# ADDRESSING SOCIAL ISOLATION AND LONELINESS TO IMPROVE THE HEALTH OF OLDER ADULTS.

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## SOCIAL ISOLATION AND LONELINESS AS SOCIAL MEDIATORS FOR HEALTH

Social isolation and loneliness in older adults are emerging serious public health concerns and are significantly associated with a number of adverse health impacts. Older adults are more likely to face changes in living conditions and income, experience the loss of spouse or other close relationships, as well as suffer from chronic illnesses and sensory impairments. Therefore, they are at higher risk for social isolation and loneliness (1).

Although both are common indicators of low social connection, social isolation and loneliness are distinct concepts (2). A person might feel lonely despite not being socially isolated or can be isolated but not suffer from loneliness. Social isolation refers to the objective lack of social contact and/or support (1,2). On the other hand, loneliness refers to the feeling of being alone or isolated, a sentiment that occurs when a person experiences deprivation in his or her actual social relations compared to what is desired (2,3).

Growing number of research have showed substantial evidences that social isolation and loneliness are associated with increased incidence of psychological, cognitive, and physical morbidities as well as increased risk of premature mortality (1). In fact, the increased risk on all-cause mortality by social isolation was found to be potentially comparable to that of smoking, obesity, and physical inactivity (4). Meanwhile, among patients with heart failure, loneliness is associated with almost four times increased risk of death, 68 percent increased risk of hospital admissions, and 57 percent more frequent visits to emergency department (5). Furthermore, both social isolation and loneliness have been linked with quicker loss of cognitive function in older adults, increased risk of dementia and also negatively affect older adults' perception on quality of life (1). Loneliness also has been associated with significantly greater prevalence of clinical depression, anxiety, and suicidal ideation (6).

The mechanisms of social isolation and loneliness influence on health are complex. They may be biological or behavioural and the plausible mechanisms are proposed in Figure 1 (7).

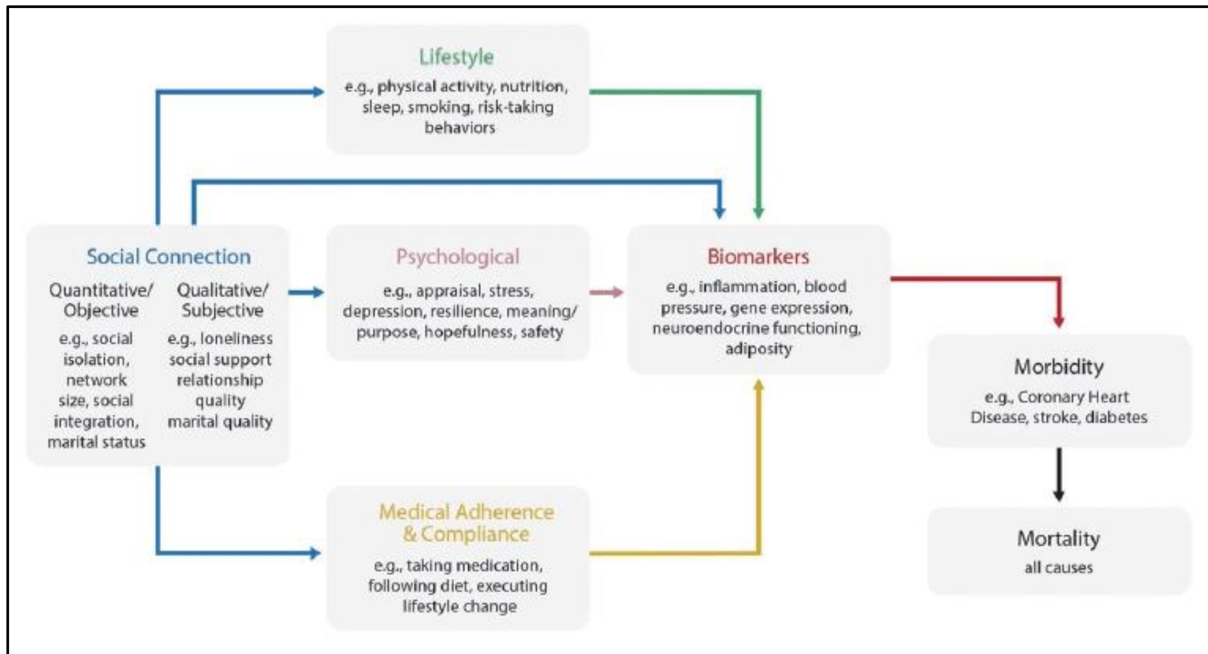


**FIGURE 1** Possible mechanisms by which social connections influence disease morbidity and mortality.

It is important to note that the relationships between social isolation or loneliness and their risk factors are likely bidirectional, whereby not only do social isolation and loneliness act as mediators for health and well-being, but health conditions themselves can lead to social isolation or loneliness (1,3). For example, presence of multiple chronic conditions has been linked with more limited social activities engagement (1). Other than that, factors that contribute to social isolation and loneliness at the individual level are also potentially influenced by the factors at the community and society levels (1). At the community level, factors that influence social isolation and loneliness include transportation network, internet coverage, occurrence of natural disasters and gentrification of neighbourhoods. Factors that influence social isolation and loneliness at the society level may include shift in family structure such as fewer intergenerational living and higher number of divorce and childlessness, non-inclusive technology adaptation in services, and local laws and policies that may exacerbate social isolation and loneliness in older adults.

## CURRENT SITUATION

Starting at the turn of the 21st century, despite numerous indicators for social relationships being studied in research and recognized as potential mediators for health, large-scale efforts and initiatives to address social isolation and loneliness and their health implications are fairly recent. For example, the United Kingdom appointed a Minister of Loneliness in 2018 to develop policies for both measuring and reducing loneliness (1,2). Other initiative includes the formation of Global Network for Age-friendly Cities and Communities by the World Health Organization (WHO) to promote the inclusion of older adults into society (2).

Malaysia has reached the status of aging society in 2020. From then on, it is projected that it will take only 24 years for Malaysia to transition into aged society, and further 12 years to become super-aged, with the number of people aged 65 and older reaching 14 percent and 20 percent respectively (8). This data follows the trend for countries with high-income economies. Consequently, the longer life spans are expected to lead to accumulation of disabilities prevalence. Between 2020 and 2040, it is expected that the number of people experiencing functional limitations in activities of daily living in Malaysia to double (8).

Meanwhile, tri-generational households are decreasing from 41.1 percent in 2004 to 30.7 percent in 2016 (8). This potentially weakens the traditional role of familial provision for care of older adults. Therefore, there is a substantially growing number of Malaysians who are at risk of social isolation and loneliness. Using data obtained from a survey conducted between 2007 and 2009, a study conducted by Ibrahim et al. in 2013 found that 49.8% of older Malaysians are at risk for social isolation (9). There is increasingly serious need for better elderly and older adults' care, especially in light of the still limited public and private aged care services and initiatives in the country.

## Recommended Actions to Mitigate Social Isolation and Loneliness

The general consensus is that interventions that are most effective in reducing risk for social isolation and loneliness among older adults are participatory and supported by theoretical foundation (10).

### Identification of At-Risk Older Adults in Healthcare Facilities

At some point of time, almost all adults aged 50 and above interact with the health care system (1). Therefore, health care providers are at an advantageous position to identify older adults experiencing or at risk for social isolation and loneliness. Periodic use of validated tools (such as Berkman-Syme Social Network Index the three-item UCLA Loneliness Scale) can be used in clinical settings to assess social isolation and loneliness, and should be included into patient's medical record (1,2). This is especially beneficial for individuals lacking social connections with their wider community, such as those who do not engage in any social or religious groups, or without permanent residence. For older adults identified to be socially isolated or lonely, active effort should be made to appropriately determine and address the underlying causes, either by managing the health conditions (i.e., hearing loss, mobility limitations, depression) or providing advice and resources and actively connecting these individuals with various existing community-based organizations that provide social services and activities that can help reduce isolation and loneliness (1).

### Training, Public Awareness and Education

Health and elderly-oriented organizations as well as relevant government agencies should create large-scale public awareness and education campaigns in order to highlight the risk of social isolation and loneliness and how to mitigate them. It is necessary to educate and train all members of the healthcare

workforce, direct care workers, community health workers, volunteers, community leaders, family caregivers, and members of community, such as people living nearby to isolated elderly, police officers and mail carriers, who provide frequent services to or occasionally interact with older adults, in order to strengthen the sense of neighbourhood and relationships to encourage inclusivity and to identify individuals that require intervention (1).

### Collaborative and Community Development Approach to Interventions

Strong collaboration between healthcare and voluntary, governmental, religious and other community-based organizations will ensure that identified at-risk older adults receive the appropriate interventions needed to prevent social isolation and loneliness (1). Examples of these interventions are befriending services, group activity programs and home visits. Furthermore, regular interventions that have health care provider involved in their implementation and delivery were found to be more likely to have a positive association with either health or social isolation outcomes than interventions that did not (2). Other than that, activities organised by these community-based organizations should involve the socially isolated or lonely older adults in their design and execution (10). The interventions also should be able to preserve the older adults' autonomy by allowing them to choose which activities to be undertaken, as studies found that this seemed to be more effective (10).

### Self-Empowerment of Older Adults

Empowering older adults at-risk of being or are socially isolated and lonely can be achieved through behavioural changes and increasing capacity for self-reliance. Cognitive behavioural therapy (CBT) and developing older adults' confidence in using technology are potentially helpful in this regard (1,2). By challenging automatic and negative thought patterns, CBT may be useful in helping lonely individuals reframe the way they think about their relationships, their assumptions about others' views, or their expectations of success at overcoming loneliness (11). Educating older adults on the use of video conferencing software such as Skype or other commercially available software allows socially isolated and lonely individuals to experience some semblance of "normal" socialising and visits (1). Older adults' confidence in using technology also potentially promotes inclusivity and contribute in bridging generational gaps.

### Funding, Planning and Public Policy

Given the public health impact of social isolation and loneliness, the government should establish and fund a dedicated working group to centralize resources, training, and best practices on social isolation and loneliness (1). Major funders of health research, should fund research on effective interventions in to identify, prevent, and mitigate the effects of social isolation and loneliness in older adults (1). Public policy that prioritizes prevention of social isolation and loneliness must be implemented and should also include a systemic and actionable aged care strategy (i.e., through market-oriented incentives for aged care), financial security strategy, as well as neighbourhood and city planning for housing design

and community spaces that would facilitate bringing people together and prevent isolation (1,8). Other than that, measures of social isolation and loneliness should also be included in major large-scale national health strategies and surveys (1).

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