LSE PSSRU

Scoping Review

Health and wellbeing consequences of social isolation and loneliness in old age

KEY POINTS

- Loneliness and social isolation are increasingly recognised as risk factors for poor health and reduced wellbeing. Almost all the studies reviewed found a detrimental effect of isolation or loneliness on health. Health risks associated with isolation and loneliness have been compared to the well-established detrimental effects of smoking and obesity.
- The challenges in the published literature and the gaps in the evidence mean that although addressing loneliness/isolation is a significant issue for social care, prescribing best practice is difficult.
- Depression and cardiovascular health are the most often researched outcomes, followed by wellbeing.
- Definition and measurement in this area both remain complex and contested. Causal links and mechanisms are difficult to demonstrate and further investigation is needed.
- There is a paucity of research focusing on the use of health and social care by isolated older people and on interventions to reduce loneliness and isolation.
- Future research should aim to "connect the dots" between the literature on the risk factors for loneliness and social isolation and the research on their impact on health and wellbeing.

These findings are from a study examining the impact of social isolation and loneliness on physical health, mental health and wellbeing in old age. The aim was to provide an overview of the breadth and depth of the available literature and to highlight gaps in the evidence base.

SOCIAL ISOLATION and LONELINESS are overlapping but distinct concepts. Social isolation is often considered as an objective measure of social contacts and integration in communities, whereas loneliness refers to the subjective negative feeling associated with a perceived lack of contacts. This scoping review found quite a wide variety of definitions and measurements in the literature.

BACKGROUND

An increasing number of older people are living alone and are at risk of being socially isolated in the United Kingdom. This is of concern because social isolation has been identified as a risk factor for poor health and reduced wellbeing, including mortality, depression and cognitive decline. Because older people who are isolated have smaller networks of relatives, neighbours and friends, they have less support to draw on to help meet their social, social care or other needs. They may not have access to appropriate formal health or social care services, which in turn could have deleterious longer-term consequences for their health and wellbeing.

FINDINGS

Research on the impact of social isolation and loneliness on health constitutes a large and growing body of literature. The 128 studies included in this review

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spanned a total of 15 countries, although over half of the papers focused on the United States. In terms of the issue being studied, over half of the 128 papers focused on loneliness.

The studies included in the review had varied objectives (Table 1) but half aimed to describe the association between isolation or loneliness and the health outcome studied. Although there have been a number of such descriptive studies, this topic has received relatively little attention in the intervention literature, with only seven per cent of the papers aiming to describe or evaluate an intervention. Most interventions had mixed results. For example, Routasalo and colleagues (2009) reported that a large proportion of participants had found new friends through a psychosocial rehabilitation programme and that their wellbeing levels increased significantly. However, their loneliness and social isolation scores were not affected by taking part in the programme, suggesting that there are other mechanisms at play. Similar results were found for group activities. A randomised control trial of a model of restorative home care on physical health and social support showed significant improvements in physical function but no changes in perceived levels of social support (Parsons *et al*. 2013).

A wide range of health outcomes were examined in the papers included in the review. Overall, the review found a balance between mental health and physical health (35 per cent of the studies included for each type of outcome). The most commonly studied health outcome was depression, followed by cardiovascular health and wellbeing/quality of life. Across the 128 studies, only two did not find a detrimental effect of social isolation or loneliness on health.

The impact of social isolation and loneliness on health and wellbeing in old age was not uniform across population groups. Gender and age differences were the most researched factors in the sample of articles. In recent years, differences by socioeconomic or ethnic backgrounds have been studied as well – although to a lesser extent.

Finally, a number of papers focused on specific groups who are at higher risk of isolation and loneliness and associated negative health outcomes. These groups include older people who are cancer survivors, unpaid carers, substance users, or people who are HIV-positive, and those with a history of institutionalisation.

Table 1: Overview of the objectives of the papers included in the scoping review

Aim of the study	Percentage of papers
Description of the association between isolation/loneliness and health outcome	50%
Focus on at-risk groups, such as visually impaired older people or carers of relatives with dementia	24%
Investigation of the mechanisms linking isolation/loneliness and health	15%
Description or evaluation of an intervention	7%
Health or social care service use	2%
Focus on health of isolated older people	2%

GAPS IN EVIDENCE AND IMPLICATIONS FOR RESEARCH AND PRACTICE

The lack of consistency in the definitions and measures of isolation and loneliness is problematic as it limits considerably the comparability of the findings between studies, and therefore between settings, population groups and time periods. Very broad and general measures may not fully detect the impacts on physical and mental health of older adults, and could ultimately impair the design of effective interventions. Closer integration of the research on the drivers of loneliness and isolation and the research on their impact on health would allow future researchers to understand better which dimensions are crucial to include in their studies.

Only a third of the studies included in the scoping review used a longitudinal design to explain the health and wellbeing effects of social isolation and loneliness. Cross-sectional studies in this context can say nothing about

the direction of causality between factors. It means that relatively little is known about mechanisms of change or influence. Indeed, older people may become lonelier or more isolated, be chronically isolated, or become so because of trigger events such as retirement or bereavement. A better understanding of these mechanisms is necessary to help policy-makers, commissioners and service providers plan and design appropriate interventions.

Health and social care service use of isolated older people is also under-researched. Available studies focusing on other population groups provide important insights for future research. For example, general practitioners, nurses, social workers and other frontline health and social care professionals potentially have a role to play (Wilson *et al*. 2011, van der Zwet *et al*. 2009) to support lonely people who (typically) have poorer access to adequate health information (Askeslon *et al*. 2011).

The review revealed a paucity of research on specific population sub-groups. It should also be noted that the available evidence focuses almost exclusively on individual-level analyses. We suggest that to understand the scope and magnitude of the impact of loneliness and isolation on health, future research should further take into account ecological factors such as the nature and characteristics of communities and neighbourhoods where older people live.

Finally, only very little published work on interventions to reduce loneliness/isolation and increase health/wellbeing was identified, clearly indicating a gap that makes it hard to develop evidence-based practice. As the findings of longitudinal studies become available, potential causal mechanisms have to be considered in the design of these interventions. Clear conceptual models of loneliness and isolation are also needed, as the target populations for the intervention will respond differently to interventions aimed at reducing different dimensions of loneliness or isolation.

As noted by Hawkley and Cacioppo (2010), a crucial question is whether modifying the feeling of loneliness can have an impact on health. To date, the available evidence is scarce and this should be a priority for future research.

ABOUT THE RESEARCH

A scoping review was conducted between August 2013 and March 2014. Nine databases were searched for empirical papers investigating the impact of social isolation and loneliness on a range of health outcomes in old age. The search yielded 11,736 articles, of which 128 were included in the scoping review (after filtering for relevance).

The research was carried out by Emilie Courtin and Martin Knapp from the Personal Social Services Research Unit, London School of Economics and Political Science. The authors thank Bayo Adelaja for her assistance with the identification of the studies included in the review.

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Detailed findings from the review will be available shortly.