Caption: **Men's health**

Title: **Social isolation and loneliness: a hidden killer**

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This paper was written before the COVID-19 pandemic saw the country shut down and everyone was thrust into isolation through the lockdown and requirements for social distancing. For some with pre-existing health conditions, the government introduced a 'shielding' policy where they were confined to their house, without an opportunity to go out and exercise. This extreme form of social exclusion will have magnified all the concerns we raise in our paper. Although many of the vulnerable population that we discuss that have previously been supported by third sector intervention have continued to have phone and internet interaction – it is not the same as face-to-face and group activity. As this is written the lockdown is just beginning to be relaxed, we are now waiting to see what the longer term implications will be.

Introduction

There has been increasing concern over the impact of social isolation and loneliness in primary care settings. Isolation refers to a lack of social contact or support, whereas loneliness is specifically the feeling (rather than just the physicality) of being alone and isolated (for example, it being possible to feel lonely in a room full of people).[1]

It is estimated that over a million people visit their GP as a result of loneliness, with GPs seeing between one and five lonely patients a day.[2] These numbers are also set to rise over the coming decade, with an increase in the older age population where many find that they have lost contact with old friends and colleagues and are living a more isolated life.[3] However, this is not just an issue for the elderly, and an increasing number of younger men are now becoming both socially isolated and at risk of loneliness .[4]

Health implications of isolation and loneliness

The physical state of social isolation and the perception of loneliness (objective versus subjective) are independent risk factors for poor health and an increased risk of premature death.[5] Social isolation itself increases the risk of all-cause mortality by 29%, while loneliness increases it by 26%, and living alone by 32%.[6] For those under the age of 65 years, the risk to health associated with any of these three is even greater.

For patients with existing medical conditions, there is also a higher likelihood of becoming socially isolated and lonely, which itself can impact on their health and wellbeing. Both patients with heart failure[7] and prostate cancer[8] have been found to have higher mortality and healthcare usage when socially isolated and lonely, due to embarrassment or difficulties encountered. A strong link has also been made with adverse mental health conditions and increased social isolation,[9,10] with a seemingly greater impact in men[11] and an increased risk of suicide.[12] Decreased physical activity (PA) and increased sedentary behaviour have also been associated with social isolation,[13] with high social isolation increasing the risk of becoming physically frail in men.[14]

The UK Biobank Cohort study of 466 901 men and women[5] has found that the risk of all-cause mortality as a result of loneliness could be linked to socio-economic factors(44%) and increased depressive symptoms (66%); however, the link between social isolation and mortality is independent of other risk factors. One possible explanation for the increased morality risk has been put forward by Cacioppo *et al*,[15] who suggest that social isolation triggers a proinflammatory 'defensive regime' in gene expression that increases the risk of chronic illnesses such as cardiovascular, neurodegenerative, and neoplastic diseases at the same time as negatively impacting on the bodies responses to viral infections.

Causes of social isolation/loneliness

The English Longitudinal Study on Ageing (ELSA) identifies four domains of social detachment:

- Civic participation
- Leisure activities
- Cultural engagement
- Social networks

Each of these domains are negatively affected by older age, lower education, poverty, poorer health, and (more specifically for men) living in rural areas and losing access to a car.

Statistically, men are less likely to meet with social contacts (family, friends) than women as they age,[16] with men who are single or never married consistently found to be more detached from social activity than those with a partner. This was also shown in an earlier study, which suggested that men who have never married had the highest loneliness scores, and women who had never married having the lowest loneliness scores.[17]

In part, this disparity might be due to a greater tendency in women to develop stronger social networks over their lives, which increases their social capital in times of difficulty, while the social support for men is often tied up with their partner and family so that separation or widowhood reduces this network.[10,18] The quality of the relationships has also been found to be important rather than just the number of contacts made,[10] with women also appearing to be better at creating: 'new close ties (or, alternatively, strengthen peripheral ties and add them to their close social milieu)'. [19]

In Leeds, a study of social isolation within the city[20] also found that some people deliberately absented themselves from local communities due to fear of crime or antisocial behaviour or other personal reasons (see Box 1). In reference to the above points, the study did not assess to see if gender was also a factor.

Assessment tools

Social isolation

Identifying those at risk of social isolation is important. One pragmatic approach is offered on the UK Patient.info website,[21] which outlines some characteristics of social isolation as:

- Verbal outpouring;
- Prolonged holding of your hand or arm;
- Body language: defeated demeanour, tightly crossed arms and legs;

- Drab clothing.

It is also necessary to have a more objective assessment; however, as yet there is not a preferred tool for use within clinical practice. In part, this is due to the complexity of issues that might be at play and confusion as to what needs to be considered. For social isolation there are some possible tools, including the Duke Social Support Index (DSSI), which comes with 4, 6 and 10 item options.[22] Another scale that seems to have promise is provided by Health Measures and their online short form social isolation tool PROMIS Short Form v2.0 - Social Isolation 4a (see Figure 2).

Loneliness

The Campaign to End Loneliness Measurement Tool is still relatively new and not fully validated, but some basic example questions offer a useful approach:[23]

1. I am content with my friendships and relationships;

2. I have enough people that I feel comfortable asking for help at any time;

3. My relationships are as satisfying as I would want them to be.

The Office for National Statistics has also recently completed a study[24] into the most appropriate tool for measuring loneliness and concluded that their preference is for the combined use of the University of California, Los Angeles (UCLA) 3-item tool, and a direct question-based approach currently used on the Community Life Survey (see Box 2).

In Leeds a number of commissioners have adopted the single item UCLA measure in the hope that this will enable more data across different initiatives to be aggregated.[25] If more GPs could do this across practices (or even within a practice) it would give a better understanding of the effectiveness of interventions.

Action to combat loneliness and social exclusion

The importance of tackling social isolation and loneliness has been recognised nationally, with Baroness Diana Barran named as Minister for Loneliness in the UK and a commitment by the Department of Health and Social Care and NHS England that by 2023 all GPs in England will be able to refer vulnerable patients onto a community service, along with additional funding for social prescribing schemes through the Building Connections Fund.[26] The UK Government has also established two groups: The Tackling Loneliness Team (TLT) and a Loneliness Technical Advisory Group (TAG), which are now helping to develop a coordinated national approach to tackling social isolation and loneliness.

At the moment, Public Health England advocate group based social activities and volunteering as a way of decreasing working age (16–64yrs) loneliness.[27] NICE also recommends that practitioners provide advice and resources on one-to-one and group-based social activities, and tailored community-based physical activity programmes for the older at risk population.[28] The Royal College of General Practitioners have produced a set of guidelines to help tackle loneliness,[29] with an emphasis on asking 'what matters to you', not 'what's the matter with you'. For some patients there might be a need for a referral to a psychologist or for relationship guidance, but for the majority the solution lies within their communities.

As a key part of the NHS long term plan[30] it was anticipated that Primary Care Networks should bring local general practices together, which may help with this more community focused approach. In England, there will be around 1300 geographical networks that cover populations of

approximately 30 to 50 000 patients. They are intended to help practices with some of their workforce challenges, attain economies of scale and provide a wider range of services that are closer to their patients and the wider community.

Appealing to men

An increasing number of local authorities across the UK are actively working on introducing loneliness strategies.[31] However, it is an issue in that many of the available initiatives do not appeal to men, or men are more reluctant to attend. This reluctance is either a result of the marketing of services being more focused onto women, or that the services themselves do not reflect the interests or experiences of male patients.[32] The guidance given to local commissioners by the Social Care Institute for Excellence (SCIE) is that there should be a variety of different approaches with a willingness to 'micro-commission' smaller initiatives to test out new ideas and to meet local needs that operate alongside the mainstream approach.[33] However, this requires a greater awareness of the specific needs of men and what services are currently working well.

As can be seen, there is much that can be done to meet these new challenges. Local charities and voluntary groups are well placed to understand the needs of the local community and the wider determinants on their health. They can provide holistic support such as benefits advice, aids (such as hearing aids) and adaptations and transport, alongside direct social opportunities such as befriending or social groups.

In Leeds, the Time to Shine (TTS) initiative (see Figure 1), which is run by the Leeds Older People's Forum (OPF) and is focused onto reducing loneliness in the older population, found that lonely older men benefit from initiatives that:

- provide a supportive environment;
- offer activities with a practical outcome, which generate a sense of purpose amongst men;
- offer activities that enable men to share skills;
- promote activities in locations where men go, using appropriate language which makes men feel they have something to offer. [34]

One TTS project found that their publicity often didn't appeal to men, so they changed it based on feedback; for example, taking care to use positive language to advertise activities and avoid terms such as 'lonely' or 'social isolation' in promotional materials. The same group also spent weeks with only a few men in attendance until awareness raising and trust had built sufficiently to enable many more men to attend. It is common for men's groups to need a greater length of time to establish [35].

Summary

The importance of tackling social isolation and loneliness is being recognised locally and nationally in the UK. The more men can be enabled to engage in meaningful social networks and develop supportive relationships the better their mental and physical health and well-being. GPs are a key part of both the recognition of the problem in their patients and directing them onto relevant preventative and remedial services.

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Figures/tables

Figure 1. The Time to Shine initiative is run by the Leeds Older People's Forum, and helps to target initiatives aimed at addressing the specific needs of male patients

Box 1. A description of social isolation and its characteristics

'social isolation must be viewed as a multidimensional concept, highlighting the interplay between individual characteristics, circumstances, types of social isolation (*ie*. on the basis of social, leisure or community networks), and the extent to which these are influenced by local environments (*ie*. housing type, local activities, fear of crime, transport).'[20]

Figure 2. The social isolation tool 'PROMIS Short Form v2.0' from Health Measures[23]

Social Isolation –Short Form 4a

Please respond to each item by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
	I feel left out.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	I feel that people barely know me.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	I feel isolated from others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	I feel that people are around me but not with me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Box 2. The University of California, Los Angeles (UCLA) 3-item tool, and the Community Life Survey

<u>UCLA 3-iten tool</u>

The three-item version of the UCLA scale asks indirectly about loneliness using the following questions:

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Response categories: 'Hardly ever or never', 'Some of the time' or 'Often'.

Responses to each question can be scored to provide a single loneliness score.

<u>Direct measure</u>

A single-item measure currently used on the Community Life Survey, which asks people directly about their experience of loneliness:

Example question: 'How often do you feel lonely?'

Response categories: 'Often or always'; 'Some of the time'; 'Occasionally'; 'Hardly ever' or 'Never'.