

SOCIAL ISOLATION AMONG OLDER PEOPLE IN URBAN AREAS

A review of the literature for the Ambition for Ageing programme in Greater Manchester

Tine Buffel, Samuèle Rémillard-Boilard and Chris Phillipson

MANCHESTER
1824

The University of Manchester
Institute for Collaborative
Research on Ageing

GMCVO



ambition
for
ageing



LOTTERY FUNDED

ABOUT THE AUTHORS



Dr. Tine Buffel

Dr. Tine Buffel works as a research fellow in the School of Social Sciences at the University of Manchester, and is linked to the Manchester Institute for Collaborative Research on Ageing (MICRA). As part of the Ambition for Ageing Programme, she is responsible for developing research projects linked to the programme in co-production with older people and local stakeholders. She is also a visiting professor at the Free University of Brussels (VUB). Her particular focus concerns social issues associated with ageing populations. She has been especially interested in studying questions relating to neighbourhood and community life; the dynamics of social inclusion and exclusion; the impact of cities on older people and vice versa; the development of age-friendly communities and the relationship between ageing and migration.



Samuèle Rémillard-Boilard

Samuèle Rémillard-Boilard is a PhD Student in the Department of Sociology at the University of Manchester and linked to the Manchester Institute for Collaborative Research on Ageing (MICRA). Her doctoral research will explore the topics of ageing and urbanisation, with a particular focus on social isolation of older adults. She is especially interested in exploring the themes of social inclusion/exclusion of older adults, neighbourhood dynamics and the development of age friendly cities.



Prof. Chris Phillipson

Chris Phillipson is Professor of Sociology and Social Gerontology at the University of Manchester and the executive director of the Manchester Institute for Collaborative Research on Ageing (MICRA). He has a particular interest in understanding the relationship between population ageing and urbanisation. He has undertaken a variety of research projects with colleagues focusing on social exclusion in later life, transnational migration, and the impact of globalisation on older people.

KEY MESSAGES

1. Social isolation is a term referring to the absence of contact with other people.
2. Social isolation and loneliness are two distinct concepts. Social isolation refers to an absence of or limited contacts whereas loneliness is associated with a subjective perception in which a person feels lonely.
3. Although older people are particularly vulnerable to loss of friends and family, mobility or income, the experience of social isolation and loneliness fluctuates over the years. Addressing social isolation therefore necessitates the planning of preventative strategies at all stages of the life course.
4. Research shows that people with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships.



5. Increasing social participation and social connectedness contribute to the well-being of older adults. Belonging to a social network makes people feel cared for, loved, esteemed and valued, this having a powerful protective effect on health, and a decreased use of health and social care services.
6. Social participation can be seen as a continuum ranging from a more informal way of interacting with the community (e.g. associating with friends and neighbours, walking in the neighbourhood, using public spaces) to more formal forms of engagement (e.g. volunteering, joining an association, political involvement and activism).
7. If schemes to target social isolation in old age are to be effective, they must involve older people at every stage, including the planning, development, delivery and evaluation of interventions.
8. Overall, evidence of effective interventions to reduce social isolation is limited. Research and measurements of effectiveness should therefore be built into the design of any new intervention or project.
9. Research needs to be carried out on interventions that include different groups of older people, in terms of gender, ethnicity, sexual orientation, etc.
10. Group interventions that have a training/educational component are especially effective at reducing social isolation.

11. Services to reduce social isolation need strong partnership arrangements between organisations to ensure developed services can be sustained.
12. Interventions at the neighbourhood/ community level have a greater chance of success if they utilise existing community resources and aim to build community capacity.
13. Target interventions on specific groups: e.g. LGBT communities, people diagnosed with dementia, and BME groups.



1 | INTRODUCTION: AGEING IN GREATER MANCHESTER

Interventions to tackle social isolation should be set against the GM vision of enabling older people to 'age better' and to play a central role in the cultural, economic and social life of the region. However, GM is also experiencing a number of economic and demographic challenges which have the potential to increase social isolation amongst the 50 plus age group (Buckner et al., 2011). Key areas for consideration here include:

- **Unemployment/under-employment of those 50-64 – more than a fifth of GM 50-64 year-olds are out of work and in receipt of working age benefits. Detachment from the labour market in mid-life may reduce levels of social participation in later life due to limited friendship networks and lack of financial resources.**





- The projected growth in single-person households, with a 66% increase in the numbers of people in GM 75 plus living alone (from 97,000 in 2011 to 161,000 in 2036), with one in three men aged 75 living alone by 2036.
- The projected growth in GM in the population - those 75 and over - likely to be most at risk of social isolation: from 221,000 in 2011 to 387,000 in 2036 (a 75% increase). 14% of the GM total population will be 75 and over by 2036.
- The projected growth in the number of people predicted to be diagnosed with some form of dementia: from 32,000 in GM in 2011 to 61,000 in 2036 (an increase of 85%).

The characteristics of demographic change underline the need for preventive approaches to social isolation and to develop

new approaches to providing support at a neighbourhood level. The aim of this booklet is to review what we know about the characteristics and causes of social isolation, the groups who are most at risk, the value of encouraging social participation, and evidence about the most effective forms of intervention. Three key conclusions from this booklet are:

- First, the need to support a variety of interventions to reflect an increasingly diverse population of older people.
- Second, the importance of co-production with older people from planning, delivery of programmes, to evaluation.
- Third, to build wherever possible on existing community capacity and resources.

2 | WHAT IS SOCIAL ISOLATION?

DEFINITION OF SOCIAL ISOLATION

Social isolation can be defined as 'an objective measure reflecting an individual's lack of contacts or ties with others (family, friends, acquaintances, neighbours, potentially service providers)' (Scharf, 2014). Social isolation is characterised as an absence or limitation in the quantity of social interactions. Loneliness is a subjective perception in which a person feels lonely. Social isolation can be described as 'situational' or 'chronic' (see further below).

SITUATIONAL ISOLATION

Ageing can be a period of considerable change, which can lead to temporary or what may be termed 'situational isolation'. Certain life stages such as retirement, or decline in general health or loss of a partner can be particularly unsettling at an older age and force people to adjust to a new reality and rethink their social networks. Although the experience of isolation and loneliness may vary over time, these periods of transition are important to consider as they can lead to a temporary shrinkage in social networks and cause social isolation.

CHRONIC ISOLATION

A persistent lack of social ties may lead to the development of a chronic condition that poses serious health risks for older people. While situational and chronic isolation may be addressed differently, attention should be paid to these two forms of isolation as they can both have an impact on the well-being of older adults.

Interacting with others and taking part in social networks represents an important aspect of later life. Levitas et al. (2007, p.25) state that:

The impossibility to fully participate in social activities or engage socially constitutes a dimension of social exclusion that can 'affect both the quality of life of individuals and the equity and cohesion of society as a whole'.





Research suggests that older people are especially vulnerable to social isolation or exclusion from social relationships, owing to loss of friends and family, mobility or income (Windle et al., 2014; Barnes et al., 2006). According to Barnes et al. (2006), people living alone, those who are retired, have a low income, and those who define themselves as permanently sick or disabled, are amongst the most at risk of limited social contacts.

DIFFERENCES BETWEEN SOCIAL ISOLATION AND LONELINESS

Although they are often used as synonyms, a distinction must be made between the concepts of social isolation and loneliness. Social isolation broadly refers to the absence of contact with other people. Loneliness is a subjective perspective in which a person feels lonely. Or as one service provider expressed it: 'Isolation is being by yourself. Loneliness is not liking it' (Beach and Bamford, 2014).

The relationship between isolation and loneliness remains complex because 'the presence of a large social network does not necessarily imply the presence of a confiding relationship' (Victor et al., 2000, p.410). Consequently, it is possible for someone to be isolated without feeling lonely, as much as it is possible to feel lonely and left out while being surrounded by people.

MEASUREMENT OF SOCIAL ISOLATION

There is no agreed upon way of measuring social isolation. Dickens et al.'s (2011) review of existing measures shows that the most commonly used tools (e.g. de Jong Gierveld Loneliness Scale or the UCLA Loneliness Scale) focus on the measurement of subjective isolation and loneliness (Elder and Retrum, 2012). However, according to the American Association of Retired Persons, 'additional measures of isolation other than loneliness should be considered to have a

broad or comprehensive measure of isolation' (Elder and Retrum, 2012, p. 29). Cornwell and Waite (2009) also suggest that both the quantity and quality of social interactions should be taken into account when measuring social isolation.

In order to achieve this goal, the authors studied social isolation by using two scales: one measuring social disconnectedness; one measuring perceived social isolation. Focusing on the quantity of social interaction, the social disconnectedness scale explores different aspects of social life such as:

- **Social network size and range**
- **Physical proximity and frequency of interactions with network members**
- **Number of friends**
- **Participation in social activities or group meetings.**

Focusing on the quality of social interaction, the perceived isolation scale explores the different forms of emotional and social support available to people by addressing elements such as:

- **Perceived lack of companionship**
- **Frequency of feeling left out and isolated**
- **Possibility to open up to family, friends or spouse/partner**
- **Possibility to rely on family, friends or spouse/partner**



KEY MESSAGES

1. 'Older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income.' (Windle et al., 2014)
2. Social isolation and loneliness are distinct notions. Social isolation refers to an absence of contact with other people whereas loneliness is associated with a more subjective perception in which a person feels lonely (Beach and Bamford, 2014)
3. There is no agreed upon way to measure social isolation, however a broad and comprehensive measure of social isolation should take into account both its objective (social disconnectedness) and subjective dimensions (perceived social isolation).



3 | WHY IS IT IMPORTANT TO TACKLE SOCIAL ISOLATION?

THE EFFECT OF SOCIAL ISOLATION ON INDIVIDUALS

We know that social isolation affects a large number of older people. Beach and Bamford (2014) undertook an analysis of social isolation using the English Longitudinal Study of Ageing (ELSA). They produced an estimate of 1.2 million men aged 50 and over (14%) who experienced a moderate to high degree of social isolation. In contrast, just over a million (11%) of women aged 50 and over experienced a moderate to high degree of social isolation. Extrapolating these figures for Greater Manchester means that around 61,000 men experience social isolation, and 53,000 women.

The LGBT Foundation (2015, p.10) highlighted national research that showed that older LGBT people are more likely than both their heterosexual peers and younger generations of LGBT people to be single and living alone, and are less likely to have children. The report noted results from one of its own surveys which found that 1 in 5 older LGBT people in Manchester have no one to contact for support in times of a crisis (LGBT Foundation, 2015).

Social isolation represents a significant risk factor for physical and mental health problems. A review conducted by Holt-Lunstad et al. (2010) revealed that individuals lacking social contact 'carry a health risk equivalent to smoking up to 15 cigarettes a day and being an alcoholic' and describes social isolation as being 'more harmful than not exercising and twice as harmful as



obesity' (Bolton, 2012, p.10). Research also shows that social isolation puts older adults at greater risk of early mortality (Holt-Lunstad et al. 2010; Steptoe et al., 2013), dementia (Fratiglioni et al., 2004), suicide (Conwell et al., 2011), and cognitive decline (James et al., 2011).

This issue is even more important to address given that social connectedness plays an important role in the mental well-being of older adults. Individuals who lack social contacts are prone to be socially and psychologically weakened (Pan Ké Shon, 2003), leaving them at greater risk of developing low self-esteem (Scharf, 2014), depression, and loneliness (Djernes, 2006).

SOCIETAL IMPACTS OF SOCIAL ISOLATION

Social isolation affects both individuals and the wider community. Health issues arising from isolation and loneliness lead to an increased use of health and social care services as well as a higher number of emergency admissions and GP consultations (Scharf, 2014; Windle et al., 2014), adding significant pressures to available financial resources.

Tackling social isolation and supporting social engagement is of great importance in the context of an ageing population. Research shows that: 'people with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships' (Holt-Lunstad et al., 2010). They are also more

likely to engage in voluntary associations and provide informal care (Hortulanus and Machielse, 2006), which may increase social connectedness and alleviate pressure on the health-care system. Social isolation not only constitutes a public health issue, but also represents a broader social problem.

As Hortulanus and Machielse (2006, p.7) emphasise, 'if people are no longer part of regular society they can also lose contact with the norms and values prevailing in that society - values that are essential for social integration and societal stability'. Therefore, social isolation of older adults not only deprives society from an important source of knowledge and experience but it can also play a role in the weakening of social bonds and solidarity within communities.

KEY MESSAGES

- 1. Social isolation carries a health risk equivalent to smoking up to 15 cigarettes a day and being an alcoholic. Lack of social contact can be more harmful than not exercising and twice as harmful as obesity. (Bolton, 2012; Holt-Lunstad et al. 2010).**
- 2. Health issues arising from isolation and loneliness add important pressure on financial resources and existing structures. Tackling this issue may limit 'dependence on more costly intensive services'. (Windle et al., 2014).**

4 | WHO IS MORE AT RISK OF SOCIAL ISOLATION?

Although the experience of social isolation fluctuates across the life course, some risks factors increase the likelihood of feeling isolated at an older age. Risk factors can be observed at an individual, community and structural level (Scharf, 2014; Elder and Retrum, 2012; Forrest and Kearns, 2001; Buffel et al., 2014; Buffel et al., 2013).

RISK FACTORS AT AN INDIVIDUAL LEVEL

The following individual characteristics and life transition periods are associated with higher risks of social isolation:

INDIVIDUAL CHARACTERISTICS

- **Being aged 75 and over**
- **Having psychological vulnerabilities (shyness, social anxiety depression, etc.)**
- **Living or spending a lot of time alone**
- **Being widowed or divorced**
- **Living on limited material resources**
- **Belonging to certain minority groups**

TRANSITIONS ACROSS THE LIFE COURSE

- **Decline in general health**
- **Physical disability and/or loss of mobility**
- **Loss of income**
- **Retirement**
- **Having to move to residential care**

- **Migration patterns, language barriers**
- **Loss of loved ones**
- **Losing the ability to drive**

Beach and Bamford (2014) found that just under a third (31%) of the most isolated men had no qualifications, while for those older men not isolated, 13% had no qualifications. Income has a strong relationship with social isolation – one in three of the most socially isolated in the Beach and Bamford (2014) study were in the lowest income group.

Those renting their homes are more likely to experience much higher levels of social isolation than homeowners or those paying a mortgage.

Based on the figures cited earlier, older men are at greater risk of social isolation than women. This reflects both the impact arising from loss of a partner and reduced contact with children and other family members. Drawing on ELSA data, Beach and Bamford (2014) found that almost 1 in 4 older men (23%) had less than monthly contact with their children, and close to 1 in 3 (31%) had less than monthly contact with other family members.

For women these figures were 15% and 21% respectively. Older men also had less contact with friends. Nearly 1 in 5 men (19%) had less than monthly contact with their friends compared to only 12% of women.

RISK FACTORS AT A COMMUNITY LEVEL

The environment in which people grow old can also have a significant impact on the development of social networks. Some neighbourhoods may be particularly suitable for the development of social interactions whereas others may be more likely to generate social isolation. Environmental pressures that have been found to increase the risk of social isolation in old age include:

- Presence of physical barriers
- Population change and neighbourhood turnover
- Crime and feeling of unsafety
- Living in a deprived urban environment
- Poor urban design and planning policies
- Insufficient access to resources (e.g. public transport, information)
- Age-segregated living
- Low level of place attachment
- Lack of opportunities for participation

RISK FACTORS AT A STRUCTURAL LEVEL

Finally, it is important to consider social isolation from a global perspective and explore the broader mechanisms that may increase or cause social isolation. Risk factors at the structural level include:

- Discrimination (ageism, racism, sexism, homophobia)

- Extreme social and economic inequalities
- Lack of social cohesion
- Exposure to social disorder and conflict
- Changing norms and behaviours around kin and non-kin relationships
- Migration patterns
- Individualisation

The multiple risk factors linked to social isolation emphasise the need to design interventions and preventive strategies addressing this issue at the individual, community and structural levels. Examples of successful interventions will be provided in a later section.



5 | WHY IS IT IMPORTANT TO PROMOTE SOCIAL PARTICIPATION AND SOCIAL CONNECTEDNESS FOR OLDER PEOPLE?

The consequences of social isolation reaffirm the importance of promoting social participation and social connectedness for older people. Whilst social isolation is associated with greater risks of loneliness and depression (Djernes, 2006), research shows that social connectedness and participation is linked to higher survival rates (Holt-Lunstad et al., 2010), a greater sense of value and inclusion (Gilmour, 2012), and increased opportunities for seniors to share interests and aspirations (Raymond et al., 2008). As the World Health Organization emphasises, belonging to a social network can also 'make people feel cared for, loved, esteemed and valued [which] has a powerful protective effect on health' (Wilkinson, 2004, p.22).

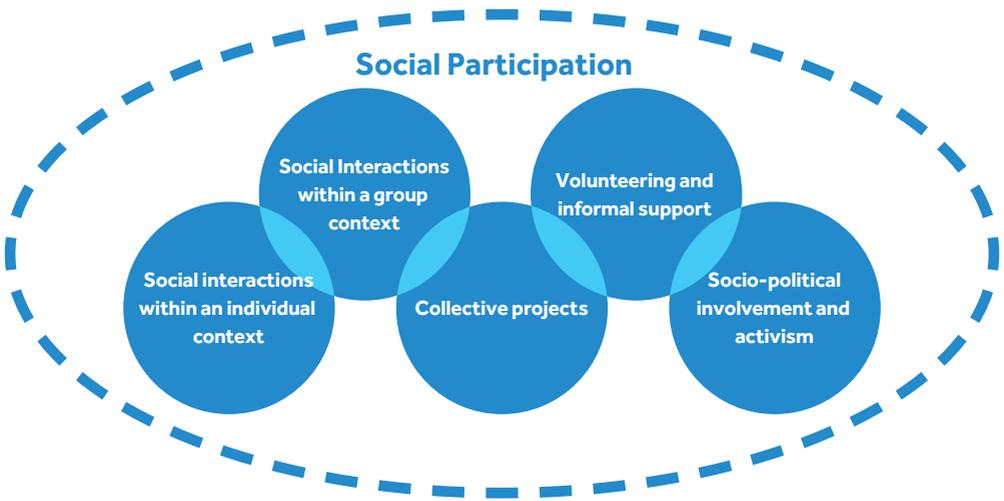
DIFFERENT FORMS OF SOCIAL PARTICIPATIONS

Contrary to popular belief, social participation does not necessarily refer to formal or civic engagement (Levasseur et al., 2010). Walker (2002, p.124) makes the point that being active should not only be linked to paid employment or production; instead, it should include 'all meaningful pursuits which contribute to the well-being of the individual concerned, his or her family, the community or society at large.' Social participation can therefore be seen as a continuum, ranging from a more informal way of interacting with the community (e.g. interacting with friends and neighbours, walking in the neighbourhood, using public spaces) to a more formal form of engagement (e.g.

volunteering, joining an association, political involvement and activism). Although social and community engagement remains desirable, stakeholders should remain mindful of the diverse needs and level of autonomy of older people when designing their activities. While some older adults may easily engage with peers, others may perceive leaving the house or interacting with others as a challenge.

The work of Raymond et al. (2013) may be of particular interest when designing interventions aimed at reducing social isolation among older people. Building on the results of a systematic review of evidence, the authors developed a typology of social programmes promoting the social participation of older adults (Figure 1). In order to achieve this goal, a total of 32 social programmes were classified according to their definition and operationalization of the term 'social participation'. The proposed typology is divided into 5 categories gradually ranging from a more individualised to a more collective approach.





As the authors emphasise, the model is intended to be used as a tool - the categories are not exclusive but may provide decision-makers with an inclusive framework upon which to develop their work. Raymond et al. (2013, p.275) encourage stakeholders to be innovative when designing their activities and affirm that 'overlapping is possible and even desirable'. As they highlight:

Figure 1. Typology of social programmes promoting the social participation of seniors (Raymond et al., 2013).

“Programmes that combine various types of interventions may well be considered to be better suited to the diverse characteristics and needs of seniors”.

KEY MESSAGES

1. Increasing social participation and social connectedness contribute to the well-being of older adults. Belonging to a social network can ‘make people feel cared for, loved, esteemed and valued [which] has a powerful protective effect on health’ (Wilkinson, 2004, p. 22).
2. Social participation does not necessary refer to formal or civic engagement. It can be seen as a continuum ranging from a more informal way of interacting with the community to a more formal form of engagement.

6 | HOW CAN WE RESPOND TO SOCIAL ISOLATION?

A number of intervention programmes have been developed aimed at reducing social isolation amongst older people. These include: first, one-to-one interventions; second, group interventions, (Findlay, 2003); third, service provision interventions (Dickens et al., 2011); and fourth, community development/neighbourhood interventions (Cattan et al., 2005).

A) ONE-TO-ONE INTERVENTIONS

Evidence regarding the value of one-to-one interventions is mixed. Cattan et al. (2005) found that group interventions are more effective at reducing social isolation than one-to-one social support schemes, such as home visiting and befriending services. In contrast, Masi et al. (2011), in their analysis of interventions to reduce loneliness, found that cognitive training targeting how a person feels about themselves and others can be an effective approach. One-to-one schemes may allow for a deeper and more meaningful connection, which may have a greater impact on loneliness rather than social isolation.

EXAMPLES OF ONE-TO-ONE INTERVENTIONS

There is some evidence that Community Navigator Services can be effective in reducing social isolation (Windle et al., 2014). Such schemes typically involve volunteers who provide 'hard-to-reach' or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services, and helping

individuals to find appropriate activities. The structure and processes of this type of service vary across localities and are dependent on population need. 'For example, Community Navigators working with frail older individuals may carry out a series of home-based-face-to-face visits to discuss concerns and plan, alongside the older person, what service or community provision may be beneficial. For less frail populations a telephone conversation may be more appropriate, followed by written information that the individual can access and take forward if they choose' (Windle et al., 2014, p.4).

Other examples of one-to-one interventions that have been found effective in reducing social isolation include: home visits by a nurse to patients aged 75 or more years registered with a health centre (Cattan et al., 2005); older volunteers who participated in a foster grandparent programme for developmentally disabled children; individual counselling, provided either by professionals or peers, for adult daughters and daughters-in-law who are the primary caregiver for a relative suffering from multiple chronic disabilities; internet training intervention for older people who live alone, and who are housebound through chronic illness or physical disability; volunteer home visiting interventions to older people in receipt of home nursing who were considered by their nurses to be socially isolated (Dickens et al., 2011); and cognitive training (CBT) interventions (Masi et al., 2011).



B) GROUP INTERVENTIONS

Group interventions that connect older people with opportunities to develop and maintain meaningful interpersonal relationships have also been shown to reduce social isolation. Cattan et al. (2005) and Dickens et al. (2011)'s systematic evidence review found that:

Group interventions that target specific groups and have a training/educational component are especially effective at reducing social isolation.

According to the Social Care Institute for Excellence (2012) 'research evidence is particularly supportive of [...] group activities with a creative, therapeutic or discussion-based focus' (Windle et al., 2014). Most interventions tend to be 'gender

neutral' but with evidence that services are disproportionately used by women. This raises issues about the benefits of targeted interventions, focused on gender, ethnicity and sexual orientation. The section below provides some examples from the literature in this area.

EXAMPLES OF GROUP INTERVENTIONS

Reference has been made to the issues facing older men in contrast to older women and this has generated interest in male-specific interventions. Men in Sheds was one of the earliest approaches to tackling isolation amongst men. The aim of this type of work is to: 'attract older men to a social setting where they can foster new friendships through engagement with hand-on DIY activities' (Beach and Bamford, 2014, p.37). An evaluation of this type of work has been undertaken by Milligan et al. (2012, p.2) who found that the Shed project which they

studied 'achieved its aims of reducing social isolation and contributing to the mental well-being of older men through social contact and meaningful activity...The Sheds have had some limited success in reaching their specified target populations, e.g. older men from BME groups, those who are living alone and those with caring responsibilities...Where target populations have been reached there is some evidence to suggest that Sheds provide access to social support for those experiencing [...] isolation or depression following challenging life events'.

Wilkens (2015), in a study exploring loneliness and isolation among older lesbians, found that group settings provided a place of safety and offered a sanctuary where participants could be themselves and where new friendships and other groups were formed. She states (Wilkens, 2015, p. 90) that:

'For many women, the group's exclusivity to older lesbians and bisexual woman was deeply significant and influenced their decision to attend.' Social groups, she concludes, have a vital role to play in promoting older lesbian, gay, bisexual, and transgender well-being and offering protection against loneliness and isolation in older age. The author argued for the enhancement of social activities for LGBT elders as a priority to help reduce isolation and loneliness.

In a study of social isolation and health amongst different ethnic and racial groups of older people in the US, Miyawaki (2015) suggests that referring older people to local or ethnic-specific senior centres may be one way of widening their social networks, since many senior centres provide age and culturally relevant educational and recreational activities. She develops the point



that: 'For those older people who are unable to participate in outside activities on a regular basis, family members, neighbours as well as health-care professionals can be key to preventing and reducing social isolation.

Bilingual and bicultural health-care professionals are in a critical position to reach out and monitor older adults' well-being, especially during doctor's visits. Bilingual and bicultural social workers in ethnic communities can play vital roles when visiting older individuals at home as well. By building rapport with minority elders, they may be able to assess and screen their risk of social isolation. Volunteers, acting as friendly visitors from the same racial and ethnic groups and speaking the elder's language, can enhance older people' sense of belonging, monitor their physical and mental well-being, and alleviate some aspects of social isolation' (Miyawaki, 2015, p. 2223).

Other examples of group interventions that produced beneficial effects in reducing social isolation include: discussion groups around health-related topics among small groups of older women who live alone; a skills course for isolated older women; health education sessions combined with physical exercise; bereavement support for recently widowed older people; therapy-type discussion groups for older people with mental health problems; peer- and professionally-led discussion groups for adult daughters and daughters-in-law who are primary carers (Cattan et al., 2005); psychosocial activity/support groups; programmes supporting older people to volunteer to read books for school children; discussion groups for older people with a

handicap; and a tele-based group therapy programme that helped older people cope with the loss of their sight (Dickens et al., 2011).

C) SERVICE PROVISION INTERVENTIONS

According to Cattan et al. (2005), interventions that are developed within an existing service have greater chances to be successful in reducing social isolation. Such programmes aim to provide older people who are affected by social isolation with access to services relevant to their situation and have the potential to include them in a supportive network. In other words, 'these programmes act as bridges to social connectivity' (Raymond et al., 2013, p. 215). In this context, Windle et al. (2014) found that older people receiving services need interventions tailored to their own preferences.



This includes being able to change the day a volunteer visits an older person's home (Butler, 2006), and ensuring that mentoring is tailored to their individual needs and interests. Again, this demonstrates the importance of involving older people in the planning and implementation of services and support, this increasing the effectiveness of interventions in reducing social isolation. Windle et al. (2014) also suggest that:

“Services to reduce social isolation need strong partnership arrangements between organisations to ensure developed services can be sustained.”

EXAMPLES OF SERVICE PROVISION INTERVENTIONS

There is only limited research that has evaluated the effectiveness of interventions developed within an existing service. One example of service provision interventions that has been found effective in reducing social isolation include alternative forms of nursing home care whereby nursing home residents have daily contact with children, pets and plants (Dickens et al., 2011).

Another example is an Intergenerational Programme (Short-DeGraff and Diamond, 1996) set in an adult care centre which offers participants the possibility to join three or four-year old children in play activities (dressing-up, puzzles, etc.). The services offered helped diminish older people's feelings of loneliness whilst improving their level of social participation and satisfaction with their life.

D) WIDER COMMUNITY DEVELOPMENT/ NEIGHBOURHOOD INTERVENTIONS

There is limited evidence about the effect of community development and neighbourhood interventions on reducing social isolation. However, the literature suggests that there is a great potential in developing such approaches. For example:

“Efforts to create age-friendly communities may include the removal of barriers to continued participation in social activities.”

Many older people report difficulties in walking around their neighbourhood as an impediment to leaving the house and connecting with others (Scharlach and Lehning, 2012). Seating areas, safer pedestrian crossings, and priority seating on public transport make communities more accessible to older people. Additionally, public buildings may be made more accessible through ramps, elevators and adequate toilets.

EXAMPLES OF WIDER COMMUNITY/ NEIGHBOURHOOD INTERVENTIONS

One example of a neighbourhood/ community intervention is a project developed by the Joseph Rowntree Foundation and the Joseph Rowntree Housing Trust (Collins and Wrigley, 2014). Whilst the project was aimed at alleviating loneliness rather than social isolation, some of the lessons learnt from the programme delivery can be useful for developing neighbourhood approaches to explore social isolation and develop measures that could address it.



The programme took an action research and participatory approach. It followed eight stages in four neighbourhoods (2 in Bradford, 2 in York), though the programme team adopted a flexible approach so that, according to need or readiness, some neighbourhoods gave more focus to certain stages than others.

THE STAGES WERE:

1. Building awareness of social isolation and loneliness and within neighbourhoods.
2. Recruiting community researchers.
3. Training community researchers.
4. Active fieldwork, collecting comments and thoughts about loneliness and isolation.
5. Analysis of data by community researchers.
6. Presenting the issues and collecting solutions.
7. Prioritising.
8. Solutions implementation.

The evaluation asked community researchers and stakeholders from partner organisations to reflect on the strengths and weaknesses of the project. Some key lessons from the project include:

- It was crucial for a key catalyst – one person or organisation – to take responsibility for drawing people together and communicating messages.
- Partnership working was crucial for achieving the aims of the project, and it was important that the different partners identified with the goals of the programme. Face-to-face contact with partners, rather than email communication, was found to be essential for this buy-in.
- The community research approach has the ability to empower local people. The programme team worked with current community groups or networks where they existed to identify potential community researchers, alongside a more creative, outreach method to reach a wider range of potential volunteers.

The project had an impact on multiple levels, including:

- **A range of impacts on the community researchers, such as increased confidence, increased social responsibility, moving into other education programmes, improved well-being, increased insights into the issue of loneliness, etc.**
- **Social relationships: Social benefits were felt as community researchers widened their social network and worked with people from different backgrounds and different ages.**
- **Benefits to society: In all four neighbourhoods, community researchers succeeded in setting up activities aiming to bring people together and improve their social networks.**
- **Stakeholders were more aware of the issues around loneliness and social isolation. They increased their understanding of the local determinants of loneliness. These provided a resource for the implementation of change, informing local plans and supporting the setting of local priorities by the respective local authority.**

Other examples of community interventions include programmes that support individuals to increase their participation in existing activities (e.g. sport, use of parks, libraries, museums) as well as to use and join outreach programmes and volunteer schemes. Windle et al. (2014, p. 14) state that 'volunteer schemes are extremely broad, involving the structured engagement of befriending or mentoring or, for example,



community organised 'Time Banks' that use hours of time rather than currency and where the type of support volunteers undertake depends on their own skills as well as the needs of the wider community'. Raymond et al. (2013) discuss a number of intergenerational projects that bring older people together with school-aged children.

In the Experience Corps Baltimore Model (Fried et al., 2004), for example, older people commit 15 hours per week to projects aimed at supporting the academic progress of elementary school children, including improving reading skills and school attendance. In-person training activities and volunteer meetings were central features of the programme. The project showed multiple benefits for the older people involved, including improved social relationships, and better mental and physical health.

A number of factors have been identified as crucial to the success of neighbourhood and community-based interventions in reducing social isolation:

- Firstly, interventions at the neighbourhood/community level have a greater chance of success if they utilise existing community resources and aim to build community capacity (Findlay, 2003). Interventions must recognise local assets, opportunities and resources as well as local constraints and individual needs (Cattan et al., 2005; Buffel, 2015).
- Secondly, it is recommended that participants are recruited from within their own living environments, while building on community-based partnerships (Raymond et al., 2013).
- Thirdly, it is essential to conceive activities that acknowledge and respect the interests, needs, experiences and culture of older people in the community, as well as the existing diversity within this population group (Raymond et al., 2013).

Finally, a key factor to success, that is applicable to all interventions aimed at reducing social isolation among older people can be summarised as follows (Raymond et al., 2013, p. 289)

“Older people must be true actors in projects targeting social isolation. They should participate in the planning, realisation and evaluation of programmes, and this, not only at the level of instrumental tasks, but also as full-fledged partners of the decision-making process.”

The next section will summarise the range of success factors that have been identified in relation to programmes aimed at reducing social isolation among older people.



7 | WHAT HAS BEEN DONE AND HOW SUCCESSFUL WAS IT?

Many authors (Findlay, 2003; Dickens et al., 2011; Andersson, 1998; Cohen-Mansfield and Perach, 2015) highlight that there is relatively little evidence about the types of intervention programmes that are successful in reducing social isolation amongst older people.

The lack of evidence highlights the need for further experimentation and evaluation of existing programmes. Such

programmes should have evaluation built into them at inception, in order to increase our understanding of the characteristics that make for effective (or otherwise) interventions.

Previous research has identified some key elements of successful interventions to counter social isolation but further research is needed. Characteristics of successful interventions include:

KEY MESSAGES

1. Interventions are more successful if they are developed within the context of a theoretical framework (Dickens et al., 2011).
2. High quality approaches to the selection, training and support of the facilitators or co-ordinators of the interventions appear to be one of the most important factors underpinning successful interventions W(Findlay, 2003).
3. Interventions are more successful if they involve older people as active participants in the planning, implementation and evaluation stages (Findlay, 2003; Cattan et al., 2005; Dickens et al., 2011).
4. Older people who participate in intervention programmes often emphasise the need for reciprocity in

social support (they are not just ‘service recipients’ but also support givers) (Dickens et al., 2011).

5. Interventions have a greater chance of success if they utilise existing community resources and aim to build community capacity (Findlay, 2003).

6. Interventions seem more effective when they offer social activity and support within a group format (Cattan et al., 2005; Dickens et al., 2011).

7. Educational group interventions or programmes with a training element have a greater chance of success (Cattan et al., 2005)

8. Interventions that target specific groups of older people have a greater chance of success (Cattan et al., 2005).

There is a growing evidence for example around targeted interventions for adults with specific medical condition triggers, e.g. stroke, dementia, heart failure (Henderson, 2013)

9. Interventions that are developed within an existing service seem be more likely to be successful (Cattan et al., 2005).

10. The importance of the evaluation of interventions, both process and outcome evaluation, and the dissemination of the research findings should not be undervalued (Findlay, 2003; Cattan et al., 2005; Dickens et al., 2011).

From reviewing the evidence, there are some concerns about whether socially isolated people are being appropriately reached by some of the interventions. There is also little robust data on interventions that have included ethnic minority elders, LGBT communities, or the most frail and excluded such as those in care homes, refugees, etc.

All intervention programmes should be aware of potential disparities related to race, disability, gender, etc. Raymond et al. (2013) suggest that there is considerable space for 'experimentation that could rely on good practices while pushing for continued innovations, for example by participatory action research processes'. Involving older people as participants in all stages of programme interventions, from the design to the evaluation phases, will be a key issue to address.

CONCLUSION: DEVELOPING INTERVENTIONS ON SOCIAL ISOLATION

Developing interventions which acknowledge the diversity of the older population is an important lesson from this review. Priority areas include:

- **Support for the Lesbian, Gay and Bisexual and Transgender Communities: evidence about the importance of developing 'safe spaces' for people to meet is an important finding from the literature.**
- **Census figures suggest a growth in the population of BMEs living alone but provision will need to be targeted at different groups within this population.**
- **The substantial increase in those diagnosed with dementia will be a major driver in increasing isolation and require innovation in terms of the development of services and support for carers.**
- **The growth in the number of older men living alone is highly significant and reflects social changes associated with increased rates of divorce and separation. Social isolation amongst men entering late old age has become an important issue, with a particular need to focus on those in poor health and low incomes.**





REFERENCES

- Andersson, L. (1998). Loneliness research and interventions: A review of the literature. *Aging & Mental Health*, 2(4), 264-274.
- Beach, B. and Bamford, S-M. (2014) Isolation: The emerging crisis for older men. A report exploring experiences of social isolation and loneliness among older men in England. London: Independent Age in association with ILC-UK.
- Barnes, M., Blom, A., Cox, K., Lessof, C., Walker, A. (2006). *The Social Exclusion of Older People: Evidence from the first wave of the English Longitudinal Study of Ageing (ELSA)*. London: Office of the Deputy Prime Minister, Social Exclusion Unit.
- Bolton, M. (2012). *Loneliness - the state we're in. A report of evidence compiled for the Campaign to End Loneliness*. Age UK Oxfordshire.
- Buckner, L. et al. (2011). *The impact of demographic change on the infrastructure for housing, health and social care in the functional economies of the North of England*. N8 Research partnership. York: University of York.
- Buffel, T., Phillipson, C. and Scharf, T. (2013) Experiences of neighbourhood exclusion and inclusion among older people living in deprived inner-city areas in Belgium and England. *Ageing & Society*, 33(1), 89-109.
- Buffel, T., De Donder, L., Phillipson, C., De Witte, N., Dury S. and Verté, D. (2014). Place attachment among older adults living in four communities in Flanders, Belgium. *Housing Studies*, 29(6), 800-822.
- Buffel, T. (Ed) (2015) *Researching Age-Friendly Communities. Stories from Older People as Co-Investigators*. Manchester: The University of Manchester Library.
- Butler, S.S. (2006) Evaluating the Senior Companion Programme: A mixed method approach. *Journal of Gerontological Social Work*, 47 (1-2), 45-70.
- Cattan, M., White, M., Bond, J. and Learmouth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing and Society*, 25(01), 41-67.
- Cohen-Mansfield, J., & Perach, R. (2015). Interventions for alleviating loneliness among older persons: A critical review. *American Journal of Health Promotion*, Jan-Feb, 29(3): 109-125.
- Collins, A.B. and Wrigley, J. (2014). *Can a neighbourhood approach to loneliness contribute to people's well-being?* Joseph Rowntree Foundation. Report.
- Conwell, Y., Van Orden, K. and Caine, E.D. (2011). Suicide in Older Adults. *Psychiatric Clinics of North America*, 34(4), 451-468.
- Cornwell, E.Y. and Waite, L.J. (2009). Measuring Social Isolation Among Older Adults Using Multiple Indicators From the NSHAP Study. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences*, 64 B, (Suppl 1), i38-i46.
- Dickens, A.P., Richards, S.H., Greaves, C.J. and Campbell, J.L. (2011). Interventions targeting social isolation in older people: a systematic review. *BMC Public Health*, 11, 647.
- De Jong Gierveld, J. and Havens, B. (2004). Cross-national Comparisons of Social Isolation and Loneliness: Introduction and Overview. *Canadian Journal on Aging*, 23(2), 109-113
- Djernes, J.K., (2006). Prevalence and predictors of depression in populations of elderly: a review. *Acta Psychiatrica Scandinavica*, 113(5), 372-387.
- Elder, K. and Retrum, J. (2012). Framework for Isolation in Adults Over 50. American Association of Retired Persons Foundation.
- Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: Where is the evidence? *Ageing and Society*, 23(05), 647-658.
- Forrest, R. and Kearns, A. (2001). Social Cohesion, Social Capital and the Neighbourhood. *Urban Studies*, 38(12), 2125-2143.
- Fratiglioni, L., Paillard-Borg, S. and Winblad, B. (2004). An active and socially integrated lifestyle in late life might protect against dementia. *The Lancet Neurology*, 3(6), 343-353.
- Fried, L.P., Carlson, M.C., Freedman, M. et al. (2004). A social model for health promotion for an aging population: initial evidence on the Experience Corps Model. *Journal of Urban Health*, 81, 64-78.
- Gilmour, H. (2012). Participation sociale et santé et bien-être des personnes âgées au Canada. *Rapports sur la santé*, 23(4), 3-13.

- Greenfield, E., Scharlach, A., Lehning, A. and Davitt, J. (2012). A conceptual framework for examining the promise of the NORC Program and Village models to promote aging in place. *Journal of Aging Studies*, 26. doi:10.1016/j.jaging.2012.01.003
- Henderson, G. (2013). Public Health Approaches to Social Isolation and Loneliness: A Health and Wellbeing Directorate Seminar. Public Health England.
- Holt-Lunstad J, Smith T.B, Layton J.B. (2010). Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316. doi:10.1371/journal.pmed.1000316.
- Hortulanus, R. and Machielse, A. (2006). 'The issue of social isolation', in Hortulanus, R, Machielse, A. and Meeuwesen, L. (eds) *Social Isolation in Modern Society*, London: Routledge, 3-12.
- James, B. D., Wilson, R. S., Barnes, L.L. and Bennett, D.A. (2011). Late-life social activity and cognitive decline in old age. *Journal of the International Neuropsychological Society*, 17(06), 998-1005.
- Lavasieur, M. Richard, L., Gauvin, L. and Raymond, E. (2010). Inventory and analysis of definitions of social participation found in the aging literature: Proposed taxonomy of social activities. *Social Science & Medicine*, 71, 2141-2149.
- Levitas, R., Pantazis, C., Fahmy, E., Gordon, D., Lloyd, E. and Patsios, D. (2007). *The Multi-Dimensional Analysis of Social Exclusion*. Social Exclusion Task Force, London.
- LGBT Foundation (2015) *The state of the city for Manchester's Lesbian, Gay and Bisexual Communities*. Manchester: Manchester City Council.
- Masi, C. M., Chen, H. Y., Hawkey, L. C., and Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*, 15(3), 219-266.
- Milligan, C. et al. (2012) *Evaluation of the men in sheds pilot programme final report*. Lancaster: Lancaster University, Centre for Ageing Research.
- Miyawaki, C.E. (2015). Association of social isolation and health across different racial and ethnic groups of older Americans. *Ageing and Society*, 35, 2201-2228.
- Pan Ké Shon, J-L. (2003). *Isolement relationnel et mal-être*. Insee Première, 931. Paris : Institut national de la statistique et des études économique.
- Raymond, E., Gagné D., Sévigny, A. and Tourigny, A. (2008). *La participation sociale des aînés dans une perspective de vieillissement en santé. Réflexion critique appuyée sur une analyse documentaire*. Québec : Institut national de santé publique du Québec.
- Raymond, E., Sévigny, A., Tourigny, A., Vézina, A., Verreault, R. and Guilbert, A.C. (2013). On the track of evaluated programmes targeting the social participation of seniors: a typology proposal. *Ageing and Society*, 33(2), 267-296.
- Scharf, T. (2014). *Isolation, Loneliness, Ageing: Key Issues for Urban Areas*. Ambition for Ageing workshop, Manchester.
- Short-DeGraff, M. A. and Diamond, K. (1996). Intergenerational program effects on social responses of elderly adult day care members. *Educational Gerontology*, 22, 467-482.
- Stephoe, A., Shankar, A., Demakakos, P. and Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America*, 110(15), 5797-5801.
- Victor, C., Scambler, S., Bond, J. and Bowling, A. (2000). Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology*, 10, 407-417.
- Walker, A. (2002). A Strategy of Active Ageing. *International Social Security Review*, 55(1), 121-139.
- Wilkens, J. (2015). Loneliness and belongingness in older lesbians: the role of social groups as "community". *Journal of Lesbian Studies*, 19(1), 90-101.
- Wilkinson, R. and Marmot, M. (Eds) (2004). *Social Determinants of Health: The Solid Facts*. 2nd edition. Copenhagen : World Health Organization Regional Office for Europe.
- Windle, K., Francis, J. and Coomber, C. (2014). *Preventing loneliness and social isolation: Interventions and outcomes*. Social Care Institute for Excellence. Research Briefing.

