were performed on incident dementia between waves 5 & 6.

Sample Characteristics

Those with dementia…

n= 18
Mean Loneliness Scores = 2.15
Mean Social Network Index = 3.45

n = 4696
Mean Loneliness Scores = 3.67
Mean Social Network Index = 3.22

Those without…

Results

The model containing the interaction term was an improvement in fit over the model without (AIC = 177.62 vs. AIC = 189.05; χ^2_1 = 13.42, p<0.001).

The model was an improvement over baseline (χ^2_{55} = 55, p<0.001; Nagelkerke's R^2 = 0.28).

Interaction Term

There was a significant interaction between Loneliness and Social Isolation (log odds = 0.79, p<0.001; OR = 2.19, CI_{95} = 1.42, 3.48). As Social Isolation increases, loneliness has more of an effect on incident dementia.

Main Effects

Loneliness predicted incident dementia at follow-up (log odds = 0.59, p<0.05, OR = 1.8, CI_{95} = 1.02, 3.18).

Social Isolation did not predict incident dementia at follow-up (log odds = -0.28, p>0.05; OR = 0.75, CI_{95} = 0.4, 1.39).
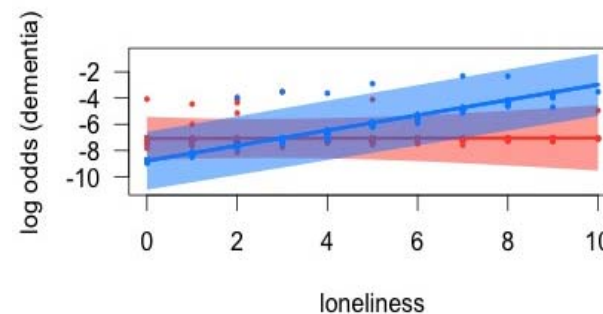
Scores on the UCLA Loneliness Scale plotted against log odds of incident dementia (blue line indicates individuals with low social isolation, red line indicates individuals with high social isolation (shaded areas indicate confidence bands; partial residuals also included). As log odds (dementia) increases, the probability of incident dementia at 8 year follow-up increases.

Conclusion

In individuals with lower social isolation, loneliness has a greater effect on incident dementia than among those with higher levels of social isolation.

This may indicate that susceptibility to the experience of loneliness even in the absence of objective isolation (a term that we previously **called Social Asymmetry[6]**) is clinically meaningful.

References

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2. Fratiglioni, L., Wang, H.X., Ericsson, K., Maytan, M. & Winblad, B. (2000). Influence of social network on occurrence of dementia: A community-based longitudinal study. Lancet, 355(9212) 1315-1319.
3. Holwerda, T.J., Deeg, D., Beekman, A., Tilburg, T., Stek, M., Jonker, C. & Schoevers, R. (2012). Feelings of loneliness, but not social isolation, predict dementia onset: Results from the Amsterdam Study of the Elderly (AMSTEL). Journal of Neurology, Neurosurgery and Psychiatry, 85(2), 135-142.
4. Russell, , D. W. 1996. UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. Journal of Personality Assessment, 66, 20-40.
5. Berkman, L. & Syme,, S. 1979. Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. American Journal of Epidemiology, 109, 186-204.
6. McHugh, J.E., Kenny, R.A., Lawlor, B.A., Steptoe, A. & Kee, F. (In Press). The Discrepancy between Social Isolation and Loneliness as a Clinically Meaningful Metric: Findings from the Irish and English Longitudinal Studies of Ageing (TILDA & ELSA). International Journal of Geriatric Psychiatry.

CARDI Fellow
Leadership Programme in Ageing Research

Depression & loneliness

- Loneliness is close to depression but is not depression
- Loneliness is a risk factor for depression
- But you can be lonely and not depressed or depressed and not lonely

Overlap between depression, social network and loneliness
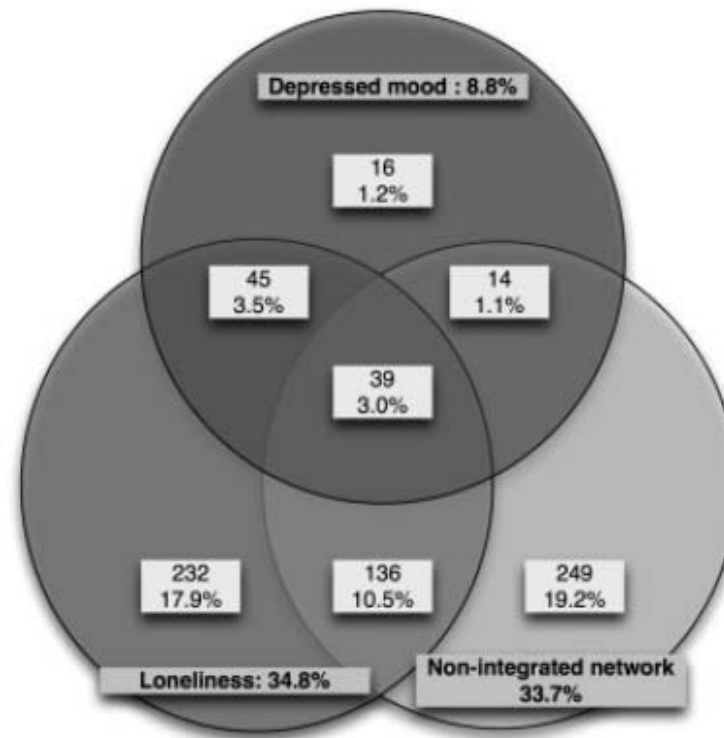
Figure 1. The overlap between loneliness, non-integrated social network and depressed mood.

Golden et al. In J Geriatr Psychiatry 2009

Depression & loneliness

Prevalence of depression
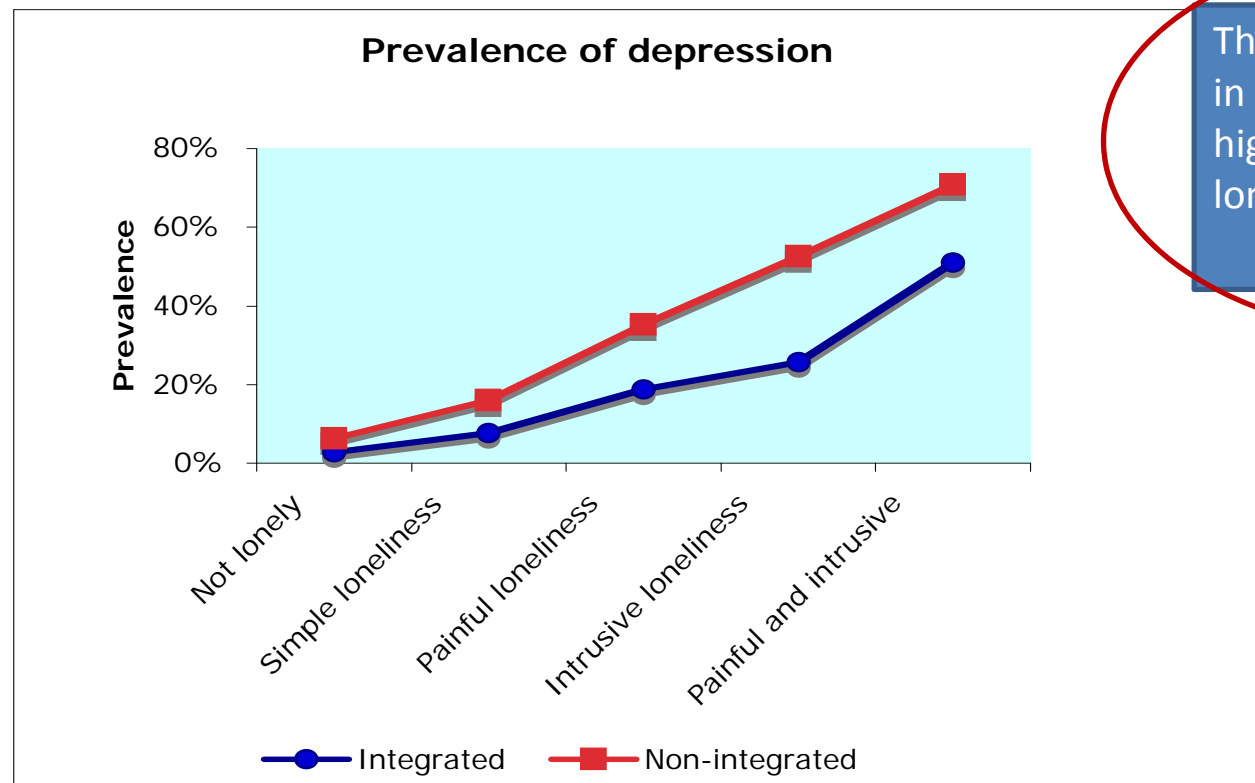
The excess risk of depression in widowhood is due to the higher prevalence of loneliness

Golden et al. 2009 Int J Geriatr Psychiatry

Exposure to loneliness is more important than network in terms of development of depressed mood

Table 2. Attributable risks for depressed mood associated with loneliness and non-integrated social network

Factor	Prevalence	Odds Ratio*	Attributable risk (exposed)	Attributable risk (population)
Loneliness	34.8%	6.4**	82%**	61%**
Non-integrated network	33.7%	1.6***	40%***	19%***
Either lonely or non-integrated network	55.0%	5.8	81%	70%

*Odds ratios and attributable risks adjusted for age, never married, lives alone, physical disability.
**Also adjusted for non-integrated network.
***Also adjusted for lonliness.

Golden et al. 2009

Effect of loneliness on depression is mediated by social support
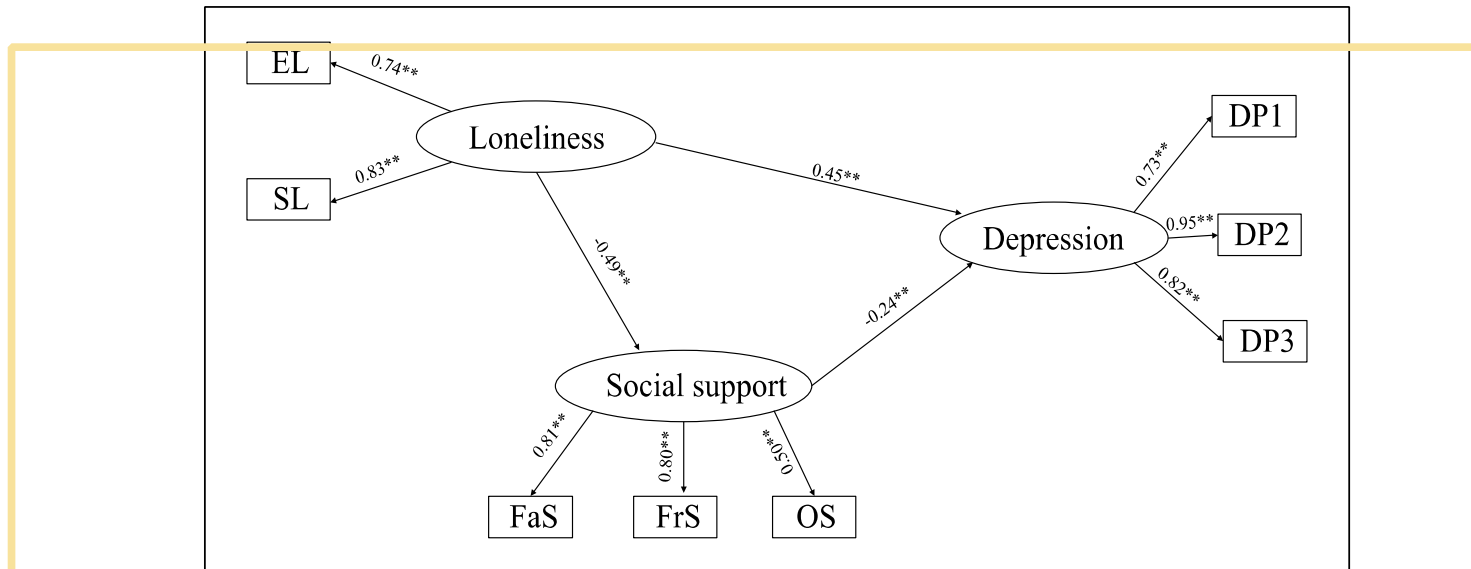
Figure 1. The final structural model (*N* = 310).
EL: emotional loneliness; SL social loneliness; FaS: family support; FrS: friends' support, OS: significant other support
DP1-DP3: three parcels of depression.
Factor loadings are standardized.
**p < 0.01.

Liu et al.J Health Psychology 2016

Need to address both isolation & loneliness but should customise

Both objective and subjective measures of social isolation should be considered in risk assessment

Different combinations of social isolation and loneliness may represent different levels of risk

Social Asymmetry: Concordantly Lonely and Isolated, Discordant: Robust to Loneliness, or Discordant: Susceptible to Loneliness -Robust to Loneliness individuals were superior (cognitive) performers (McHugh et al. 2015)

Loneliness as a DSM V Mental Disorder?

- **A behavioral or psychological syndrome** or pattern that occurs in an individual
- The consequences of which are clinically **significant distress** (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
- Must **not be merely an expectable response** to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
- That **reflects an underlying psychobiological dysfunction**
- That is not solely a result of social deviance or conflicts with society
- That has diagnostic validity using one or more sets of diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment)
- That has clinical utility (e.g., contributes to better conceptualization of diagnoses, or to better assessment and treatment)

Potential to prevent or reduce loneliness
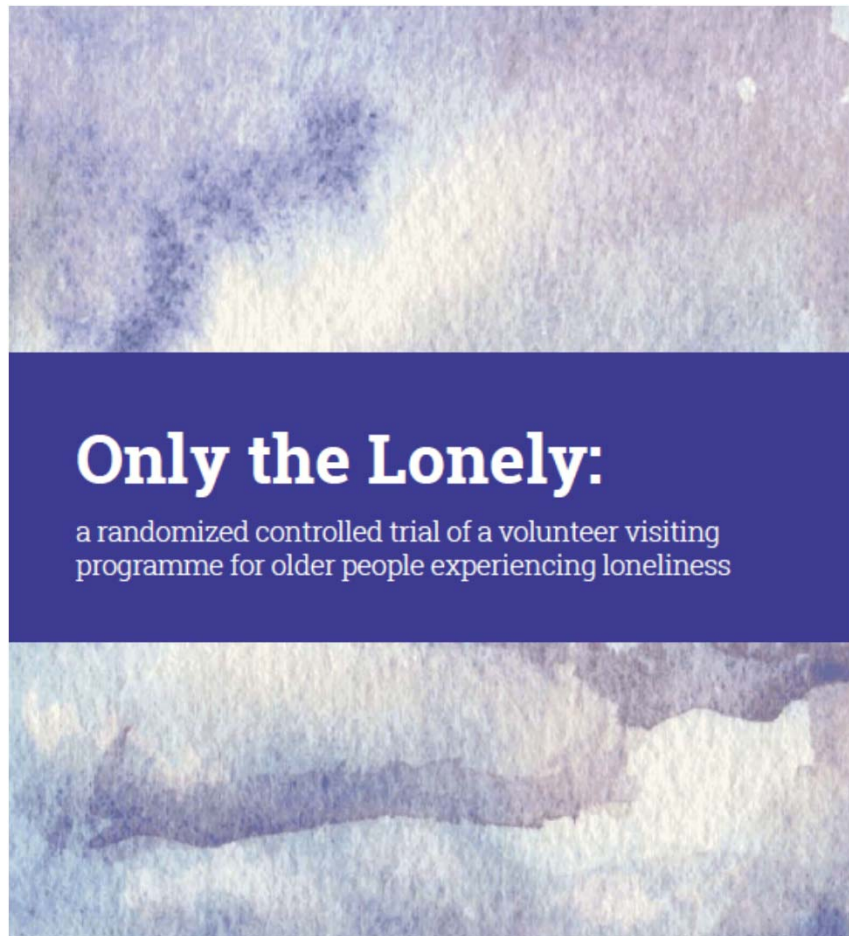
Trained **volunteer** who visits the participant for 1 hour for 10 weeks

Decreased loneliness at 1 and 3 months in participants compared to controls

Less loneliness in volunteers at 1 month

No effect on isolation

Potentially **scalable intervention** to reduce loneliness in older people

It engages **volunteers** as a valuable natural resource of the community for the community

Only the Lonely:
a randomized controlled trial of a volunteer visiting programme for older people experiencing loneliness

Trinity College Dublin
The University of Dublin

Qualitative evaluation

'It's a very lonely life all night and day at home looking out especially in the winter'

'Yes I live alone I have no one to talk to only the dog and cat'

'I would be in the house and I wouldn't see a soul, not a soul'

The benefits of intervention

'He comes every Wednesday we went out for lunch yesterday I hadn't done that in ten years I enjoyed it'

'It was like one of the family coming...it has made life a little bit brighter for us '

'My volunteer used to come down and say that he really enjoyed it and I'd be saying the same to him. It's a two way street and the relationship that builds up. You would look forward to it'

What can we do?

- Creating 'stable communities'

- Volunteer 'relational' interventions

- Building a natural resilience addressing cognitions

- Prevention in 'at risk' groups

More qualitative & quantitative research is needed to tease apart the contribution of isolation and loneliness to health & how best to intervene

Policy & implementation

Prevention
Risk assessment
Education

WHO now lists 'Social Support Networks' as a determinant of health
http://www.who.int/hia/evidence/doh/en/).

Conclusions

- Loneliness and isolation are important health issues
- Impact on health outcomes including depression, heart disease and mortality
- More research required on the relative contributions of isolation & loneliness and what constiutes effective interventions
- Assessment & interventions for social relationship must be mainstreamed in public health, medical care and medical education

A cure for loneliness…….?

Responding to loneliness: opportunities and potential pitfalls

Thomas Scharf

Professor of Social Gerontology, Newcastle University

Fuse QRM, Healthy Ageing Research Programme

'Loneliness and social isolation in an ageing society: a public health challenge?'

5 October 2016, Newcastle University

Loneliness and social isolation

- Social isolation and loneliness are related but distinct concepts
- *Loneliness* is a subjective and negative experience:

    "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively" (Perlman & Peplau, 1981, p.31)

- *Social isolation* is an objective measure reflecting an individual's lack of contacts or ties with others (family, friends, acquaintances, neighbours, potentially service providers)

Forms of loneliness

Weiss (1973) distinguishes between emotional and social forms of loneliness:

- *Emotional loneliness* reflects a person's perceived lack of an intimate attachment – a spouse/partner, a best friend, or another confidant

- *Social loneliness* refers to a person's sense that they are not part of an engaging social network of family, friends and others (Dykstra, 2009)

Individuals may experience emotional and social forms of loneliness at the same time

Duration of loneliness

- *'Transient'* loneliness may occur from time to time, but passes over the course of a day
- *'Situational'* loneliness may arise after a specific change in an individual's circumstances, but passes with time
- *'Chronic'* loneliness refers to persistent feelings of loneliness that may endure over a considerable period of time (Young, 1982)
- '*Seasonal'* loneliness is typically associated with winter months and/or with particular seasonal events (e.g. Christmas and New Year period)

Individual impacts of loneliness

Increasing research evidence linking loneliness to:

- Reduced quality of life

- Premature mortality

- Broad range of physical and mental health conditions (e.g. sleep disorders, risk of cardiovascular disease, low self-esteem, dementia, depression)

- Increased use of medications

- Increased alcohol consumption

Caveat: evidence of growing tendency in policy (and research) to 'pathologise' loneliness; loneliness affects only a small proportion of older people at any one time

Broader impacts of loneliness

Social and economic impacts that reach beyond individuals:

- Impacts on families, friends and neighbours

- Impacts on communities (e.g. community-based interventions to tackle isolation and loneliness)

- Impacts on broader society (e.g. increased use of health/social care services; GP consultations; emergency admissions to hospital; re-admission to hospital; entry into institutional care)

Rethinking loneliness as a life-course issue

- Experience of loneliness fluctuates across the life course, reflecting changing personal circumstances
- Loneliness may be characteristic of certain life stages (e.g. 'empty-nest' stage; advanced old age for some)
- Some life transitions may be more closely associated with loneliness (e.g. leaving home; relationship breakdown; migration; bereavement; retirement; onset of chronic ill health; assumption of caring roles)
- Loneliness may be regarded as a cohort issue (e.g. impact of AIDS/HIV; migration trends)

Rethinking loneliness as a form of social exclusion

- Loneliness as a form of exclusion experienced by older people

- Social exclusion understood as:
  - "a multidimensional process of progressive social rupture, detaching groups and individuals from social relations and institutions and preventing them from full participation in the normal, normatively prescribed activities of the society in which they live." (Silver, 2007)

- 'Exclusion from social relations' linked to other features of exclusion (e.g. poverty, lack of civic engagement, limited use of/access to services) (Scharf et al., 2005)

Pathways to exclusion from social relations

Continuation of longstanding difficult relationships with other people:

"The way I look at it, if I want to go anywhere I've got no-one to tell where I'm going and what time I'll be back. I've just got my own free life … I mean my husband's been dead 11 years and I used to have a terrible life with him. But it's just the way I want it now, free, please myself what I do."

(60 year-old Indian woman)

Pathways to exclusion from social relations

Impact of life events and/or age-related losses:

"My husband was only 49 when he died. And I didn't have much time to mix up with anybody, because I used to stay here with the children. And we'd say when they're older we'll go out together. But he died when he was 49 so I never got the chance."

(71 year-old white woman)

Pathways to exclusion from social relations

Changing communities:

"[We] had lovely neighbours … no such thing as neighbours now … well you don't congregate like same as like on bonfire night. In the old days all the neighbours used to be outside with chairs and what have you … having treacle toffee and roasted potatoes and all this lot, nobody cares about you now."

(68 year-old white man)

Drivers of exclusion from social relations

- **Structural drivers**: changing norms and behaviours around social relationships; social and economic policies; global trends (demographic change, migration patterns, individualisation, secularisation, ITCs)
- **Environmental drivers**: changing (urban/rural) communities; planning policies; service depletion; poor housing; age-segregated living; crime
- **Individual drivers**: disrupted social (support) networks; transitions/life events; ill health and disability; loss of mobility; personal and family migration patterns; psychological factors

Potential responses to exclusion from social relations

- **Structural**: addressing values/behaviours towards ageing adults; guaranteeing access to resources/supports at all life stages; anti-poverty measures; broad public health approach; human rights approach
- **Environmental**: creating and maintaining sociable, age-friendly environments; community development; age-integrated housing; crime reduction; engaging older people in planning local responses
- **Individual**: preventative strategies across the life course; co-ordinated services/supports to help individuals at times of need; talking therapies; forms of befriending; digital literacy schemes, ICTs etc.

'Risky' responses to exclusion from social relations

- Some approaches likely to focus on behaviour of those who experience loneliness or social isolation rather than on societal and/or environmental drivers.

- Examples :
  - People who choose not to engage with traditional service responses (e.g. befriending schemes; digital schemes) could lose access to other types of support
  - Excessive focus on increased risk of dependency on state supports arising from relationship breakdown may lead to reduced supports for people experiencing such transitions

Key issues for policy and practice

- Identifying whether the issue is loneliness and/or social isolation

- Having a sound theoretical foundation for interventions

- Considering whether responses should target people experiencing social and/or emotional forms of loneliness

- Thinking about when and where to intervene: At the point where people are identified as being 'chronically' lonely? Early in the life course? Late in the life course? In people's homes? In the community? In cyberspace?

- Addressing links between loneliness and other forms of disadvantage

- Need for a strategic (public health) approach that avoids overly moralistic, behavioural responses

- Collecting and interpreting evidence

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OUR
THIRD AGE
CAN BE OUR
BEST AGE

Dr Kellie Payne

Learning and Research Manager

Campaign to End Loneliness
CONNECTIONS IN OLDER AGE

The Campaign to End Loneliness ...

- Five years old (young) this year

- Campaigning body to promote a major shift in thinking about loneliness

- Drive increased awareness of loneliness as a major health and economic problem

- Campaign for positive policies and plans on the ground

- Promote sharing of knowledge and best practice

- Over 1200 organisations in our Learning network

The Missing Million Report

Main Aims:

1. To help commissioners and service providers develop methods to allow them to identify older people experiencing loneliness

2. To help commissioners and service providers to put these methods into practice

3. To help frontline workers to better understand and respond to loneliness and engage older people in constructive dialogue.

THE MISSING MILLION:
IN SEARCH OF THE
LONELIEST IN OUR
COMMUNITIES

Campaign to EndLoneliness
CONNECTIONS IN OLDER AGE

Structure of Report

Three sections

**1.	Identifying loneliness**

-what data is available to help identify lonely older people

2. Applying the methods

- Case studies illustrating how the data has been used

3. Talking about loneliness

- Ways to have a conversation about loneliness

THE MISSING MILLION:
IN SEARCH OF THE
LONELIEST IN OUR
COMMUNITIES

Campaign to
EndLoneliness
CONNECTIONS IN OLDER AGE

ADDRESSING LONELINESS

Foundation Services

Direct Interventions

Gateway Services

Structural Enablers

Reach

Understand

Support

Existing relationships

New connections

Change thinking

Transport

Technology

Community

Volunteering

Positive ageing

http://campaigntoendloneliness.org/guidance/
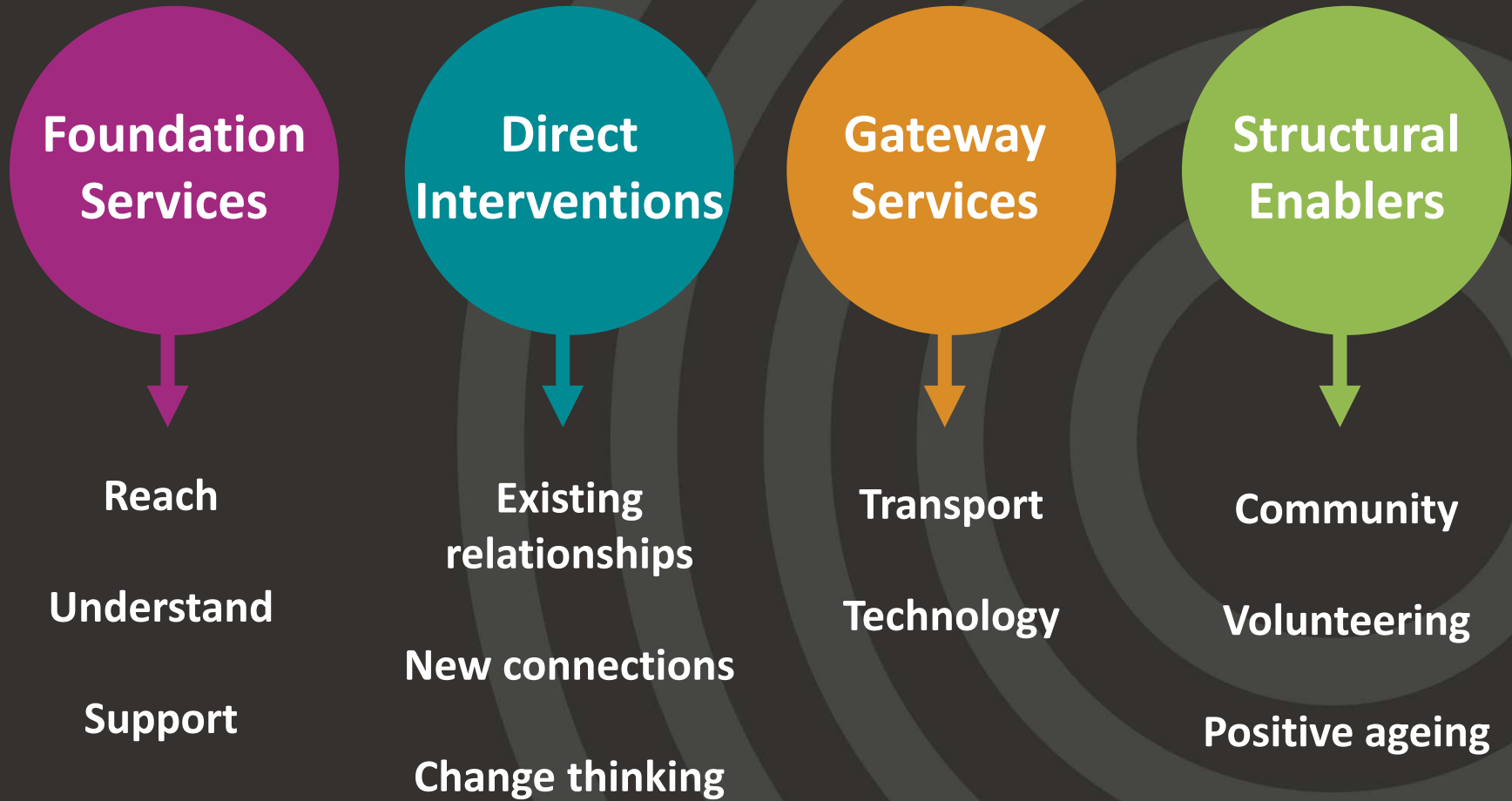
FOUNDATION SERVICES

- **Understanding risk factors & using existing data to predict and 'map' where the most lonely/isolated residents live**

- **Eyes & feet on the ground**

- **Establish systems with health services to identify and refer individuals**

- **Mass media and mailouts**

- **Business as usual methods**

- **Specific needs must be understood to ensure interventions are personalised and appropriate**

DIRECT INTERVENTIONS

One-to-one approaches

◎ For individuals with difficulty making new connections or with physical barriers

◎ Generally befriending services

◎ Specialist models available for at-risk groups

◎ Schemes often expand to engage recipients to become befrienders

Groups for new connections

◎ Social activities are particularly effective when targeted at specific groups, i.e. men

◎ Also effective when they involve participants in running the group

◎ Offer additional benefits such as health promotion and learning

PSYCHOLOGICAL SUPPORT SERVICES

Mindfulness

◎ A popular technique for people to stop and reflect

◎ Sessions offer the safety and comfort of a group

◎ Invites people to better understand themselves

Cognitive Behavioural Therapy

◎ People focus on their habitual patterns to see what is more and less helpful

◎ Lonely people may choose to make changes that help them better engage with and connect with others

Direct Interventions

GATEWAY SERVICES

Transport

- ◎ Vital to support existing relationships and help people develop new relationships

- ◎ Community transport should be flexible and responsive

- ◎ Public transport should be accessible and affordable

- ◎ Driving conditions should be age-friendly

Technology

- ◎ Supports existing relationships

- ◎ Creates/sustains new relationships

- ◎ Can support independent living for longer

- ◎ Older people should be assisted to make technology work for them

Gateway Services

STRUCTURAL ENABLERS

Making the best use of community capacity

◎ Build a picture of local assets (particularly those likely to enhance social interaction)

◎ Foster regular discussions between local service providers and gatekeepers of resources (GPs, faith groups, housing providers, social services etc.)

◎ Create infrastructure for delivery – support volunteering, increase intergenerational activity, create community navigators

◎ Involve older people in delivering services (volunteers, advocates)

◎ Establish timebanking (builds connections, fosters reciprocity and sense of purpose)

◎ Support community events (through small grants, staff time)

◎ Identify and empower community leaders

Structural Enablers

AGE-FRIENDLY CITIES & COMMUNITIES

Creating age-friendly communities requires action in three key domains:

◎ Action on places

◎ Action on people

◎ Action on services

These include:

◎ Outdoor spaces and buildings

◎ Transport

◎ Housing

◎ Social participation

◎ Respect and social inclusion

◎ Civic participation and employment

◎ Communication and information

◎ Community support and health services

Structural Enablers

EVALUATING YOUR IMPACT

Planning an evaluation

◎ What are the desired outcomes?

◎ What services or mechanisms are delivering these outcomes?

◎ How they will be measured?

◎ Who will measure them, and when?

◎ How long the evaluation will run for?

◎ How will the information be used?

◎ What are the savings to local health and social care (return on investment)

Loneliness scales

◎ Campaign to End Loneliness measurement tool

◎ the De Jong Gierveld loneliness scale

◎ the UCLA loneliness scale

◎ single-item scale

Structural Enablers

Future Research

This summer the Campaign conducted a research scoping exercise to determine its research priorities for the upcoming years.

Upcoming research projects:
- Cost effectiveness of loneliness interventions (2017)
- Experience measuring and evaluating loneliness(2017-8)
- Psychological approaches to loneliness including CBT (2018)

- Big need for more evidence on interventions that work

Find out more

campaigntoendloneliness.org

Guidance for Local Authorities and Commissioners
Hidden Citizens
Missing Million

Email: kellie@campaigntoendloneliness.org.uk

Loneliness and social isolation : A public health challenge?

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Presentation outline

1. **Loneliness and social isolation: definitions**

2. **The epidemiological evidence: links with mortality and morbidity**

3. **The challenges for public health:**

   - Identifying people at risk

   - Measuring loneliness and social isolation

   - Quantifying the impact on health and service use

   - Designing effective prevention strategies

4. **Conclusions**

1. Definitions

In research, loneliness and social isolation are frequently defined in opposition:

Loneliness

An individual's subjective and negative evaluation of his or her social relationships - Cattan (2005), 'Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions', *Ageing and Society*

Social Isolation

A more objective measure of the absence of contacts or ties with others
- de Jong Gierveld (2006), 'Loneliness and social isolation', in Vangelisti et al., *Cambridge handbook of personal relationships*

2. Loneliness, social isolation and health

- Loneliness **and** social isolation have been linked to an increased risk of premature mortality and morbidity.

- **Mortality**: According to the most recent meta-analysis on the subject, the average increased risk associated with loneliness and social isolation is 25-30% (Holt-Lunstad 2015, 'Loneliness and social isolation as risk factors for mortality: A meta-analytic review', Perspectives on Psychological Science).

- **Morbidity**: Recent systematic reviews have identified loneliness and social isolation as risk factors for: incident dementia (+40-50% increased risk), cognitive decline (+10% increased risk), incident cardiovascular disease (+30% increased risk).

Figure 2.1 Conceptual model of how loneliness and social isolation influence health. Based on Berkman and Krishna, 214, p.242.

Social structural conditions — determine the extent, shape, nature of... → **Social relationships** — which provide opportunities for... → **Psychosocial mechanisms** — which impact health through... → **Pathways**

Socio-cultural factors
- Norms and values
- Social cohesion
- Racism
- Competition/cooperation
- Social capital

Socio-economic factors
- Relations of production
- Inequality
- Discrimination
- Conflict
- Labour market structure
Poverty
- Social exclusion

Politics
- Laws
- Public policy
- Differential political enfranchisement/participation

Social change
- Urbanization
- War/civil unrest
- Economic recessions

Objective characteristics
Spectrum ranging from **social isolation** to connectedness, based on:
- Number of relationships
- Frequency of contact
- Access to others

Subjective dimension
- positive appraisal, e.g. satisfaction, trust
- negative feelings: dissatisfaction, **loneliness**

Social support
- Instrumental and financial
- Informational
- Appraisal
- Emotional

Social influence
- Constraining/enabling influences on health behaviours
- Norms towards help seeking/ adherence
- Peer pressure
- Social comparison processes

Social engagement
- Physical/cogntive effects
- Reinforcement of meaningful social roles
- Bonding/interpersonal attachment

Person to person contact
- Close personal contact
- Intimate contact, sexual or romantic

Access to resources and material goods
- Jobs/economic opportunities
- Access to healthcare
- Housing
- Institutional contact

Negative social interactions
- Demands
- Criticism
- Direct conflict and abuse

Health-behavioural pathways
- Smoking
- Alcohol and drug consumption
- Diet
- Exercise
- Adherence to treatments
- Help-seeking behaviour

Psychological pathways
- Self-efficacy
- Self-esteem
- Coping
- Depression/distress
- Emotional regulation

Physiological pathways
- HPA axis response
- Allostatic load
- Immune function
- Cardiovascular reactivity
- Inflammation
- Ageing pathways
- Transmission of infectious disease

3. The challenge(s) for public health

A. Identifying people at risk

B. Measuring loneliness and social isolation

C. Quantifying the impact on health and service use

D. Designing effective prevention strategies

3. A. Identifying people

Identifying

Engaging

Impacting

Sustaining

What works	How	Why
Place based/ population based approaches	Drawing on local knowledge, networks and community organisations	Understanding of local needs and provision gaps, trusted by beneficiaries
Proactive approaches	Letters, phone calls, door knocking, home visits	Reaches hidden populations including isolated people, those not accessing support and those initially reluctant to engage
Broad based approaches	Public spaces, radio, advertising, leaflets, referral from Health and Social Care, Voluntary and Community sector	Moves beyond traditional organisational reach, receives referrals from public, creates project buzz

Newcastle University

Institute of Health & Society

Loneliness and the oldest old

- The Newcastle 85+ study has shown that around half of people aged 85 and over reported feelings of loneliness

- Age associated factors (living alone, widowhood) are important, not age *per se*

- Loneliness is common in institutional settings

Source: Pinquart 2003, 'Risk factors for loneliness in adulthood and old age', Advances in Psychology Research

Inequalities – gender

- **Men** are more likely to be **isolated** than women[1]

- More **women** than men report feeling **lonely**[2]

Isolation among men and women ages 50 and over: England 2012/13

	Women	Men
Less than monthly contact with friends	12%	19%
Less than monthly contact with other family members	21%	31%
Less than monthly contact with children	15%	23%
Moderate to high social isolation	11%	14%
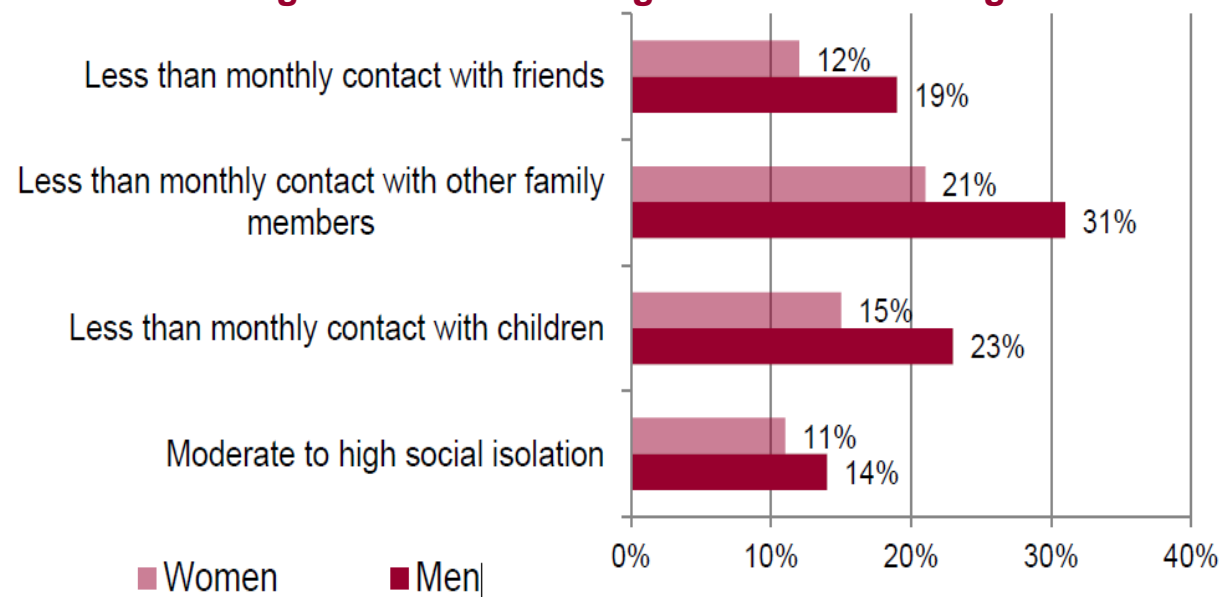
1 Beach 2014 , Isolation: The emerging crisis for older men, Report from Independent Age and the International Longevity Centre, 2 ONS 2013

Inequalities – ethnic minority

- Some evidence suggests that levels of loneliness are higher among older adults from ethnic minorities[1]

- Older adults in ethnic minority groups may also experience language barriers levels of poverty that are higher than the general population[2]

1. Victor 2012, 'Loneliness and ethnic minority elders' in Great Britain: an exploratory study, *Journal of Cross Cultural Gerontology*
2. Khan 2014, *Poverty and ethnicity: Balancing caring and earning for British Caribbean, Pakistani and Somali people*)

Inequalities – carers

- There are approximately 1.2 million carers aged 65 and over in England, and the numbers are increasing.

- Providing high levels of care is associated with less time out of the house, socialising with friends, and negative health impacts, all of which increase risk of social isolation.

- A 2009 study found that male caregivers were four times more likely to be socially isolated than their female counterparts.

Robinson 2009, 'A broader view of family caregiving: effects of caregiving and caregiver conditions on depressive symptoms, health, work, and social isolation', *Journals of Gerontology Series B*

Inequalities and wider determinants

There is evidence to suggest a significant correlation between low socioeconomic status and social isolation. Action on structural determinants including economic disadvantage is vital

Social disadvantage linked to life experiences that increase risk of isolation, e.g. poor maternal health, teenage pregnancy, unemployment, illness in later life

Wider issues such as access to green/public spaces, transport (to enable social connections) can help or hinder

3.B. Measurement

- Stigma associated with loneliness

- Different dimensions: social v. emotional loneliness; transient v. chronic

- When choosing a tool, we need to consider:
  - the tool's psychometric properties;
  - the target population;
  - the context and setting within which the tool is to be delivered.

3.C. Impact on services?
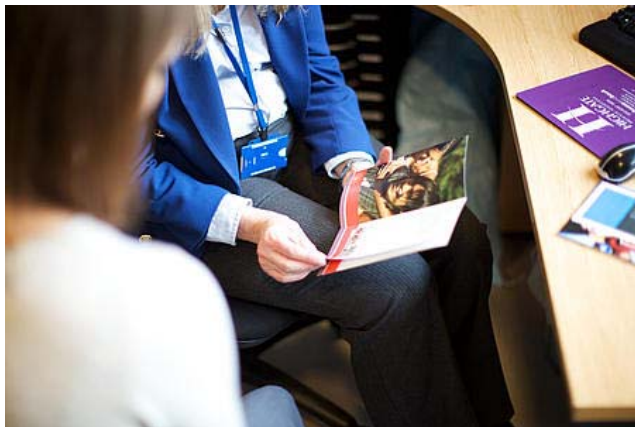
- Isolation and loneliness **may** increase the pressure on services.

- Individuals **may be** more likely to:

    - visit their GP often?
    - use accident and emergency services independent of chronic illness
    - be admitted to adult social care
    - more use of mental health services
    - have early admission to residential or nursing care

3.C. Impact on services?

What does our research suggest?

Systematic review evidence for
>   Increased hospital readmission rate
>   Increased ED attendances
>   No evidence for impact on
>   ambulatory or primary care
>   *Valtorta, Hanratty, et al submitted 2016*

Evidence from the English Longitudinal Study of Ageing
>   Loneliness as an independent risk factor for
>   care home entry
>   *Hanratty B, Stow D, Collingridge Moore D,*
>   *Valtorta N, Matthews F. submitted 2016*

3.D. Designing and selecting effective interventions

- Reduce 'stigma'– avoid the 'L' word

- Base interventions on effective evidence

- Group activities achieve good outcomes especially those with an arts, educational learning or social focus

- Participatory initiatives are most beneficial

- One-to-one initiatives (e.g. befriending) only appear to be effective in certain circumstances

3.D. Designing and selecting effective interventions
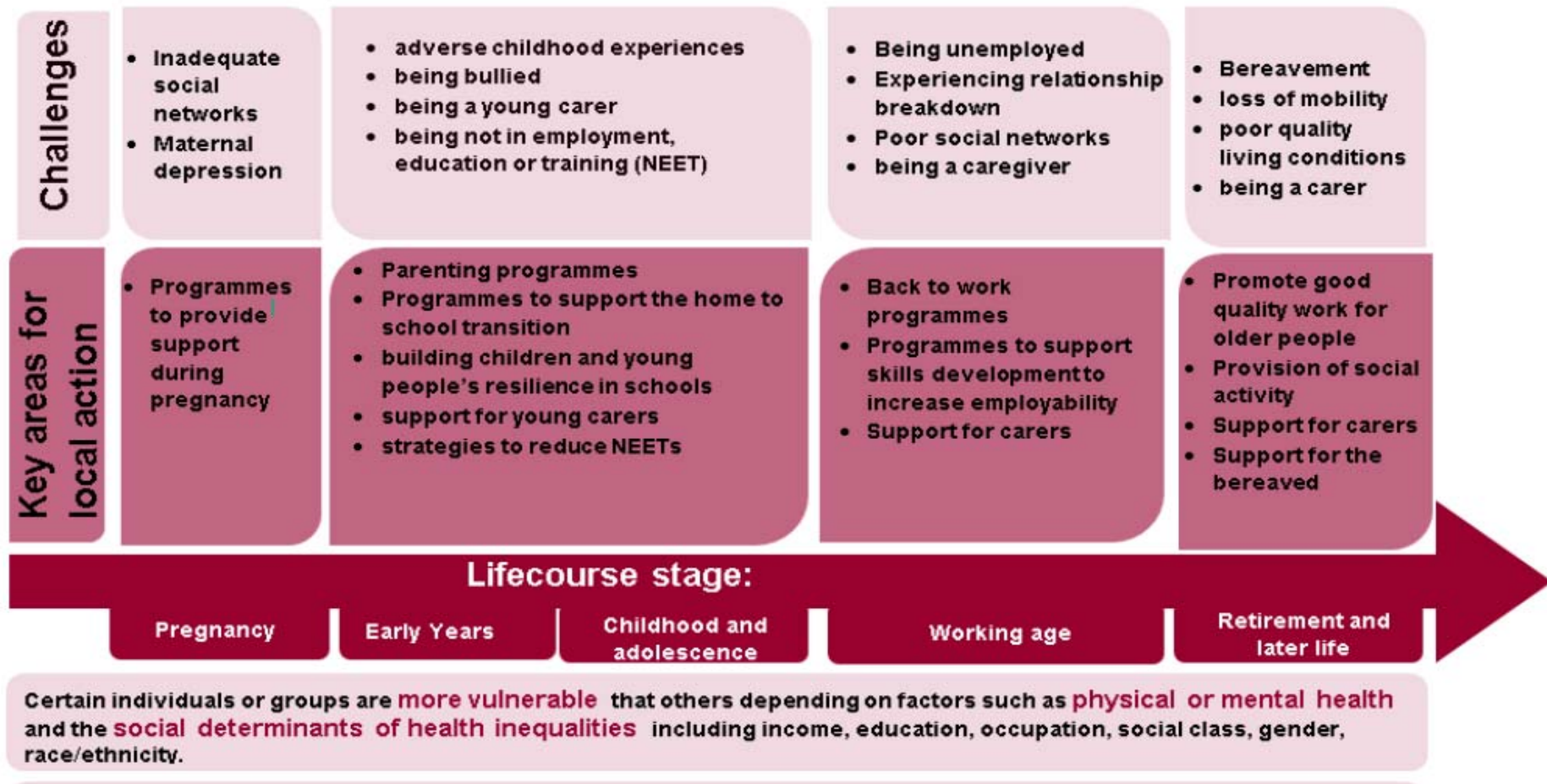
- Impact of new technologies is unknown.
- Real & practical barriers should be the focus of joint efforts by all agencies concerned with the wellbeing of older adults
- Earlier interventions could help prevent some of the negative effects of social isolation from accumulating in later life.
- Opportunities for strengthening social resources throughout the lifecourse?

3.D. Benefits of taking a public health approach

- **Primary, secondary and tertiary** prevention strategies:
  - **Design of cities and towns** : provision of public seating and toilets, and good public transport can encourage older people to get out and about, increase their mobility, and socialise
  - **Physical activity**: promotion of physical activity to meet new guidelines for activity among the over 50s also create opportunities to increase social interactions and build social networks

- **Health screening and preventative interventions** (e.g. NHS Health Checks) can be capitalised upon to also identify, and address, or build resilience to, loneliness and isolation

- **Falls prevention programmes** are not just a means of reducing costly hospital admissions, but also an opportunity to maintain mobility and independence

Social isolation across the life course

Challenges	• Inadequate social networks • Maternal depression	• adverse childhood experiences • being bullied • being a young carer • being not in employment, education or training (NEET)	• Being unemployed • Experiencing relationship breakdown • Poor social networks • being a caregiver	• Bereavement • loss of mobility • poor quality living conditions • being a carer
Key areas for local action	• Programmes to provide support during pregnancy	• Parenting programmes • Programmes to support the home to school transition • building children and young people's resilience in schools • support for young carers • strategies to reduce NEETs	• Back to work programmes • Programmes to support skills development to increase employability • Support for carers	• Promote good quality work for older people • Provision of social activity • Support for carers • Support for the bereaved

Lifecourse stage:

| Pregnancy | Early Years | Childhood and adolescence | Working age | Retirement and later life |

Certain individuals or groups are more vulnerable that others depending on factors such as physical or mental health and the social determinants of health inequalities including income, education, occupation, social class, gender, race/ethnicity.

Conclusions

- There are gaps in our knowledge (epidemiology of loneliness and isolation, effective strategies)

- Material disadvantage is an important factor

- A lifecourse approach is essential

- Creative and collaborative approaches needed to improve the wellbeing of lonely individuals