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ISOLATION AND LONELINESS

An overview of the literature

Refusing to ignore people in crisis

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Background

The literature on isolation and loneliness has grown considerably over the last 40 years to the point where there is a wealth of research on the causes and impact of isolation and loneliness, and the effectiveness of various interventions. While isolation and loneliness are known to have an impact on health, they can also be viewed as important indicators for a whole host of social and/or emotional problems that a person may be facing during a particular phase or transition in their lives.

The purpose of this review is to highlight some of the key factors or risks associated with isolation and/or loneliness, and to paint a picture of the groups and subgroups of people who might meaningfully benefit from interventions designed to tackle loneliness or isolation. Despite the growth in the research there are still a number of gaps in the research. Moreover, many interventions rely on anecdotal evidence and where data have been collected there are often issues around reliability and robustness. These issues must be taken into account when making decisions about who might benefit from a particular intervention and questions about the research that has been conducted to date.

This review focuses on changes that are, in many cases, beyond the control of the individual: ageing, migration, changes in a person's health, changes in a person's caring responsibilities and deliberate isolation. Almost anyone can experience isolation or loneliness at some point in their lives, but these "risk factors" can be used to help identify and target people potentially susceptible to isolation or loneliness, especially those going through an important, and perhaps complex, transition or change in their lives.

The majority of the literature reviewed for this report focuses on particular groups or subgroups of people at risk of isolation or loneliness. In this review, an attempt has been made to link several groups under broader categories, to help draw out linkages and to emphasise the need to think beyond demographic strands. These categories could be reconfigured to include more or fewer people at risk of loneliness, leading to less targeted or more targeted interventions. At the same time, some groups could be placed in multiple categories. The purpose of the categories is to help kick start a discussion, rather than to lock people into discrete categories, and to encourage a holistic and non-compartmentalised view of the people affected by loneliness and isolation across the UK.

Throughout the review there are several comment boxes containing additional points to consider. Ultimately, the purpose of this review is to support the decision-making process for the project team leading on the partnership between the British Red Cross and the Co-op. However, we hope that by making our findings publicly available, others are able to draw on this evidence to inform their own consideration of and responses to the serious issue of loneliness and social isolation in the UK.
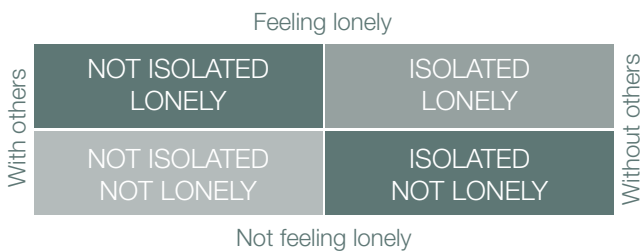
Isolation and loneliness

Distinct but related concepts

Loneliness is the subjective feeling or mood associated with actual or perceived isolation. Loneliness occurs when there is something missing or lacking in a person's social relationships or when there is a mismatch between a person's actual social relations and the person's needs or desires for social contact. Sometimes loneliness results from a shift in an individual's social needs rather than from a change in their actual level of social contact.

Although it sounds counterintuitive, isolation and loneliness are not necessarily related. You can feel lonely without being isolated, or isolated without feeling lonely, as shown in the diagram below. The idea of feeling lonely even in the midst of a large social network can also be described as "alienation".

Feeling lonely

	NOT ISOLATED LONELY	ISOLATED LONELY	
With others	NOT ISOLATED NOT LONELY	ISOLATED NOT LONELY	Without others

Not feeling lonely

Part of the reason for this discrepancy is that isolation and loneliness may be more social or emotional in nature. In his seminal work, Weiss (1973) identified two types of loneliness: loneliness through social isolation and loneliness through emotional isolation. The former describes loneliness caused by a lack of social ties, social integration or sense of community, which might be experienced following relocation. The latter refers to an absence of a personal, intimate relationship or reliable "attachment figure", such as a partner. While emotional isolation seems to be linked with emotional loneliness, social isolation has stronger associations with social loneliness.

On the other hand, Perlman and Peplau (1984: 15) describe loneliness as the "unpleasant experience that occurs when a person's network of social relationships is significantly deficient in either quality or quantity", although it could be argued that quality and quantity are slightly

different ways of referring to the emotional and social aspects of isolation and loneliness. Nicholson suggests that social isolation is "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships" (Nicholson 2009: 1344).

This review maintains the distinction between the social and emotional aspects of loneliness, because this distinction can help improve our understanding of how loneliness develops within individuals (van Baarsen et al. 2001), but it also important to consider the quality and quantity of relationships that people hold.

Another important dimension of isolation or loneliness is that it can be positive as well as negative. For example, solitude may be an important part of self-growth, allowing time for reflection and meditation. The literature reviewed in this report refers only to isolation and loneliness in the negative sense, rather than solitude in the positive sense.

The duration of loneliness over time is an important dimension and Young (1982) distinguishes between three types of loneliness:

> Transient/everyday loneliness includes brief and occasional lonely moods. These experiences have not been of much concern to researchers or clinicians.

> Situational/transitional loneliness involves people who had satisfying relationships until some specific change occurred, such as divorce, bereavement or moving to a new town.

> Chronic loneliness occurs when a person has lacked satisfactory social relations for a period of two or more years.

From the standpoint of intervention, greatest attention should be directed at preventing situational loneliness from becoming a severe and chronic experience, as the health consequences of chronic loneliness are more detrimental.

Demographic trends

Several people have suggested that the prevalence of loneliness could increase in the coming decades. One of the key factors is the ageing population. Older age is associated with disability-related obstacles to social interaction as well as with longer periods of time living as widows or widowers. Moreover, delayed marriage, increased dual-career families, increased single-residence households, and reduced fertility rates may also contribute to an increased prevalence of loneliness and its associated health effects (Masi et al. 2010).

Data from the 2011 census has shown that the proportion of people at retirement age living on their own has dropped from 34% to 31% in the last decade. More than a quarter of a million people over the age of 65 in England and Wales are living unmarried with a partner – double the number recorded a decade earlier, according to the Office for National Statistics. By 2021, however, it is projected that the proportion of divorced men over 65 will increase rapidly to 13%, while the proportion who are widowed will fall to 13%, mainly because of improvements in mortality, and eight per cent will be never married (Davidson et al. 2003: 81-2).

However, findings looking at long-term trends concerning loneliness in Europe showed the opposite trend: levels of loneliness have been decreasing over time, albeit slightly, or they have remained unchanged, depending on the studies that are considered (Veenhoven and Hagerty 2006). Loneliness is not the only outcome showing a change for the better; in so far as they are available, trend data reveal that since the 1950s average happiness has increased slightly in rich nations and considerably in developing nations.

However, if the proportion of loneliness remains fairly constant, we can expect an increase in the absolute number of people experiencing loneliness over the next few years as a result of population growth and ageing.
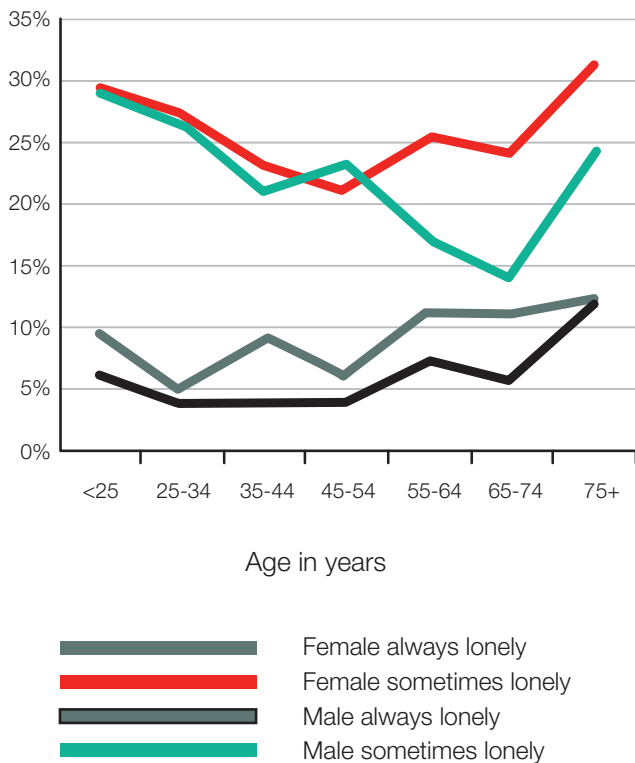
Research recommendation

A discrepancy between reported feelings of loneliness in direct and indirect surveys makes it difficult to assess the levels of isolation and loneliness in the UK. None of the literature reviewed showed reliable, geographical breakdowns of loneliness or social isolation across the UK. However, it may be possible to get a regional picture of loneliness with analyses of existing survey data (see Appendix 1), or by identifying areas in the UK with a high prevalence of some of the risk factors associated with isolation and loneliness.

In general, women seem to be more likely to report feelings of loneliness than men (see below), but this does not necessarily mean that women are lonelier than men. Surveys which assess loneliness indirectly (i.e. without using the term "lonely") generally find that men feel lonelier than women (and this difference is statistically significant). The research also suggests there is a slight U-shape in terms of age, with younger people (under the age of 25) and older people (above the age of 75) most likely to experience loneliness.

However, data from the ONS showed a W-shaped pattern, with people of middle age (45-54) reported to be the loneliest (see Fig. 1 below). Middle aged people (aged 45 to 54) were the most likely to feel lonely of all age groups (15% in 2011 to 2012) and the least likely to socialise, with nearly half (49%) reporting meeting socially with family, friends or colleagues less than once a week (2012 to 2013) (Siegler et al. 2015). This discrepancy may be due to the way the questions were asked. Most loneliness research uses indirect measures, while the ONS asked people directly about how lonely they felt. Younger and older people may feel reluctant to responding to direct questions.

Another possibility is that loneliness amongst middle-aged people has been underestimated in previous research. Looking at the Fig. 2 below, for example, there is a slight peak in reported loneliness in the pre-retirement years (55-64) for those who always feel lonely. Mid-life is an important transition and often a stressful time, burdened with simultaneous demands from work, childcare and ageing parents, but also a time where people re-evaluate and recalibrate their life, and might be more likely to suffer from mental health issues (Siegler et al. 2015).

Fig. 1: Age, gender and loneliness in the UK (2006)

Fig. 2: People reporting social interactions and feelings of loneliness in the UK by age group (Siegler et al. 2015)
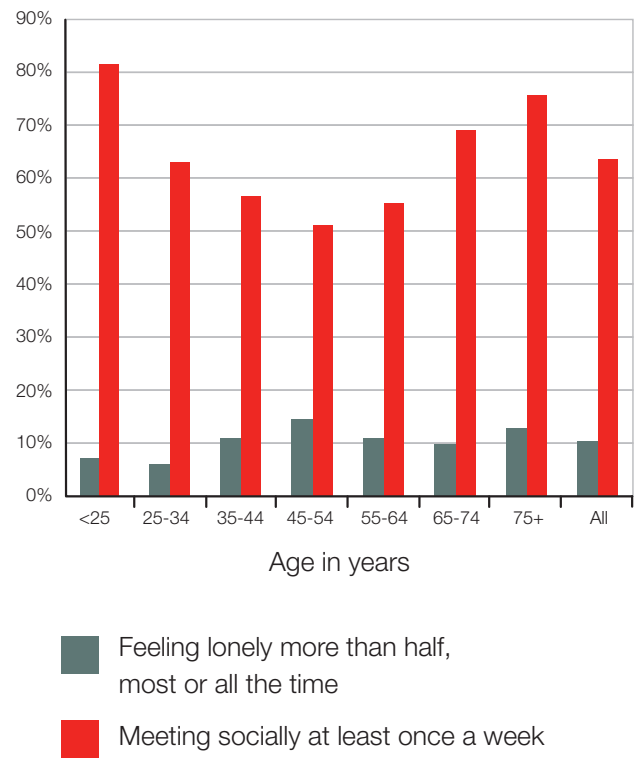
Causes of loneliness

Many factors can contribute to the experience of isolation and especially loneliness. Following Perlman and Peplau (1984) it may be helpful to distinguish between the predisposing factors and situational determinants which make people vulnerable to loneliness and precipitating events that trigger the onset of loneliness.

Predisposing factors can include characteristics of the person (e.g. low self-esteem, shyness, lack of assertiveness), characteristics of the situation (e.g. lack of resources, competitive environments), and general cultural values (e.g. individualism). Precipitating events are factors such as the breakup of a relationship or moving to a new community which change a person's social life in some significant way.

Circumstances that test our resilience to loneliness include major transitions such as moving home or job, bereavement, divorce or separation, the arrival of a new baby or the departure of an older child from the family home. Situations that cut us off from the mainstream of society, such as unemployment, poverty, mental illness or old age, also put us at a heightened risk of feeling lonely, as do those in which people need an unusual level of support: disability, drug or alcohol addiction, caring for a relative or being a lone parent. Research carried out in the US suggests that people from ethnic minority groups may be more prone to experiencing loneliness, but there is not enough evidence in the UK context to confirm this.

"Precipitating events create a mismatch between the person's actual social relations and the person's social needs or desires; a change in one of these two factors without a corresponding change in the other can produce loneliness. Finally, we believe that cognitive processes can influence the experience of loneliness." (Perlman and Peplau 1984: 23) These diverse causal factors are outlined schematically in the diagram below.

Fig. 3: Model of the causes of loneliness (Perlman and Peplau 1984)
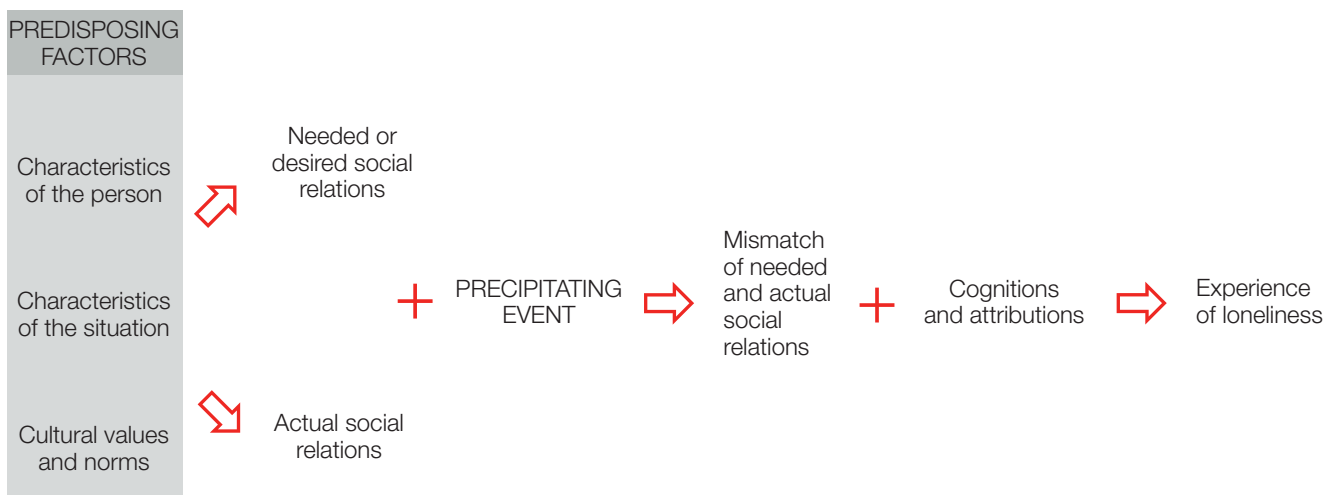
It is important to note that the causes of isolation and loneliness are not necessarily the same, adding more weight to the argument to treat them as separate concepts. For example, one study found that some variables were better at predicting social isolation than loneliness, while some predicted both.

Photo © Simon Rawles

Table 1: Predictors of social isolation, loneliness or both (Grenade and Boldy 2007)

Both	Social isolation	Loneliness
Household composition	"Lower" social class	Self-assessed health
Morale / self-esteem	Number of years widowed	Desire for new friends
Support network type		

Excluding age and gender, evidence regarding the impact of other socio-demographic factors on loneliness tends to vary. Steed et al. (2010) suggest that this variability may be related to the type of data (i.e. cross-sectional data versus longitudinal) or the measures used (e.g. direct questions versus a scale where the word "loneliness" is not used), and confounding with other variables.

Evidence for an association between level of education, geographical location (e.g. rural versus urban), material circumstances (e.g. limited income), ethnicity and loneliness/isolation is inconclusive. For example, there is some evidence to suggest that adolescents in rural areas are more likely to experience loneliness than their peers in urban areas, but this may be due to their socio-economic circumstances rather than where they live (Woodward and

Kalyan Masih 1990). Similarly, the extent to which people from ethnic minority backgrounds feel isolated or lonely will depend on several factors other than their ethnicity, including the extent to which they are assimilated and their sense of "belonging" (Sharma 2012). Hence, we need to be wary about blanket statements which ignore individuals' histories and experiences.

Another group of risk factors relate to health, both physical (e.g. poor self-assessed physical health status, chronic illness) and mental health (e.g. reported depression). Although deteriorating physical health (or perceived poor health) is one of the most consistently identified factors, the direction of causation is still not well understood (Grenade and Boldy 2008: 471). That is to say, it is unclear whether poor physical health leads to feelings of loneliness or vice versa.

Measuring isolation and loneliness

The de Jong-Gierveld loneliness scale and the UCLA loneliness scale (see Appendix 1) are widely used to measure loneliness and neither have any explicit references to loneliness. Unlike loneliness, for which a number of measures have been developed and are widely used, "there are no universally accepted measures or established criteria for measuring social isolation or its severity" (Grenade and Boldy 2007). The English Longitudinal Study of Aging (ELSA) uses a simple index to measure social isolation, but it is not clear how robust it is (see Appendix 1).

Surveys have been, and can be, used to measure loneliness. However, some research suggests that levels of reported loneliness will differ depending on how the data is collected, e.g. surveys versus in-depth interviews (e.g. Victor et al. 2003) or aggregate measures versus self-rating scales, i.e. people are less likely to say they are lonely unless they are experiencing severe loneliness. This is less of an issue if the same instrument and method is consistently used throughout a research project, but it makes it difficult to compare results across projects.

Consequences of isolation and loneliness

Research has consistently demonstrated the health-damaging effects of social isolation and loneliness, and the health-promoting effects of social support.

A growing body of longitudinal research indicates that loneliness predicts increased morbidity and mortality (Hawkley and Cacioppo 2010: 219). The effects of loneliness seem to accrue over time to accelerate physiological ageing. For instance, the greater the number of measurement occasions at which participants were lonely, the higher the cardiovascular health risk in young adulthood. Similarly, loneliness was associated with increased blood pressure and other symptoms in a population-based sample of middle-aged adults.

Social isolation also has damaging effects. Social isolation has been found to be a significant risk factor for broad-based morbidity and mortality (Holt-Lunstad et al. 2010). What was especially surprising was that social isolation was found to be as strong a risk factor for morbidity and mortality as smoking, obesity, sedentary lifestyle, and high blood pressure (House et al. 1988). In a more recent research project carried out in the UK, it was found that mortality was higher among more socially-isolated and lonely participants, but social isolation was more significantly associated with mortality than loneliness, after adjusting for demographic factors and baseline health (Steptoe et al. 2013).

The impact of loneliness on cognition has also been assessed. Perhaps the most striking finding in this literature is the breadth of emotional and cognitive processes and outcomes that seem susceptible to the influence of loneliness. Loneliness has been associated with personality disorders and psychoses, suicide, impaired cognitive performance and cognitive decline over time (Shankar et al. 2013), increased risk of dementia (Holwerda et al. 2014), and increases in depressive symptoms (Hawkley and Cacioppo 2010: 219). In fact, Holwerda and colleagues (2014) found that people experiencing a high degree of loneliness were potentially twice as likely to develop Alzheimer's as those experiencing a lower degree of loneliness.

As Hawkley and Cacioppo point out, "these data suggest that a perceived sense of social connectedness serves as a scaffold for the self – damage the scaffold and the rest of the self begins to crumble" (2010: 219).

Loneliness may also impact on the body's capacity to restore itself. According to some research, the same amount of sleep has fewer health benefits in individuals who feel more socially isolated and poor sleep further exacerbates feelings of social isolation. This recursive loop operates outside of consciousness and speaks to the difficulty of trying to manage loneliness (Hawkley and Cacioppo 2010: 219).

Loneliness also has a strong relationship with low personal well-being ratings. People who report feeling lonely are almost 10 times more likely to

report low feelings of worth (10.5% compared with 1.1%), over 7 times more likely to report low life satisfaction (15.2% compared to 1.9%) and over 3 times more likely to report feeling unhappy (18.8% compared to 5.6%) than those who have low ratings of loneliness. They are also twice as likely to report feeling anxious (34.8% compared to 15.1%) (Thomas 2015).

According to Nicholson (2009), researchers have reported a number of specific negative effects linked to low social networks, such as heavy drinking, falls, depression/depressive symptoms and poor outcomes after stroke, increased rates of re-hospitalization, loneliness and alteration in the family process.

Other consequences reported were nutritional risk (Locher et al. 2005), Researchers from the Centre for Diet and Activity Research (CEDAR) looked at data from nearly 15,000 adults aged over 50 (Conklin et al. 2014). They found that:

> Being single or widowed decreased the daily variety of fruit and vegetables eaten (compared to those who were married or living with a partner)

> Single, separated and widowed men ate fewer different vegetables than women in similar circumstances

> Both living alone and having less frequent contact with friends increased the effect of widowhood by reducing the variety of vegetables an individual ate

> People who lived alone and had infrequent contact with friends ate fewer vegetables each day.

Nutrition plays a key role in healthy ageing. In the UK, it is estimated that around 70,000 avoidable deaths are caused by diets that do not match current guidelines. This research therefore has implications for policy and practice. For example, interventions that increase various types of social relationships could support adults to eat a healthy diet – these could include social activities or targeting health-eating interventions at people who also at risk of loneliness or isolation (e.g. recently bereaved people).

There is no generalizable evidence on the financial costs of loneliness or isolation, but a number of research projects seem to be underway to evaluate these costs. Fulton and Jupp (2015) attempted to quantify the financial impact of loneliness in terms of increased service usage by older people, and estimated that this could cost up to £12,000 per person over the next 15 years. However, the model is based on several assumptions about the impact of loneliness on service usage and until there is reliable data about people's pathways through health and social care services, it will be difficult to estimate these costs with any certainty.

Evaluating the benefits of the Second Half Centre

Based on a Preventative Care Model, the first Second Half Centre opened in Kensington, London in 2012. It has an average of over 250 people each week coming through its doors to participate on activities on offer. This report looks at the potential for Second Half Foundation 'local hubs' model to reduce social isolation amongst older people and deliver savings to local and national health services. The report concluded that services based on the model of the Second Half Centre produce returns of over 135% a year to the NHS and local Clinical Commissioning Groups (Shaw Ruddock 2014).

Clustered groups at risk of isolation or loneliness

In this section people at risk of loneliness or isolation have been grouped under six clusters:

> Family-related loneliness

> Disability and ageing

> Resource-constrained groups

> Stigmatised groups

> Occupational loneliness

> Deliberately isolated groups.

These clusters were identified specifically for this review and are not necessarily reflected in the literature in these terms (with the exception of groups experiencing family-related loneliness). However, the value of clustering groups is that it may help to draw out common themes and linkages amongst different groups at risk of isolation or loneliness.

Certain demographic characteristics cut across groups and clusters, and some people are likely to fit under more than one cluster. For example, older people are more likely to have physical or sensory impairments and may have spent several years acting as a carer for their partner. People such as these are likely to be at high risk of experiencing isolation or loneliness, but may need specialised support due to the complexity of their situation.

Family-related loneliness

Hombrados-Mendieta et al. (2013) recommend that social intervention programmes should be developed that promote positive relationships within the family, since the perception of being supported by a partner and family is significantly associated with decreased loneliness and increased well-being.

Family-related loneliness includes people experiencing bereavement or divorce, and older people who live alone and/or are widowed, separated or divorced are more likely to report that they feel lonely often or some of the time (Beaumont 2015). Young people suddenly experiencing independence from their parents or guardians are also at risk of experiencing loneliness, and this is especially true of young care leavers who may not have regular contact (or any contact) with their birth family or their foster family.

Bereavement

Widows and widowers do not just suffer from emotional loneliness because they have lost an intimate relationship. Research has found that having a partner is also important for keeping someone connected to a wider circle of friends and acquaintances (Dahlberg and McKee 2014). This means services should aim to address both the loneliness caused by losing a loved one and support them to maintain social networks.

In general, though, research investigating stressful life events such as widowhood emphasises that bereaved people are especially vulnerable to emotional isolation rather than social isolation (Weiss, 1973). Stroebe et al. (1996) found that marital status affected emotional loneliness but not social loneliness, while van Baarsen et al. (1999) showed that six months after bereavement, older widows and widowers felt emotionally lonelier than before the loss, whereas social loneliness had not increased.

This ties in with the definition of emotional loneliness – as the absence or loss of an attachment figure – and further underlines the need to maintain a distinction between these forms of loneliness. Moreover, it points to the need for introducing interventions that align with isolated/lonely individuals' experiences.

Divorce and living without a partner

There are several "pathways" leading to living alone in mid-life (see appendix 2). The research showed that divorce (or the end of a cohabiting relationship) is the main reason for middle-aged men and women to live alone. Children leaving home and death of a partner were other triggers. However, the researchers found a significant proportion of men in mid-life who had never lived with a partner. Adults living alone in mid-life had lower incomes than those living with a partner. Further analysis showed two distinct groups that were more likely to lack family and financial support: men living alone who do not have (or never had) a partner or children, and older mothers who had broken up with their partner.

This does not necessarily translate into isolation or loneliness but the findings indicate that more

than one fifth of men living alone in late mid-life will not be able to rely on children for informal support and might not have sufficient financial resources to purchase home-based health-care, as suggested by their housing tenure status which is strongly related to wealth. Furthermore, previous research has shown that those who are not home owners face a higher risk of admission to a care home (McCann et al. 2012). Men in these situations may be at an increased risk of becoming isolated or developing situational loneliness, but more research would be needed to confirm this.

This research is important because middle-aged men and women living alone will have different social and financial needs as they grow older, and we may need to predict these changes. Services may want to consider providing social support to the most "at risk" e.g. middle-age men living alone who have not had children, have no educational qualifications, are unemployed and who live in rented housing – as they are more likely to need a social and economic 'safety net' in old age (Demey et al. 2013).

Anecdotal evidence submitted to the Scottish Parliament's Equal Opportunities Committee inquiry into ageing and social isolation suggested that LGBT older adults are "more likely to live alone, to be estranged from their families of origin, not to have had children and not necessarily to have had a relationship" (Scottish Parliament 2015). As with ethnicity, while there is no definitive evidence that LGBT people as a whole are more likely to be lonely or isolated than non-LGBT people, it is worth considering how sexual identity, ethnicity and so on might interact with other factors to affect the likelihood of isolation or loneliness.

Young care leavers

Young people leaving home for the first time are likely to experience feelings of isolation or loneliness. While this is often temporary, it can become an issue of concern for some young people.[1] However, young people leaving the care system (either care homes or foster

1. http://www.theguardian.com/education/2012/sep/19/lonely-in-freshers-week

parents' homes) leave home earlier and have less support than their peers. Many go on to face outcomes that are much worse than those of the general population, including those relating to educational achievement, teenage pregnancies, homelessness, offending and mental health (Knight et al. 2006; Gentleman 2009).

The evidence suggests that poor outcomes for care leavers are linked to weak support networks, few friends and feelings of isolation and loneliness (Stein 2004). The loneliness, isolation and lack of support felt by care leavers was one of the most frequently recurring themes in a consultation undertaken by the Centre for Social Justice (CSJ). Three-quarters (77%) of the care leavers surveyed said that feeling lonely or isolated was difficult when leaving care and 43% said it was very difficult; while 11% of care leavers report there were one or no people they would be able to tell if they were harmed (Devereux 2014).

Building strong supportive relationships whilst they are in care and ensuring they are maintained upon leaving is key if care leavers are going to gain resilience and avoid poor outcomes. Protective factors include having someone to turn to for support and developing and maintaining positive links with family or former carers and these should be encouraged and worked towards (Stein 2004; NCAS 2009). At the same time re-establishing or increasing contact with birth families can lead to disappointment or have a negative impact on the young person's well-being (Munro et al. 2011: 58).

Yet there are key points when opportunities are lost to sustain relationships such as separation from siblings, frequent movement and placements far away from home. Care teams aim to fully support young people leaving care, but research by the CSJ also found they were often too busy to build relationships with young people: the average caseload of a personal adviser is 23 young people, going as high as 49 in some local authorities.

Despite the fact that the role of family and social relationships and emotional and behavioural support are both in the pathway plan set out as

a requirement in the Leaving Care Act (2000), there remains a gap in the offering of emotional support, with studies highlighting that 71% of leaving care professionals and personal advisers feel that there is insufficient attention paid to emotional support for young care leavers (CSJ 2008: 165).

Advocacy opportunity

The Centre for Social Justice has done considerable work in this area, with reasonable success in getting the Government to shift its policies towards young care leavers. If young care leavers are targeted in work to address loneliness and social isolation, it may be worth considering whether there is potential to align advocacy objectives with those of the CSJ and whether there are opportunities for complementary or joint advocacy.

Disability and ageing

This cluster explores embodied changes and how they affect people's relationships and ability to live independently. This includes people whose impairment or long-term condition has made them more at risk of experiencing isolation or loneliness, including older people who are more likely to become disabled.

Physical and sensory impairments

Long-term health conditions and impairments can have a negative impact on various aspects of individual well-being. Impairments involve a reduction or loss of function and difficulty in performing activities of normal daily living, such as walking or reading.

Because disabling health problems are often associated with the loss of independence and autonomy, they affect not only the lives of the disabled but also the lives of those who are close to them. For married older adults with a disability, the partner may be affected the most (Johnson 1983). Depending on the severity of the disability of the disabled partner, the non-disabled partner might have to assume more responsibilities for previously shared activities. Overall, both partners need to adjust to significant role changes. As a result, one's own and one's partner's health condition or disability can impact on both partners' well-being.

To consider both partners' health is especially relevant for older adults. Older couples are particularly at risk of disability of both partners for two reasons. First, both partners of the older couple have an increased risk of disabling health problems because of the increased longevity for both men and women. Second, caring for a disabled spouse is a risk factor for one's own health as mentioned above. If a non-disabled partner assumes more care responsibilities, he or she is particularly at risk of developing health problems (Korporaal et al. 2008).

The majority of people receiving social care also have one or more impairments or long-term conditions and are over the age of 65. Around half of the 65 and over population in England have a longstanding health condition or disability, with most people in this limited group living at home (93.5%) (Lloyd and Ross 2014). Age notwithstanding, people receiving care in residential or community-based settings are both at risk of experiencing social isolation or loneliness. An unintended consequence of at-home care for some older people may be an increased risk for social isolation. It is therefore important for care providers to take preventative steps, as far as possible, to stop these issues from becoming chronic. However, this also requires awareness on the part of care providers and caregivers of the impact that loneliness and isolation can have on people's well-being.

While disability disproportionately affects older people, people may acquire a physical or sensory impairment or condition at any age. One study found that for people with visual impairments, merely having a visual impairment is associated with more feelings of loneliness, whereas the severity and the duration of the visual impairment played no additional or significant role (Alma et al. 2011: 14).

Ageing and later life

Unsurprisingly, the literature looking at loneliness and isolation affecting older people is the most extensive, and the same goes for evaluations of interventions targeting this age group.

The losses associated with becoming old involve not only loss of physical and cognitive capacity and functional ability, but also the loss of friends and family members (van Baarsen, 2002). Any or all of these losses may contribute to experiences of loneliness among the very old (Graneheim and Lundman 2010).

According to figures from the ONS (Siegler et al. 2015), 1 in 8 (13%) people aged 75 and over who reported feeling lonely more than half, most or all the time in 2011 to 2012, the second highest proportion of all age groups (see figure 2 above). Personal circumstances, such as poor health, living alone, caring for someone else, going through a relationship break-up or loss, or moving to a new area away from existing social networks can all be factors contributing to feelings of loneliness.

Just 1 in 4 people aged 75 and over reported meeting with friends, relatives or work colleagues less than once week in 2012 to 2013 (see Fig. 2 on page 9). It is known that older people, especially those aged 75 and over, are vulnerable to social isolation which can impact on their physical and mental health. People can become socially isolated for various reasons, including long-term health conditions and illnesses (Lloyd and Ross 2014), or owing to the deaths of partners or friends. Similarly, there was a strong association between age and the presence of at least one close friend. Around 11% of people aged 75 and over reported having no close friend at all in 2011 to 2012 (Siegler et al. 2015), the highest proportion of all age groups. This compared to 2% of those aged 18 to 34. Another 10% of people aged 75 and over reported having one close friend only. More men than women reported having no close friend across all ages, with the difference between sexes being more marked at older age: around 14% of men aged 75 and over reported having no close friend compared to 9% of women aged 75 and over.

Of course, older people are not a homogenous group, with older people of different genders or with different socioeconomic backgrounds more or less likely to be "at risk". In their research on isolation and loneliness as they affect older men,

Beach and Bamford (2014) found that:

> Isolated and lonely men were much more likely to be in poor health. Over a quarter (28%) of the loneliest men said their health was poor, in contrast to just 1 in 20 (5%) men who were not lonely

> A partner's poor health also affected men's isolation and loneliness. Nearly 15% of men aged 85 and over were carers and were more likely to be lonely than those without caring roles

> Mental health, particularly depression, was also important. Over 1 in 4 (26%) of the most isolated men were depressed, in contrast to just 6% of the least isolated

> Around a third of the most isolated men (36%) were in the lowest income group compared to just 7% of the least isolated.

Moreover, work by Scharf et al. (2005) in the UK revealed considerably higher estimates of severe loneliness among older people living in low income urban neighbourhoods (15%) than those found in Victor et al's (2003) research (7%), which focused on older people living in the general population. Similarly, research suggests that prevalence rates among specific sub-groups, such as older people living alone, and those who are chronically physically or mentally ill, may also be higher than within the general older population (Grenade and Boldy 2008).

In addition, older adults with lower levels of contact with friends and family in receipt of social care, or those who feel they are not integrated into their community, are more likely to experience social loneliness. Older adults are more likely to feel emotionally lonely if they have to rely on informal care and have a physical disability or simply problems with normal activities of daily living.

In general, the research reinforces the need to minimise the risks of loneliness and social isolation to maximise health outcomes. Social isolation is modifiable, and so there is an opportunity for creative programs and interventions to foster social connections for older adults. For example,

volunteer friendly-visiting programs, psychosocial group rehabilitation, or the use of technology for social networking are approaches that could be harnessed to reduce isolation. These types of interventions have been effective in connecting isolated adults to new network members, inducing feelings of "being needed", and increasing well-being (Routasalo et al. 2009).

An important target for the government is to help improve the quality of the ageing experience in the UK and make sure the impact of the ageing population is a positive one for citizens of all ages.[2] The UK therefore needs to consider how to minimise some of the impact arising from risk factors of loneliness, particularly bereavement, poor health, and housing tenure. This support could be from public, private or community services, or provided by family, friends and neighbours.

The evidence suggests that we are conscious of our roles in supporting older people in our communities; almost half of us (46%) believe we need to keep in touch with elderly family members who may be lonely and 4 in 10 of us feel the need to keep in touch with elderly neighbours who may be lonely.[3] However there is still room for improvement in awareness of the scale of loneliness and its impact, not just in relation to older people but also as it affects younger and middle-aged people.

It should be noted that the general public's perception of loneliness among older people is much higher than the actual reported rate of loneliness. Even allowing for under-reporting, Dykstra (2009) suggests that the mismatch between people's perceptions and older people's experiences may well be an example of "ageist stereotyping".

"Gap in the market"

Most of the research, and interventions, on social isolation and loneliness focuses on older people. Much less research has been carried out with younger and middle-aged people and there have been fewer evaluated interventions carried out with people from these age groups. Organisations such as Age UK and the Royal Voluntary Service provide a range of support for older people, as does the Campaign to End Loneliness. This gap presents opportunities for targeted, and much needed, support.

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2. https://www.gov.uk/government/collections/future-of-ageing
3. http://cdn.yougov.com/cumulus_uploads/document/zk1wvpxxt3/Independent%20Age%20Results%20101217%20Barriers%20to%20the%20Big%20Society.pdf

Clustered groups at risk of isolation or loneliness

Resource-constrained groups

Poverty and deprivation

Generally speaking, the research around poverty and social exclusion is well-developed, but there seems to be little research that incorporates isolation or loneliness into poverty studies. Similarly, there is a lack of research that explores the connections between unemployment and isolation or loneliness. A recent survey by the Prince's Trust found that 43% of unemployed young people often or sometimes feel isolated, but it is not clear whether this is due to being unemployed or other factors.[5]

A report by New Economics Foundation (2013) concluded that poverty in inner-city areas such as Islington is contributing to, and made worse by, social isolation. They found that people on lower incomes often have very small and weak social networks, rarely go out and have few friends (who in turn were also affected by poverty and isolation). Rising housing rents are also pushing lower and middle-income residents out of areas like Islington, separating families and making it harder for neighbours to mix. Feelings of isolation were made significantly worse by poor mental health (nef 2013).

While some studies have found that urban density levels may contribute to feelings of isolation or loneliness (e.g., Delmelle et al., 2013), other studies have not found evidence to support his claim (van den Berg et al. 2015). However, people who are more satisfied with their neighbourhood and the facilities in the neighbourhood tend to feel less lonely. The availability of local facilities and amenities (shops, post offices, libraries, pharmacies, cafes, pubs and parks), transport, perceptions of safety and freedom from crime can all affect an individual's ability and readiness to get out and about and maintain their social connections (van den Berg et al. 2015).

Life skills

Given that a lack of resources can contribute to or exacerbate isolation and loneliness, it might be worth considering how community members could use their knowledge and experience to support people experiencing isolation or loneliness. For example while experiencing loneliness many people say that they struggle with basic life skills such as budgeting and paying bills. Supporting people with practical skills might put them in a better position to tackle the other problems that they are facing.

Transport and mobility [6]

Although it might be assumed that frequent home-moving increases loneliness, empirical evidence fails to support this view (Perlman and Peplau 1984: 25). While the immediate impact of moving may be to create loneliness, these effects are typically short-lived. For example, Rubenstein and Shaver (1982) found no relationship between current loneliness and how frequently an individual had moved during his or her life time. Constraints on mobility, on the other hand, are linked to isolation and loneliness, and may be more of an issue in underserved rural areas (Scottish Parliament 2015).

While the impact of mobility characteristics on loneliness are often overlooked, the use of different transport modes (bicycle, car and public transport) significantly reduces loneliness and may even explain age-related effects (van den Berg et al. 2015). Transportation modes provide access to social relations outside the neighbourhood and may be essential to maintain one's social network. In addition, public transport provides a space where people are in close proximity and where social interactions can take place.

Being able to use the public transport network isn't just about getting around. It is also about feeling part of the community and having a chance to interact with other people, especially on the bus network (Green et al. 2014). The

5. https://www.princes-trust.org.uk/support-our-work/news-views/anxiety-is-gripping-young-lives
6. While mobility has a range of meanings, here it refers to how people travel in the course of their everyday lives (Green et al. 2014).

freedom to just take a bus to get out and about was widely reported as a major and non-stigmatising defence against isolation, particularly for older people who live alone (Green et al. 2014: 481).

For groups of friends and peers, bus journeys may be the core of an organised outing, ranging from regular shared trips to local shopping amenities, to more ambitious projects such as visits to places of interest, or (for one group) educational outings linked to museums, or lectures (Green et al. 2014: 482). Of course, older people also recognise the negative aspects of using public transport, including adverse interactions with rude, loud or aggressive people, but generally the freedom that older people have in being able to use public transport is, for many older people, an important "lifeline".

It's not just older people who benefit from free bus travel. Some research suggests that free bus travel may also provide a route to social participation for younger people (Jones et al. 2000). While older people and younger people in London value their ability to use public transport, many disabled people are forced to use special transport or taxi cabs. This puts a limit on some people's freedom to travel, but also their opportunities for everyday interactions that many of us take for granted.

Stigmatised groups

Stigmatised groups are at risk of social (and emotional) isolation and a key part of supporting such groups will involve tackling the stigma too. However, it is also worth considering that identifying or labelling particular groups as being at risk of loneliness could also contribute to this stigma. It could even lead to stereotyping where previously none existed. Being mindful of this risk, and thinking of ways to mitigate it, is an important consideration for any intervention.

Refugees and asylum seekers

Despite several researchers identifying refugees and asylum seekers as people potentially vulnerable to social isolation and loneliness as a result of the migration process, much of the research seems to be speculative rather than based on robust evidence. This may be because most of the data focuses on other aspects of the migration process (such as integration) and wider physical and mental health issues, with loneliness being mentioned in passing rather than explored in detail.

Many young refugees and asylum seekers report depression, loneliness and isolation and experience difficulties making friends as opportunities for creating social networks are limited by language, cultural differences, racism, and exclusion from education and employment opportunities. Unaccompanied minors frequently experience social and economic exclusion which are known risk factors for problematic drug use (Kapasi 2009). Some researchers have noted that although (limited) opportunities for assimilation may protect some from adopting local drug-using patterns, they may be highly vulnerable to future problematic drug use.

Many immigrants also have experience of moving internally within the UK – especially if they feel isolated from co-ethnics or their community or experience discrimination in their present location (Kapasi 2009: 20). Others will actively avoid people from similar ethnic or linguistic backgrounds, despite facing language and cultural barriers, because they may have different values or beliefs, or due to the circumstances under which they left their home country (Griffin 2010).

Housing providers can play a crucial role in preventing isolation. Housing Officers, concierges, and other case workers provide a unique means of communication and link between individual refugees and community groups and services. Records enabling the identification of new refugees would facilitate outreach to those who have become withdrawn and reluctant to engage (Strang and Quinn 2010).

People with developmental disabilities or mental health conditions

Many people with mental health conditions or learning disabilities experience stigma (Scottish Parliament 2015), but their conditions may also influence the way in which they engage and interact with the people around them.

Individuals with autism spectrum disorder (ASD), for instance, suffer direct and indirect consequences related to social interaction deficits. Youth with ASD often report a desire for more peer social interaction, and may also express poor social support and more loneliness than their peers (Bauminger & Kasari 2000). When integrated with peers in mainstream classrooms, children and adolescents with ASD may be at increased risk of peer rejection and social isolation (Chamberlain et al. 2007). There is also evidence that social skill deficits in youth with ASD contribute to academic and occupational under-achievement (Howlin and Goode 1998), and may point to mood and anxiety problems later in life (Myles et al. 2001).

Supporting people with enduring mental illness to socialise, either by being matched with a volunteer or by being given the financial means (a small stipend) to engage in social activities, leads to improved social functioning, reduced levels of social isolation and loneliness (Sheridan et al. 2015).

Loneliness as occupational hazard

Loneliness in the workplace

In her review of three separate studies assessing loneliness in managers and non-managers, Wright (2012) concluded that loneliness did not differ by managerial status. In other words, managers were found to be no more or less lonely than their non-manager counterparts. This suggests that factors beyond seniority may be contributing to loneliness in organisational settings. In earlier work, Wright (2005) found that a negative emotional climate and lack of collegial support adversely influences the experience of loneliness in workers. The results suggest that addressing interpersonal problems in the workplace and improving the psychological work environment within an organisation may enhance the social and emotional well-being of employees. There is also a question about the wider role that employers could take in helping to tackle social isolation.

Informal carers

While the social care system supports over a million people, the majority of care and support is provided informally by family and close friends. These "informal carers" are also at risk of becoming isolated or lonely in their roles as carers. It is important to remember that this role is a form of unpaid work with an estimated value of over £60bn to the economy.[7] Without adequate support, young carers are also at risk of developing feelings of loneliness and other health issues.

Many informal carers have care duties that take 20 or more hours per week. Charities such as Carers UK have been pushing the government to provide more respite care for informal carers, and, where appropriate, training to handle difficult health conditions.

Imposed isolation

Some people have isolation imposed on them as a form of punishment (especially those people who have been incarcerated) and others experience isolation as a form of bullying. In both cases isolation is deliberately imposed on individuals to harm them in some way.

Relational bullying is a form of bullying that involves damaging an individual's social relations, for example by ignoring them or by spreading rumours about them. This leaves the targeted person at a greater risk of becoming socially or emotionally isolated and of feeling lonely. Disabled young people, young people who identify as LGBT and young people from minority ethnic / religious backgrounds are more likely to experience bullying (EHRC 2010), but it is not clear whether this increases the risk of isolation or loneliness.

While relational bullying may directly increase the risk of isolation, other forms of bullying (physical, cyber) may also increase the risk of isolation or loneliness in later life. Research undertaken with young adults and their parents in the US showed that parental loneliness and a history of being bullied each had direct effects on young adults' loneliness as well as indirect effects through reduced social skills (Segrin et al. 2012). A family environment that supports open communication can act as a buffer against young adults' loneliness.

7. http://www.ons.gov.uk/ons/dcp171766_315820.pdf

Interventions

As the literature on loneliness and isolation has grown, researchers have been able to identify characteristics of effective (as well as ineffective) interventions. However, these characteristics have been drawn from a finite pool of academic evaluations of interventions. Most interventions have never been held up to scrutiny, perhaps due to a lack of resources or capacity, a lack of understanding about the benefits of rigorous evaluations, or even reluctance to undertake research that could be critical of the intervention in question. Whatever the reasons, it remains the case that there are many effective and ineffective interventions currently underway about which we know very little.

This section makes a clear distinction between approaches and methods, which is often unclear in much of the literature. Four primary strategies for reducing loneliness or isolation are presented here: improving social skills, enhancing social support, increasing opportunities for social interaction, and addressing negative thoughts about self-worth.

Common types of intervention include self-management, peer support, community-based interventions, technology-based interventions and animal-assisted interventions, and so on. There is no "right" approach or intervention, but the literature stresses the importance of matching individuals with appropriate approaches and interventions. This often boils down to asking people about their needs and involving them in choosing an appropriate intervention, which seems to be more effective than one-sided approaches such as self-selection.

Framework for loneliness interventions

The Campaign to End Loneliness has produced a comprehensive framework to tackle loneliness (http://campaigntoendloneliness.org/guidance/theoretical-framework/. Their framework distinguishes between direct interventions or "foundation services" (such as lunch clubs or book groups) and "structural enablers" – the mechanisms by which these groups come into being (including neighbourhood approaches, asset-based community development and volunteering).

Characteristics of effective and ineffective interventions.

Despite the limited evaluation evidence available, it has been suggested that the most effective interventions share a number of common characteristics. These include: involving a combination of strategies; involving [older] people and/or their representative groups in intervention planning and implementation; having well trained, appropriately supported and resourced facilitators and coordinators; utilising existing community resources; and targeting specific groups (Grenade and Boldy 2008).

In their review of the literature, Cattan and others (2005: 57) found that effective interventions shared several characteristics. In general, ones which were effective:

> Included group-based interventions with a focused educational input, or ones that provided targeted support activities

> Targeted specific groups, such as women, care-givers, the widowed, the physically inactive, or people with serious mental health conditions

> Enabled some level of participant and/or facilitator control or consulted with the intended target group before the intervention

> Evaluated an existing service or activity (demonstration study) or were developed and conducted within an existing service

> Identified participants from agency lists (GPs, social services, service waiting lists), obituaries, or through mass-media solicitation (while self-selection was a problem noted in many studies)

> Included some form of process evaluation and their quality was judged to be high.

The same authors found that the only major characteristic among the "ineffective" interventions was that they were one-to-one interventions conducted in people's own homes. Four evaluated home-visiting schemes, while the fifth considered the effectiveness of social support using the telephone. Inconclusive studies covered diverse interventions and were characterised by

poor reporting, weak study design, high attrition rates, and small or unrepresentative samples (Cattan et al. 2005: 57-8).

This should not be seen as conclusive evidence that one-to-one or at-home interventions do not work. It may be the case that these interventions were ineffective in particular studies, but equally the study design or choice of outcome measurements may have been problematic (Dickens et al. 2011). Either way, it does emphasise the need to fully engage with, and consider the needs of, the individuals being supported while designing and implementing any interventions.

Intervention strategies

Improving social skills

Social skills can take a range of forms, including conversational skills, speaking on the telephone, giving and receiving compliments, handling periods of silence, non-verbal communication methods, and approaches to physical intimacy (Masi et al. 2008).

Social skills training (SST) is one type of child-specific intervention, which involves teaching specific skills (e.g. maintaining eye contact, initiating conversation) through behavioural and social learning techniques (Cooper et al. 1999). SST is an appealing intervention approach for use with children with ASD because it provides the opportunity to practise newly learned skills in a relatively natural format that may promote interaction with other children (Barry et al. 2003). Other promising strategies were developed based on knowledge of the literature, including characteristic learning styles and specific deficits associated with ASD, as well as knowledge of the individual participants in the groups (Williams White et al. 2007).

According to McConnell (2002), environmental modifications involve modifications to the physical and social environment that promote social interactions between children with ASD and their peers. Child-specific interventions involve the direct instruction of social behaviours, such as initiating and responding. Collateral skills interventions involve strategies that promote

social interactions by delivering training in related skills, such as play behaviour and language, rather than training specific social behaviours. Peer mediated interventions involve training non-disabled peers to direct and respond to the social behaviours of children with ASD. Finally, comprehensive interventions involve social skills interventions that combine two or more of the aforementioned intervention categories (Bellini et al. 2007).

Gresham and others noted that the weak outcomes of social skills interventions may be attributed to location: they often take place in "contrived, restricted, and decontextualised" (2001: 340) settings. In contrast, interventions that are implemented in a normal classroom setting are more effective across a range of measures (Bellini et al. 2007). This finding has clear implications for school-based social skills interventions, but it also suggests that social skills interventions in general may be more effective in natural, rather than artificial, settings. The researchers also recommended that social skills interventions be implemented more intensely and frequently than the level presently delivered to children with social skills deficits.

Underdeveloped social skills can impede one's ability to establish meaningful social relationships, which often leads to withdrawal and a life of social isolation, yet few children receive adequate social skills training (Hume, Bellini and Pratt 2005). Social skills are an important factor in ensuring successful social, emotional, and cognitive development. As such, effective social skills training from a young age can help reduce the risk of isolation and loneliness in later life.

Enhancing social support

To some extent, loneliness and social support can be seen as opposite concepts. Loneliness refers to the experience of deficits in social relations, while social support refers to the availability of interpersonal resources (Perlman and Peplau 1984: 18). Research on social support has investigated both subjective (perceived) support and objective social support (House 1981). Researchers also distinguish between tangible

or instrumental support, which consists of things such as actual physical assistance, financial assistance, information, or other help useful for solving a problem or answering questions; and emotional support, on the other hand, which refers more to a feeling of group belonging or the feeling that one is cared for by some significant other or others. Second, researchers distinguish among different sources of support, including significant others such as partners or spouses, family members, friends, co-workers, neighbours, and even pets (Tomaka et al. 2006).

In general, the data confirms that social support decreases loneliness. Differential analysis of the three types of support shows that emotional support is significantly associated with family, romantic, and social loneliness, whereas the effect of instrumental support is very limited and informational support does not significantly affect loneliness (Hombrados-Mendieta et al. 2013: 1028-29). There is some consensus that emotional support is the most relevant regarding a large number of problems (Cutrona 1986), although it is clear that each type of support fulfils a specific function. In this regard, some authors (e.g. Blazer 2002) suggest that emotional support is a key element in the experience of loneliness since this occurs when there is a discrepancy between desired emotional support and available emotional support.

Interventions which enhance social support include professionally initiated interventions for the bereaved (Vachon et al. 1980), for the elderly whose personal networks have been disrupted by relocation (Kowalski 1981), and for children whose parents have divorced (Wallerstein & Kelly 1977).

Cognitive approaches

Finally, programmes that focus on addressing negative thoughts (e.g. of self-worth) through interventions such as cognitive behavioural therapy (CBT) appear to be somewhat successful in reducing loneliness (Young 1982). The cornerstone of this intervention is to teach lonely individuals to identify automatic negative thoughts and how to manage these feelings.

Interventions that address "maladaptive social cognition" have been found to have a larger mean effect size compared to interventions that addressed social support, social skills, and opportunities for social intervention (Masi et al. 2010). According to Masi et al. this result is consistent with the model of loneliness as "regulatory loop" (Cacioppo and Hawkley 2009), in which lonely individuals have increased sensitivity to and surveillance for social threats, preferentially attend to negative social information, tend to remember more of the negative aspects of social events, hold more negative social expectations, and are more likely to behave in ways that confirm their negative expectations. Regardless of whether this model is accurate or not, it seems that CBT and related interventions may have a role to play in supporting individuals with chronic loneliness.

Intervention methods

Self-management

As mentioned from the outset, many people experience isolation or feelings of loneliness at some point in their lives. For the majority of people, these experiences are temporary or situational and people often learn to manage these experiences in some way.

Self-management techniques aim to support people's resilience in two key ways. The first encompasses external resources which contribute to well-being from the "outside" such as friends and social support. The second encompasses internal resources which refer to behavioural and cognitive abilities that people use to manage their external resources and thus achieve well-being. Having external resources is essential but not sufficient for the maintenance of well-being; people also need to be able to manage these external resources (Steverink et al. 2005). For example, having social relationships requires the management ability to indeed achieve and maintain social support from these relationships. Steverink et al. (2005) introduced the term self-management abilities (SMAs) to represent these internal resources, which were identified as self-efficacy, positive frame of

mind, taking initiatives, investment behaviour, multi-functionality of resources, and variety in resources.

Peer support/befriending

Befriending schemes, where an individual befriender provides social support, have been shown to have a modest effect on depression in a range of population groups, but the benefit of such schemes for individuals experiencing isolation or loneliness in particular circumstances is unclear. Again, it would depend on assessing the individual's or group's needs.

Support groups and discussion sessions also appear to be beneficial for specific populations, for example people who are bereaved or have a chronic condition. Findlay (2003) found that support groups are only effective for people who have the social skills to participate, and where they were sustained for at least five months. In another study, the researchers found that participants attending a particular community centre became socialised as peer supporters without following any formal system and it seemed to work quite well.

Community and activity-based interventions

Although other interventions can be "community-based", many researchers seem to conflate community-based interventions with activities that involve different members of a local community. These include community navigator services, where navigators act as a link between hard-to-reach individuals and local services. These "gatekeeper" programmes appear to have been successful in the US at identifying and referring on socially-isolated older people who have not routinely come to the attention of services (Findlay 2003).

In their research on interventions for older people, Davidson and colleagues (2003) suggested that policy changes are needed to make day centres, lunch clubs and other clubs more congenial for older men so that they do not feel they are "yielding up" their individuality, or admitting some sort of "defeat" by attending. For example, these clubs might offer wine and

beer with lunch, a snooker table or a computer club. More importantly, they find themselves in an environment which enhances quality of life owing to increased social involvement, with the potential of reducing social isolation at the same time. The authors recommend that local authorities and voluntary organisations should offer appropriate facilities and activities for older men, which support them to lead socially-integrated and independent lives within the community (Davidson et al. 2003).

Case study: "Friendship lunches", North Yorkshire

There lies an opportunity for public venues (e.g. restaurants, bookstores, sports venues) to leverage a meal or other leisure occasions to help people build relationships in their local communities to address loneliness. A pub in North Yorkshire, for example, has been hosting "friendship lunches" since February 2015 – marketing itself as "an opportunity for locals to come together for good food and good company". The initiative was well received by local consumers and it was quickly rolled out to another six different communities. (Source: Mintel)

Pitkala and others (2009) identified several factors which contribute to the effectiveness of group-based interventions such as lunch clubs. These include ensuring that there is some homogeneity among the group participants and that there are shared experiences and interests.

In addition, within the community setting, social policy makers should analyse existing community support resources and plan actions to meet the needs of community support, such as promoting action to encourage contact between neighbours and developing activities that increase the social network and facilitate bonding between community members (Hombrados-Mendieta et al. 2013).

Technology-based interventions

There is plenty of debate and there are many gaps in the research on digital technology, communication and loneliness, especially in older age. For many digital services – including Facebook, Skype, email and Twitter – a study can be found that shows them be successfully used. Masi et al. (2010) found that loneliness reduction interventions have "yet to harness the power of technology." Their article recognises that simply making the internet available within elderly communities – even with careful and lengthy induction – does not promise a substantial impact by itself. It considers research that shows how the internet can instead be directed towards particular social interactional opportunities.

Two systematic reviews included studies assessing computer training and internet use (delivered either individually or in groups) as a means to reduce loneliness among older people. The reviews covered community-dwelling people and people living in residential or nursing homes. The computer training ranged from two weeks to three months and aimed to help older people communicate with family and friends, as well as obtain news and other useful information. There was some limited evidence of benefit but the poor quality of included studies makes it difficult to generalise.

Case study: SharedWalk

SharedWalk is a service funded by the Nominet Trust and implemented by the Learning Science Research Institute at the University of Nottingham. It allows someone with a smartphone to capture and send (narrated) videos to a partner with access to this website. It is hoped that this will be particularly valuable for individuals who are relatively housebound and who wish to keep in contact with the experiences of friends and loved ones. There is no evidence on the effectiveness of SharedWalk, as yet, but it is an example of the kind of innovations happening in this area.

Animal-assisted interventions

Animal-assisted therapy is another method that is currently being used to increase social interactions and to combat loneliness. It is suggested that AAT can be viewed as a vehicle for social interactions, with the pet as an ice-breaker in community-based social interactions (Banks and Bank 2005). This therapy is carried out or facilitated by an AAT specialist (often a registered nurse, occupational therapist, social worker, psychologist, etc.) who has been trained to integrate the animal into therapy as a modality (Delta Society 2005).

Animal-assisted activities, although not directed toward specific therapeutic goals, "provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life" (Delta Society 2005). Such activities can include bringing cats or dogs to visit patients at a hospital or nursing home; fish tanks located in health care providers' offices for patients to watch while waiting; and even a dog-obedience group that gives a demonstration for a correctional facility. Specialists helping to facilitate these activities may include but are not limited to assistants of licensed professions (nursing, occupational and physical therapy, as well as recreational therapy), students of professionals, and animal-shelter workers (Morrison 2007: 53-54).

Animal-assisted interventions have been found to be effective among adolescents as well as older people, and found to be more effective in one-to-one settings than group settings. In addition, prompted or guided human-animal interactions appear to be more effective in improving social functioning than spontaneous interactions. Less intensive and longer animal-assisted interventions tended to show higher effects on daily living skills, suggesting that short but highly intensive programmes in elderly and psychiatric patients may lead to an exhaustion of the intervention effect (Virués-Ortega et al. 2012: 216).

Older adults who reported owning a pet are 36% less likely to report loneliness than older adults not reporting pet ownership. Further, "an

interaction effect was found, such that older adults who lived alone and did not own a pet were at increased odds of reporting loneliness" regardless of gender (Stanley et al. 2014). This finding indicates that pets may function as a meaningful source of social connectedness. Notably, pets depend on their owners for survival, potentially giving their owner a sense of worth and responsibility for another living being. This is consistent with studies of human interactions, which show that providing support to others, rather than receiving it, may confer greater health benefits (Brown et al. 2003). Caring for a pet also requires behavioural activation, such as walking or going to the veterinary office, which may bring about interactions with other people and, by virtue of increased mobility, extend into other domains of health as well.

However, it should be noted that loneliness is only a single indicator of health, and that pet ownership, if not managed properly, may actually be deleterious to the well-being of an older adult. Although limitations of pet ownership do exist, careful planning could mitigate any negative consequences of pet ownership.

The role of different sectors

Given the health-related, financial and wider community imperatives, there has been a national policy consensus that support must be provided to reduce isolation and loneliness as it affects older people. There is now an opportunity to extend this recognition to younger and working-age people.

Although there is clear recognition that the third sector must be involved in some way, there is no consensus about the roles of the third sector vis-à-vis the statutory sector, or the potential role of the private sector. However, there have been some promising developments on this front in the Scottish Parliament, largely through the efforts of the Equal Opportunities Committee (Scottish Parliament 2015).

What is clear is that GPs, social workers, housing associations, and other frontline services are well placed to identify people who are at risk of isolation or loneliness, but so are people who are active in their communities. Strong partnership arrangements need to be in place between organisations to ensure that developed services can be sustained (Windle et al. 2011).

A good example comes from the Campaign to End Loneliness, a network of national, regional and local organisations working together to reduce loneliness in later life, who have produced a toolkit for health and wellbeing boards. The toolkit provides guidance on identifying local prevalence of loneliness, strengthening partnerships and evaluating implementation when producing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. It is too early to say how successful this initiative has been, but it demonstrates the need to tackle loneliness and isolation by working with key stakeholders across different sectors.

Conclusion and recommendations

Over 100 articles and reports have been reviewed for this report. While several potential target groups have been identified, there are many more to consider and for each group there may be several articles, reports or book chapters that further our understanding of those groups' experiences of loneliness or isolation. There are also groups who are likely to experience several of the risk factors associated with different clusters, making them much more likely to be socially isolated and/or lonely. Special consideration should be given to whether these groups might be supported through the the British Red Cross and Co-op partnership.

Coherence between target groups and interventions

It is important not to think of target groups and interventions in isolation, but to keep both in mind throughout the decision-making process. Any decisions made about which groups to support through the partnership should be able to demonstrate coherence between the choice of groups and the potential interventions designed to support those groups. In other words, it might not be possible to support certain groups due to the nature of the interventions needed, whereas certain interventions may sound attractive but may not be effective for the groups selected.

Further research

Regardless of which groups are selected, it should be expected that the primary research partners undertake a rapid review of the literature to understand the nature of those groups, the impact of isolation and loneliness on the individuals concerned, and the kinds of interventions that might be effective. Some of this information may also come from experts or stakeholders of interest in different sectors.

Involving individuals throughout the process

Any individuals from the groups that are targeted should be involved in the design and implementation of the intervention as much as possible. Understanding the specific needs of individuals and the situations they are currently experiencing is essential in order to identify appropriate responses. According to the research, giving individuals more say in the support they receive, and how it is carried out, is more likely to lead to better outcomes (Cattan et al. 2005).

Tackling social versus emotional isolation

Creating opportunities for social relations does not always balance the discrepancy between desired and actual levels of social interaction, or feelings of loneliness, and these limitations should be considered when designing interventions. Ameliorating feelings of loneliness is more complex, but by reducing social isolation through the provision of social connections, there is a greater possibility to develop emotionally satisfying relationships and thereby reduce feelings of loneliness.

Evaluation and monitoring

The characteristics of effective interventions should be used as a starting point for designing new initiatives (Cattan et al. 2005; Grenade and Boldy 2008), but innovative interventions for social isolation and loneliness should be piloted and evaluated because of the magnitude of the health risks (Coyle and Dugan 2012). Interventions targeting loneliness and isolation could potentially be cost neutral, due to the potential pay-offs in health care costs that would otherwise occur. Furthermore, many current efforts to reduce social isolation in the community rely heavily on volunteers, which could also maintain low costs. However, robust process and outcome evaluations would need to be carried out in tandem with the intervention to ensure that there is evidence to support any claims about the financial and non-financial effectiveness of particular interventions.

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Appendices

Appendix 1: data sources

National level surveys

Below is a list of national-level surveys that could yield data on loneliness and social isolation.

- English Longitudinal Study of Aging (ELSA)
- Lifestyle and Opinion Survey
- Life Opportunities Survey (LOS)
- Understanding Society

De Jong Gierveld loneliness scales

Items of the 11-Item and 6-Item (green) De Jong Gierveld Loneliness Scales

Items	Emotional subscale	Social subscale
1. There is always someone I can talk to about my day-to-day problems		X
2. I miss having a really close friend	X	
3. I experience a general sense of emptiness	X	
4. There are plenty of people I can rely on when I have problems		X
5. I miss the pleasure of the company of others	X	
6. I find my circle of friends and acquaintances too limited	X	
7. There are many people I can trust completely		X
8. There are enough people I feel close to		X
9. I miss having people around	X	
10. I often feel rejected	X	
11. I can call on my friends whenever I need them		X

The 11-item De Jong Gierveld Loneliness Scale has proved to be a valid and reliable measurement instrument for overall, emotional, and social loneliness, while the 6-item scale may prove more suitable in large surveys.

UCLA loneliness scale (version 3)

A 20-item scale designed to measure one's subjective feelings of loneliness as well as feelings of social isolation.

Participants rate each item as O ("I often feel this way"), S ("I sometimes feel this way"), R ("I rarely feel this way") or N ("I never feel this way").

Scoring: O=3, S=2, R=1, N=0

Total scores range from 0, meaning never lonely, to 60, a high degree of loneliness.

1.	I am unhappy doing so many things alone	O	S	R	N
2.	I have nobody to talk to	O	S	R	N
3.	I cannot tolerate being so alone	O	S	R	N
4.	I lack companionship	O	S	R	N
5.	I feel as if nobody really understands me	O	S	R	N
6.	I find myself waiting for people to call or write	O	S	R	N
7.	There is no one I can turn to	O	S	R	N
8.	I am no longer close to anyone	O	S	R	N
9.	My interests and ideas are not shared by those around me	O	S	R	N
10.	I feel left out	O	S	R	N
11.	I feel completely alone	O	S	R	N
12.	I am unable to reach out and communicate with those around me	O	S	R	N
13.	My social relationships are superficial	O	S	R	N
14.	I feel starved for company	O	S	R	N
15.	No one really knows me well	O	S	R	N
16.	I feel isolated from others	O	S	R	N
17.	I am unhappy being so withdrawn	O	S	R	N
18.	It is difficult for me to make friends	O	S	R	N
19.	I feel shut out and excluded by others	O	S	R	N
20.	People are around me but not with me	O	S	R	N

Social isolation index

This index is used in ELSA and consists of a simple scoring system, with higher scores implying higher levels of social isolation. The index is composed of five parts:

Partnership: score of 1 if not married or not cohabiting with a partner

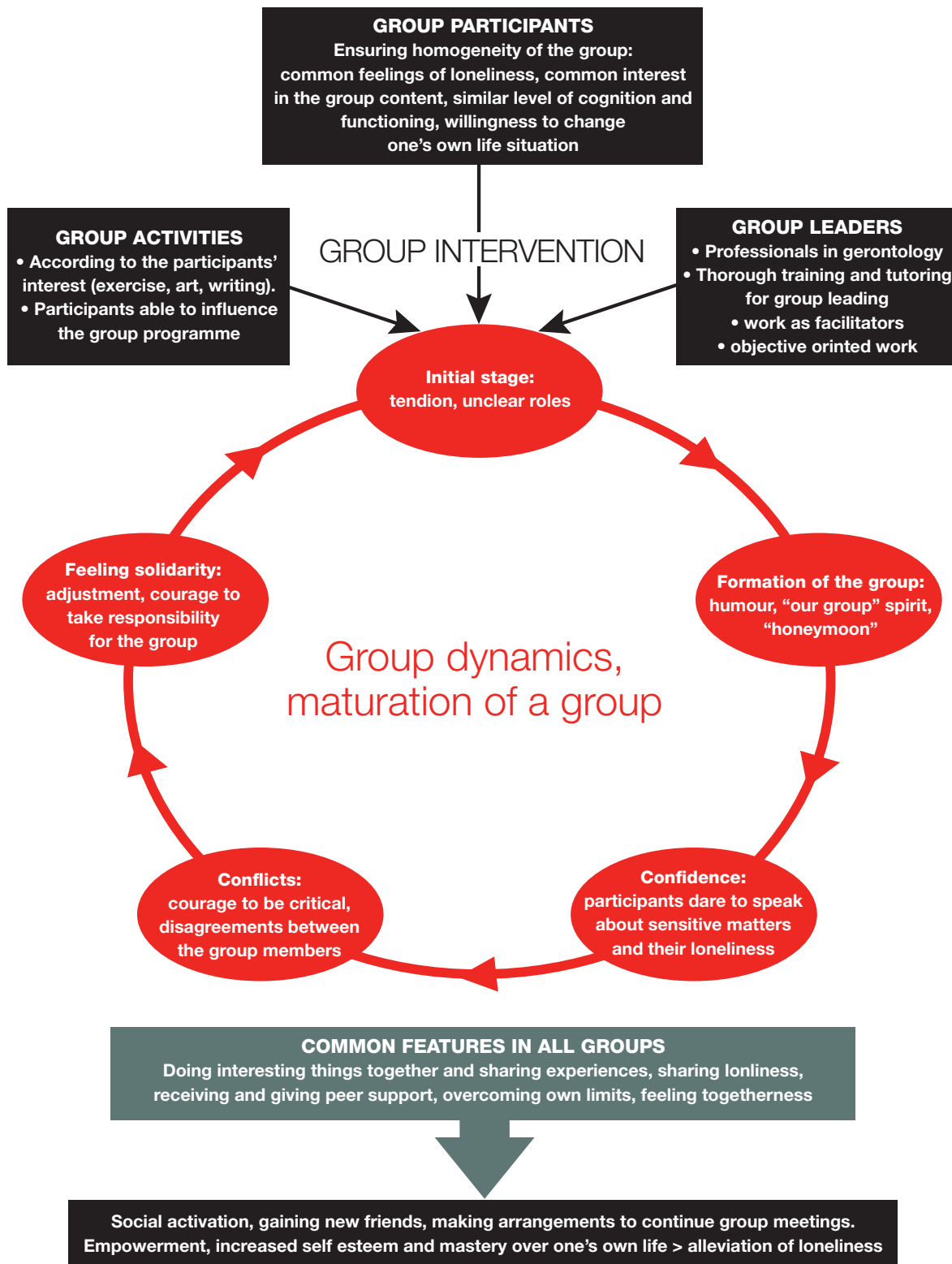Contact: score of 1 for each where there is less than monthly contact (meeting in person, speaking on the telephone, or written communication including emails) with:

- children
- other family members
- friends

Respondents also score 1 for each if contact is less than monthly for all modes.

Organisational membership: score of 1 if participant does not identify membership in a social organisation.

Appendix 2: principles of group intervention

GROUP PARTICIPANTS
Ensuring homogeneity of the group:
common feelings of loneliness, common interest
in the group content, similar level of cognition and
functioning, willingness to change
one's own life situation

GROUP ACTIVITIES
• According to the participants'
interest (exercise, art, writing).
• Participants able to influence
the group programme

GROUP INTERVENTION

GROUP LEADERS
• Professionals in gerontology
• Thorough training and tutoring
for group leading
• work as facilitators
• objective orinted work

Initial stage:
tendion, unclear roles

Feeling solidarity:
adjustment, courage to
take responsibility
for the group

Group dynamics,
maturation of a group

Formation of the group:
humour, "our group" spirit,
"honeymoon"

Conflicts:
courage to be critical,
disagreements between
the group members

Confidence:
participants dare to speak
about sensitive matters
and their loneliness

COMMON FEATURES IN ALL GROUPS
Doing interesting things together and sharing experiences, sharing lonliness,
receiving and giving peer support, overcoming own limits, feeling togetherness

Social activation, gaining new friends, making arrangements to continue group meetings.
Empowerment, increased self esteem and mastery over one's own life > alleviation of loneliness

Source: Pitkala et al. (2009)

Where we are:

British Red Cross
44 Moorfields
London
EC2Y 9AL

redcross.org.uk

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