Socialising is an essential need of all human beings; their interactions with others influence the decisions they make and the roles they play in society (Hurrelmann and Bauer, 2017). Occupation – or engagement, as Squires and Hastings (2002) called it – is another essential human need and often implies interaction with others. As people age, they are exposed to an increasing risk of reduced interactions and reduced engagement. Many factors contribute to this, including loss of physical and/or mental function, bereavement, and detachment from society (Thomas, 2015). Economic and social issues can result in, or compound, isolation. This article, the fifth in a six-part series on the assessment of older people, describes key aspects of the social domain of health assessment.

### Social isolation and ageing

On the day of the 2011 census, there were 1.25 million people residing in England and Wales who were aged 85 or over, compared with 1.01 million in 2001; among them, women outnumbered men by 2:1 (Office for National Statistics, 2013). Being in bad or very bad health was reported by 24% of men and 26% of women (ONS, 2013). Among those living in private households, 69% of women and 41% of men lived alone (ONS, 2013).

In a survey by Thomas (2015), loneliness was identified to be one of the key factors that affects wellbeing. The ONS (2013) found that older people were more likely to live alone; reported figures indicated that 59% of the over-85s and 38% of people in the 75-to-84-year age group lived alone. The same report suggested there was a correlation between poor health conditions and loneliness, which increases with age.

### Social isolation and health

Beach and Bamford (2015) acknowledged that, due to the stigma and shame attached to loneliness, the number of men who report feeling lonely may be lower than the number who actually feel lonely. The incidence of loneliness in older men may be much greater than reported and older men are more likely to be isolated than women (Beach and Bamford, 2014).
Clinical Practice

**Review**

**Negative effects of social isolation**

Toepoel (2013) found a link between ageing and a reduction in people’s social networks, resulting in social disengagement. Nicholson (2012) found that there was a link between social isolation and health decline in older people – especially those who live in the community – and explained that social isolation would “impact the health, wellbeing and quality of life of numerous older adults now and in the foreseeable future”.

Pohl et al (2018) identified a link between social isolation and increased risk of falls, which has also been noted by the National Institute for Health and Care Excellence (2013). Older people can become disengaged from their social support networks because of falls or the fear of falling, so interventions to reduce the impact of falls may not only improve physical functioning but may also maintain social engagement (Sherrington and Tiedemann, 2019). Older people’s risk of falls needs to be managed using a multifactorial approach (see part 3).

Shankar et al (2011) found there was a link between loneliness and low levels of physical activity, in addition to increased engagement in risk behaviours such as smoking.

**Social theories of ageing**

Ageing is often considered to be the result of biological processes leading to a gradual deterioration of physical and mental function. However, it should not be viewed through a single lens and other possible reasons for the ageing process need to be considered (Collins, 2014). Social theories focus on how changes in people’s roles, relationships and status affect them as they age.

In 1961, Cumming and Henry developed the disengagement theory, based on the idea that, when progressing towards older age, people gradually withdraw from their roles in society (Künemund and Kolland, 2007). People become disengaged because they are being removed from normative roles in society (Künemund and Kolland, 2007). The continuity theory, developed in 1971 by Robert Achley asserted that, as people age, their personality and behaviour traits remained the same.

Twigg and Martin (2015) discussed the idea that ageing is socially constructed, referring to Berger and Luckmann’s (1966) view that interaction and institutionalisation in society determine social position and standing. Social class will affect how a person ages: according to Moody and Sasser (2018), earlier-life events such as education, employment, relationships and financial security determine the success of the transition into older age.

“Older people can become disengaged from their social support networks because of falls or the fear of falling”

**Independence and isolation**

The focus of the National Health Service and Community Care Act 1990 (Bit.ly/CommunityCareAct1990) was to enable people to remain in their own home for as long as possible, but the reality is that older people who have been hospitalised are likely to be discharged to a care home (Gaughan et al, 2017). Landeiro et al (2016) suggested the reason for many delayed discharges after hospitalisation for hip fracture was isolation, as hip fracture patients waiting to be discharged to their own home stayed in hospital longer than those waiting to be discharged to a care home. However, there are other potential reasons why discharges are delayed, such as overcautious health professionals and a lack of resources and/or suitable accommodation in the community (Kar, 2015).

In recent years, an approach called reablement has been introduced to help older people live independently for longer, in the hope it can avoid hospital admissions and institutionalisation in long-term residential care. Reablement is an intensive, time-limited intervention provided in people’s homes or community settings; it is often multidisciplinary in nature and focuses on helping people regain skills around daily activities (Aspinal et al, 2016).

Reablement is likely to aid social and psychological recovery, allowing people to take control of their lives through engagement, however the implementation of reablement plans may encounter barriers such as:

- Anxiety and fear;
- No incentive to participate;
- Variation in understanding of the outcome (Ebrahim and Chapman, 2018).

Furthermore, while reablement may seem the right thing to do, it may have unintended consequences, for example leading to social isolation and a paradoxical increase in hospital admissions.

How can older people be supported to live independently while also maintaining social engagement? One possible answer is supportive community living, with which Sixsmith et al (2017) argued can have a positive impact on the health and wellbeing of older people. It needs to be underpinned by partnership working and the provision of affordable housing but its benefits include:

- Improved mental wellbeing;
- Reduced isolation;
- Reduced burden on informal carers.

**Social isolation versus loneliness**

When people live alone and have limited contact with others, they are said to be socially isolated. This is closely linked to, but not quite the same as, being lonely. Social isolation can be measured objectively through variables based on quantitative data. Loneliness, however, is subjective in nature, which means that research on it requires a qualitative approach (Shankar et al, 2011).

According to Pohl et al (2018), social isolation can be measured by counting the contacts a person has during a period of time and by using indicators such as networking and social participation. However, the researchers did not necessarily consider the quality of contacts and recognised this as a limitation.

For Beutel et al (2017), loneliness is an emotional, subjective state that depends on the individual’s experience of social relationships since their late adolescence. They investigated loneliness in a large representative sample of German adults aged between 35 and 74 years. One in 10 participants reported some degree of loneliness; in addition, loneliness was stronger in women, participants without a partner, and those living alone and without children.

**Assessing social isolation**

Shankar et al (2011) used a number of tools to measure the extent of loneliness and isolation, including the Social Isolation Index, which uses variables such as living alone, having restricted contact with family members and social engagement. The higher the score, the greater the risk of social isolation.
**Reducing social isolation**

Reducing social isolation is likely to have a positive impact on health and mortality. However, it could be more effective to target interventions at older people considered to be at greatest risk (for example, those recently bereaved, those with lower incomes and those with poorer health), rather than offering them indiscriminately (Kinsella, 2015). Routasalo et al (2009) stated that using psychosocial group rehabilitation to empower older people experiencing loneliness benefits not only their psychological wellbeing but also their physical outcomes.

Gardiner et al (2018) found that a number of interventions have been used successfully to increase older people’s social interactions (Box 1). However, they noted that it was difficult to identify whether the reduction in social isolation was a result of an intervention, or to what aspect of a multifactorial intervention it might be due. Patients need to participate in the assessment of interventions in which they are engaged so the health professional can establish what type of intervention is likely to meet their needs (Gardiner et al, 2018).

**Box 1. Interventions used to reduce isolation in older people**

- Social engagement interventions, for example ‘dementia friends’
- Psychological and/or physical therapies, for example, yoga, mindfulness classes
- Animal therapy
- Befriending interventions
- Leisure activities or educational intervention to encourage new skill development, for example, cake decorating or flower arranging


**Box 2. Reflection exercise: social domain assessment in hospital**

Ethel Anderson is a 72-year-old woman admitted to the acute ward via the accident and emergency department after an exacerbation of chronic obstructive pulmonary disease. She lives alone in her own home, where a carer from an agency visits her twice a day for 15 minutes to prompt her to take her medication. Her husband was her main carer until he died a year ago from a myocardial infarction. On arrival, Mrs Anderson explains to the nurse proceeding with her admission that she has been feeling low in mood lately. This information has been passed on to the team. You are one of the nurses on the team:

- What do you need to know to assess Mrs Anderson holistically?
- What are her likely care needs?
- Why else needs to be involved in her care?
- What would you include in a care plan designed to meet her social needs?

The patient’s name has been changed.

**Box 3. Reflection exercise: social domain assessment in the community**

Jim Carter is 91 years old and lives alone in his own home. Six months ago he fell and sustained a hip fracture, and was admitted to hospital for a hip replacement. Before that hospital stay, Mr Carter did his own shopping and met friends twice a week at the local bowling green. However, since his discharge, he has been unable to leave the house independently and relies on his friends for transport and company.

At a recent GP visit, Mr Carter explained that he feels increasingly lonely and low in mood. You are a practice nurse and have been asked to assess Mr Carter:

- What impact could social isolation have on Mr Carter?
- What information do you need from him to understand his social health needs?
- Who needs to be involved in his care for optimal support?
- What services are available locally to address his needs?

The patient’s name has been changed.

“To meet older people’s needs, it is important to consider signposting or referral to other agencies and services”

**Signposting and referrals**

To meet older people’s social needs, it is important to consider signposting or referral to other agencies and services, such as:

- Occupational therapy;
- Social services;
- Bereavement counsellors;
- Local charities;
- Mental health services.

**Input from occupational therapy services**

Input from occupational therapy services, using tools such as behaviour modification therapy, can increase an older person’s confidence and ability to self-care (Cara and MacRae, 2005). The occupational therapist can help by identifying the risks associated with withdrawal from society and act as a mediator and educator for the older person and their relatives (Barney and Perkinson, 2016).

Social services can help by assessing the person’s needs for, and entitlement to, services provided by local authorities or charities such as Age UK (White and Harris, 2001). Looking at interventions to reduce the impact of social isolation in vulnerable
Box 4. Questions to assess the social health of older people

- Do you have family and friends?
- How often do you get to see them?
- How often do you leave the house?
- Do you have the energy to engage in social relationships?
- Who normally does your shopping and cleaning?
- Do you ever feel lonely? If so, what triggers these feelings?
- Do you have hobbies? Do you currently actively engage in them?
- Are you a member of any organisations or interest groups?
- Are there people around you who would be able to help you feel less isolated?

Many local authorities and charities may offer free or low-cost activities such as exercise classes, coffee mornings, excursions and support groups.”

References


