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Review of the impact of loneliness and social isolation on health and well-being and whether people who experience loneliness/social isolation have higher use of public services

Executive Summary

1. Introduction

1.1 The National Assembly's Health, Social Care and Sport Committee recommended that the Welsh Government should either undertake or commission work to assess the impact of loneliness and isolation on health and well-being and whether people experiencing these issues make increased use of public services. The University of Sheffield and OB3 Research were commissioned by the Welsh Government to undertake research into this issue. The academic literature suggests that there is a strong link between social isolation, loneliness and health. For example, people who are socially isolated can have greater levels of mental health problems, cardiovascular issues and chronic illness. What we do not know is whether loneliness and social isolation are a causative factor for ill health, whether ill health is a causative factor for loneliness and social isolation, or whether there is a combination.

1.2 The terms loneliness and social isolation have been separated because they are different, although in the academic literature the terms are often used interchangeably. The area is highly complex because some people who experience loneliness can also be socially isolated whereas other people who are socially isolated do not always experience being lonely. Loneliness is how people feel about their social situation. It is not about how many people they have in their social network, instead it is about the quality of those relationships. What the literature tells us is that anyone can experience social isolation and loneliness at some stage in their life.

2. Methods

2.1 A range of methods were used to generate evidence. From December 2018 to January 2019, a scoping search of the academic and grey literature was carried out. The initial searching returned 2,777 articles and after detailed inclusion/exclusion criteria were applied a total of 40 studies were left for inclusion in the scoping review. A statistical procedure called a meta-analysis was used to combine data from multiple studies which emerged from the scoping review to increase the robustness of the findings. Nine of the 40 articles (one article contained three different studies and the statistics could be used from all three separate studies) contained usable data to provide statistical evidence. A consultation exercise was included as part of the scoping review with 10 key

organisations representing a range of groups in Wales; the groups included for interview were guided by both the existing literature and the Welsh Government. The consultation was carried out using telephone interviews, which took place from January to February 2019.

3. Findings

3.1 The scoping review suggested that although there was a link between experiences of poorer health and increased or decreased use of public services, it was highly complex and not merely a cause and effect relationship. The statistical analysis concluded that there was a small but significant association between loneliness and increased visits to a doctor. It also suggested that there were other factors present, for example existing health conditions which may have increased visits to the doctor.

3.2 The academic literature and the consultation interviews suggested that loneliness may begin in childhood and can result from social inequalities which can contribute to being socially isolated, bullied or victimized at school and not having a supportive friendship network. Counselling and pastoral care in schools was viewed as useful but the level of service was inadequate for young people who were a diverse group. Younger lesbian, gay, bisexual, transgender queer, queer and "plus" (LGBTQ+) people report more mental health issues than their non LGBTQ+ peers. This was often due to issues at school such as bullying, not being appropriately addressed and young people not being able to talk about their issues openly with others.

3.3 Feelings of social isolation and loneliness are compounded when people are stigmatised or experience discrimination, for example both the academic research and consultation interviews suggest that LGBTQ+ groups are less likely to access services because they feel professionals such as social workers, carers, GPs, hospital and medical staff display a lack of understanding about the complexity of their lives. They also feel that they are being judged about their sexuality. This adds to loneliness, especially around key stages in their lives such as bereavement. Issues relating to loneliness and social isolation tend to be more prominent amongst older LGBTQ+ people because they have grown up in a time period where homosexuality was a crime. They are therefore less likely to disclose their sexuality. Transgender people were a group that highlighted particular issues with services around discrimination.

3.4 Single parents experienced loneliness and social isolation. They were socially isolated because of lack of access to transport, a lack of confidence to make new social links and they experienced higher levels of poverty. The academic literature suggested that single and new parents had a higher incidence of accessing their GP for support and referrals to mental health services as a result of post-natal depression, sleepless nights, stress, mental frustration and distress. The consultation interviews revealed that parents who were known to social services were less likely to access services because of stigma, but also because they felt services were not appropriate to meet their complex social needs and instead tended to medicalise them and focus on treatment.

3.5 Refugees and asylum seekers appeared to experience higher levels of loneliness compared to the general population in Wales. This was a result of having come from a country/community where they previously had good access to strong family, friend and professional networks. They also had a level of distrust about services usually gained from their interactions with officials, both in their country of origin and throughout the resettlement process. Having poor English language skills prevented integration into the community and access to public services. It was questionable whether the health service understood their particular issues and perspectives. Organisations supporting refugees and asylum seekers suggested that they were not being considered seriously when requesting support and often only accessed services when in crisis.

3.6 The academic literature indicates that disabled people struggle with budget cuts and reductions in service provision. The consultation interviews supported this position. Changes to how services were delivered, for example more telephone services increased issues for people with hearing impairments because they acted as a barrier to access. Services also failed to be joined up with

duplications or omissions occurring as a result of a lack of communication and collaboration. There was also unnecessary duplication of some services or a complete absence leading to a lack of joined up care.

3.7 Poverty is cited in the academic literature as having the greatest impact, this was supported by the consultation interviews revealing that it reduced people's ability to travel around, interact with others and increase their social network. The consultation interviews revealed that refugees and asylum seekers were particularly affected. Carers whose lives had transitioned into a caring role often failed to recognise their changed status, making them unaware of benefits and grants to which they may be entitled. People who would previously have received help were no longer being supported, and this increased demands on informal carers. In turn, this increased the risk of loneliness and social isolation and exerted an effect on physical and mental health. Issues such as spending cuts on public services; lack of public transport and particularly on-demand/responsive transport, for example, voluntary transport schemes, meant older people were prevented from accessing wider services to increase social interaction. The closure of day centres where other activities were also held means that there were fewer affordable places to hold meetings and activities and older people experienced more social isolation and loneliness as a result.

3.8 Housing was cited as an area of need for older people in the academic literature, but the consultation interviews revealed that it was also an area of need for care leavers, disabled people, refugees and asylum seekers. Inadequate housing has been cited in the academic literature as an area that can increase mental health problems. Organisations reported that there was a limited amount of appropriate, affordable and accessible housing. For example, disabled people could feel trapped in their own homes because they were not adapted to meet their needs. This left them feeling isolated. Appropriate sheltered accommodation for disabled women who experienced domestic abuse was often unavailable and this left people even more isolated and vulnerable. Care leavers were frequently housed in accommodation that was sub-standard and in another geographical area with which they were unfamiliar. This meant they lost their social support network, increasing their feelings of loneliness and social isolation. Refugees and asylum seekers were often housed in areas with which they were unfamiliar and their English language skills were often inadequate to help them integrate.

3.9 Throughout the scoping review of academic literature, the meta-analysis and from the consultation interviews, loneliness and social isolation does play a part in increased use of services. The academic literature and the consultation interviews suggest that the area is highly complex and loneliness and social isolation alone do not create the conditions for increased service use. Rather it is the way society and services are structured to take into account the multiple and competing needs of a diverse population.

4. Recommendations

4.1 There are 16 recommendations for the Welsh Government to consider for policy. These are not presented in any order of importance. Recommendations 1, 7, 14 and 15 come directly from the academic evidence. Recommendations 2, 4, 5, 6, 8 and 9 come from the interviews and recommendations and 3, 10, 11, 12, 13 and 16 are combined from the interviews and academic evidence.

4.2 **Recommendation 1:** Fund more research into loneliness and social isolation, in particular measuring loneliness routinely in at risk groups attending primary care services, as recommended by the academic evidence.

4.3 **Recommendation 2:** Carry out a survey to provide evidence around the level of use of the short break directory developed by Swansea University and Bridgend Local Authority to ascertain whether it would be worthwhile extending the service across Wales.

4.4 **Recommendation 3:** Voluntary and public sectors should recruit more key or peer support workers for different groups of people into the voluntary and public sector. For example, care leavers, families, refugees and asylum seekers, and LGBTQ+ people who may need support with accessing services. These can be a mixture of voluntary and employed personnel who have insight into the particular issues for specific groups.

4.5 **Recommendation 4:** Practitioners in Wales need to remain informed about clinical governance and good practice relating to discrimination through workshops on diversity awareness within services and exploration of confirmation bias (which favours pre-existing beliefs about people). This should take place involving groups of people such as refugees, asylum seekers, LGBTQ+ people and disabled people.

4.6 **Recommendation 5:** Schools and colleges should implement teaching for all young people around the concept of positive and healthy friendships as an integral part of the curriculum. The aim is to increase peer-to-peer interaction, gain an insight into the impact of issues such as bullying and victimisation for different groups and the reasons why this occurs.

4.7 **Recommendation 6:** Within the Welsh Government, the Department of Health and Social Services and Department of Education and Skills should collaborate to develop a pathway of access for formal counselling, psychology and mental health assessment services, embedding mental health provision to create more joined up delivery of services and identify issues earlier before they reach crisis point.

4.8 **Recommendation 7:** Fund new research to work with marginalised groups and explore ways of making housing and sheltered accommodation more affordable, accessible and appropriate for people most in need. For example, care leavers; asylum seekers and refugees; disabled people and particularly disabled women experiencing domestic abuse.

4.9 **Recommendation 8:** Fund research to survey existing transport provision with a view to providing accessible and affordable or free transport for some groups. Accessible transport means people not having a long walk to the bus stop if they have physical impairments and making sure transport feels safe.

4.10 **Recommendation 9:** Encourage data sharing through Information and Communications Technology [ICT] and explore other ways of making services more joined up using technology to reduce the level of duplication and ensure that services collaborate with one another. This may also help with making assessment more individually tailored. Develop ICT related solutions for carers to adopt to enable them to carry out their daily lives.

4.11 **Recommendation 10:** Analyse existing service provision for different groups across Wales to ascertain if there is unequal access across regions and redirect resources to reduce the incidence.

4.12 **Recommendation 11:** Carry out a mapping exercise and evaluate the ways local authorities in Wales identify, assess and support carers. This may highlight good practice, indicate further gaps and create a smoother pathway for transitions and support.

4.13 **Recommendation 12:** Welsh Government should work with the British Medical Association, British Dental Association and British Nursing Association to encourage them to provide more teaching on the undergraduate curriculum on particular issues such as LGBTQ+ people and other minority groups in relation to health.

4.14 **Recommendation 13:** Funders and commissioners should build on existing research being undertaken in Wales at Swansea University to develop guidelines for services, in collaboration with transgender people.

4.15 **Recommendation 14:** Funders and commissioners should support work to close the gaps in evidence around loneliness throughout the life course. Funders should support research that uses respected and rigorous measures of loneliness. In the absence of big data sets it would make sense to focus on those groups which seem likely to be at particular risk of becoming lonely.

4.16 **Recommendation 15:** Welsh Government should provide more clarity around the different services available to older carers/people. This should include which services they can access free through the NHS versus means tested support through social services. Additionally, Welsh Government should investigate whether older people's assessments are making appropriate assumptions about older peoples care needs.

4.17 **Recommendation 16:** Welsh Government should increase support for advocacy services with external organisations that enable people to access benefits and other areas of help and support. Ensure that health services have information to signpost people. This would appear to be a non-threatening way of promoting inclusion, supporting people and alleviating poverty for some groups.

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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