
Social Isolation and Loneliness Among Older Adults in the UK: A Review

Received: 03 Jan 2026

Accepted: 25 June 2026

Published: 27 July 2026

Alfred Kojo Ntim¹, Benjamin Agyemang², Richard Nana Gyau Amoah³, Anthony Amoah⁴

Abstract

This study conducted a critical systematic review of the literature, focusing on the causes, effects, and intervention strategies for social isolation and loneliness among older adults in the UK. Through a systematic review process, 766 articles were initially identified and screened based on geographical focus, relevance, clarity and justification of the research design, quality of analysis and synthesis, and the robustness of the evidence. Of the 766 articles identified, 20 published between 2011 and 2021 met the inclusion criteria and were included in the final review. The findings revealed that loneliness and social isolation among older adults in the UK are driven by a range of interconnected factors, including life transitions and social bereavement, health-related problems, socioeconomic challenges, environmental and community factors, and demographic changes. The review also found that social isolation and loneliness are associated with adverse outcomes such as poor mental health, frailty, hypertension, cardiovascular diseases, and increased mortality. Identified intervention strategies include primary healthcare prevention, community-based support, social prescribing programmes, and individual-focused interventions. Overall, the findings suggest that implementing appropriate and evidence-based intervention strategies can substantially reduce the impact of social isolation and loneliness among older adults in the UK.

1 Assessment and Intervention West, Essex County Council, Essex, UK. Email: nakntim@yahoo.com

2 Faculty of Business and Law, University of Sunderland, London, UK. Email: benagye@yahoo.com

3 Frontier Mental Health Supervisor, Permia Care, Midland, Texas, USA. Email: nanaamoah@permiacare.org

4 School of Sustainable Development, University of Environment and Sustainable Development, Somanya, Ghana. Email: aamoah@uesd.edu.gh

Introduction

Human beings are a social species whose sustenance depends on cooperation and connectedness (Mughal, 2021). Evidence from the literature, dating back to Sheldon (1948) and Halmos (1952), Wenger (1996), and relatively more recently Komulainen et al. (2026), shows that social isolation and loneliness have generally been described as problems of old age. In the United Kingdom (UK), 11–17 percent of older adults (65 years and above) experience social isolation or loneliness (Victor et al., 2003). Victor and Bowling (2012) found that 9 percent of adults aged 65 and over experience severe loneliness, while 30 percent sometimes feel lonely. Further analysis from the same study indicates that 20–25 percent are persistently lonely, and 15 percent suffer from more severe, long-term loneliness. These findings are noteworthy, given the adverse impact loneliness and social isolation have on both mental and physical health.

Indeed, several factors contribute to older adults feeling lonely and socially isolated in the UK. Social isolation and loneliness have been consistently associated with adverse mental health outcomes, such as depression, anxiety, and cognitive decline (Cacioppo et al., 2014; Shankar et al., 2011; Khondoker et al., 2017). They are also linked to adverse effects on physical health, including an increased risk of heart disease, high blood pressure, and weakness (Valtorta et al., 2018; Gale et al., 2018; Kobayashi and Steptoe, 2018). Furthermore, evidence indicates an elevated risk of mortality among socially isolated individuals (Steptoe et al., 2013; Rafnsson et al., 2020). These findings underscore the substantial health burden associated with loneliness and social isolation (Bu et al., 2020; Hodgson et al., 2020). However, there is a paucity of empirical evidence that synthesises the causes, effects and intervention strategies, especially for older adults. As a contribution to the literature

This review, therefore, seeks to explore the causes, effects and intervention strategies of these phenomena as evidenced in the literature. Although these concepts are sometimes used interchangeably in the empirical literature (see Hakulinen et al., 2018), several studies have sought to distinguish between them. For instance, Malcolm et al. (2019, p. 2) define loneliness as “a perceived deficit between actual and desired quality or quantity of relationships,” while describing social isolation as “the objectively quantified shortfall in an individual’s social relationships, often measured in terms of social network size, diversity, or frequency of contacts.” Similarly, Steptoe et al. (2013, p. 1) describe social isolation as “an objective and quantifiable reflection of reduced social network size and paucity of social contact,” and loneliness as “the psychological embodiment of social isolation, reflecting the individual’s experienced dissatisfaction with the frequency and closeness of their social contacts, or the discrepancy between the relationships they have and the relationships they would like to have.” Courtin et al. (2017, p. 2) also define social isolation as “the lack of integration of individuals in their social environment,” and describe loneliness as “the subjective state of negative feelings associated with perceived social isolation, a lower level of contact than that desired, or the absence of a specific desired companion.” Taken together, these definitions reveal overlapping features between social isolation and loneliness, suggesting that the two terms can, to a large extent, be used interchangeably in the context of this study.

Other studies, however, have sought to define social isolation independently and with greater nuance. Cotterell et al. (2018, p. 3) describe it as “an objective measure reflecting an individual’s lack of contacts or ties with others, such as family, friends, acquaintances, and neighbours.” Findlay et al. (2003, p. 2) similarly define social isolation as “an objective measure of social

interaction, and social loneliness or emotional isolation, the subjective expression of dissatisfaction with a low number of social contacts.” Barry (2002, p. 4) characterises social isolation as the “phenomenon of non-participation (of an individual or group) in a society’s mainstream institutions,” while Luskin et al. (2013, p. 1) frame it as “a loss of place within one’s group(s).”

Loneliness has also been defined in various ways. Killeen (1998, p. 2) describes it as a “pervasive, depressing, debilitating condition that can affect all of one’s life.” Wright-St Clair et al. (2017, p. 1) take a broader view, defining loneliness as a “deficiency in the number or quality of personal, social, or community relationships, resulting in feelings of distress, dissatisfaction, or detachment.” Similarly, Bandari et al. (2019, p. 1) characterise loneliness as an “internal, unpleasant subjective experience that begins when an individual’s social network undergoes a qualitative or quantitative loss.”

These definitions suggest that, while the two terms are related and sometimes used interchangeably, they remain distinct in certain contexts and can be applied differently. In this review, therefore, instances where the terms are used independently will be treated as such, and where they are used interchangeably, they will be considered together. From the various definitions, loneliness can be understood as an unplanned, cognitive state that results from the quality and quantity of social contact. It is difficult to overcome and often has long-term effects. Social isolation, by contrast, may be deliberate or unplanned, is not cognitive in nature, and can lead to loneliness, though the reverse is not true. Unlike loneliness, social isolation can be measured quantitatively, though not qualitatively. Despite these differences, both are significant social issues that shape the life course of older adults. In both cases, the effects are severe, leading to negative

behaviours and associated consequences, particularly in relation to mental health, social relationships, and overall wellbeing.

In terms of contribution, this study advances the literature and highlights key insights that can inform policy direction. To achieve this, this review provides a comprehensive synthesis of evidence on the causes, effects, and interventions related to social isolation and loneliness among older adults in the UK. By systematically reviewing studies published between 2013 and 2022, this review highlights key contributing factors such as life transitions, health challenges, and socioeconomic conditions, alongside significant mental and physical health outcomes. Importantly, the review identifies effective intervention strategies, including community support and social prescribing, demonstrating that targeted approaches can reduce the burden of loneliness and social isolation.

Methods

The study analysed already published secondary information. It is a deductive study that seeks to understand, using published empirical data, how social isolation and loneliness affect older adults, with a focus on the UK. In this study, older adults are defined as those who are 40 years and above (Refer to Table 1).

This study obtained 321 articles from EBSCOhost, 424 from Google Scholar (GS)/PubMed (PM) and only 21 from the other sources (e.g., PsycINFO, CINAHL, etc.). This yielded a total of 766 academic articles obtained from the various search sources already identified. The outcome and search strategy are summarised in Figure 1.

Keywords

The search strategy combined keywords across four main concept blocks: Social isolation/loneliness, older adults, UK context and health-related outcomes or related factors. Details of the search have been presented in Table 3 in the Appendix.

Inclusion and Exclusion criteria

The inclusion criteria were: 1) studies reporting on social isolation or loneliness among older adults in England or the UK; and 2) studies that reported impacts, effects, or policy recommendations. Only English-language publications were included.

The exclusion criteria were: 1) studies that did not report all relevant data; 2) duplicate studies; and 3) conference papers, theses, and working papers without a corresponding peer-reviewed published version.

Selection Process

From the initial 766 records, 301 duplicate articles were identified and removed,

leaving 465 articles for screening. After screening the titles, 109 articles were excluded. A further 200 were excluded after reviewing the abstracts, leaving 156 articles for full-text assessment.

After evaluating the full text, 136 articles were excluded for the following reasons: 52 were unrelated to the subject, 50 were not focused on the UK, 20 were outdated (published over ten years ago), and 14 were non-English publications. Applying these criteria yielded a total of 20 articles that focus on the impact or effects of social isolation and loneliness among older adults in the UK, spanning the period 2011 to 2021.

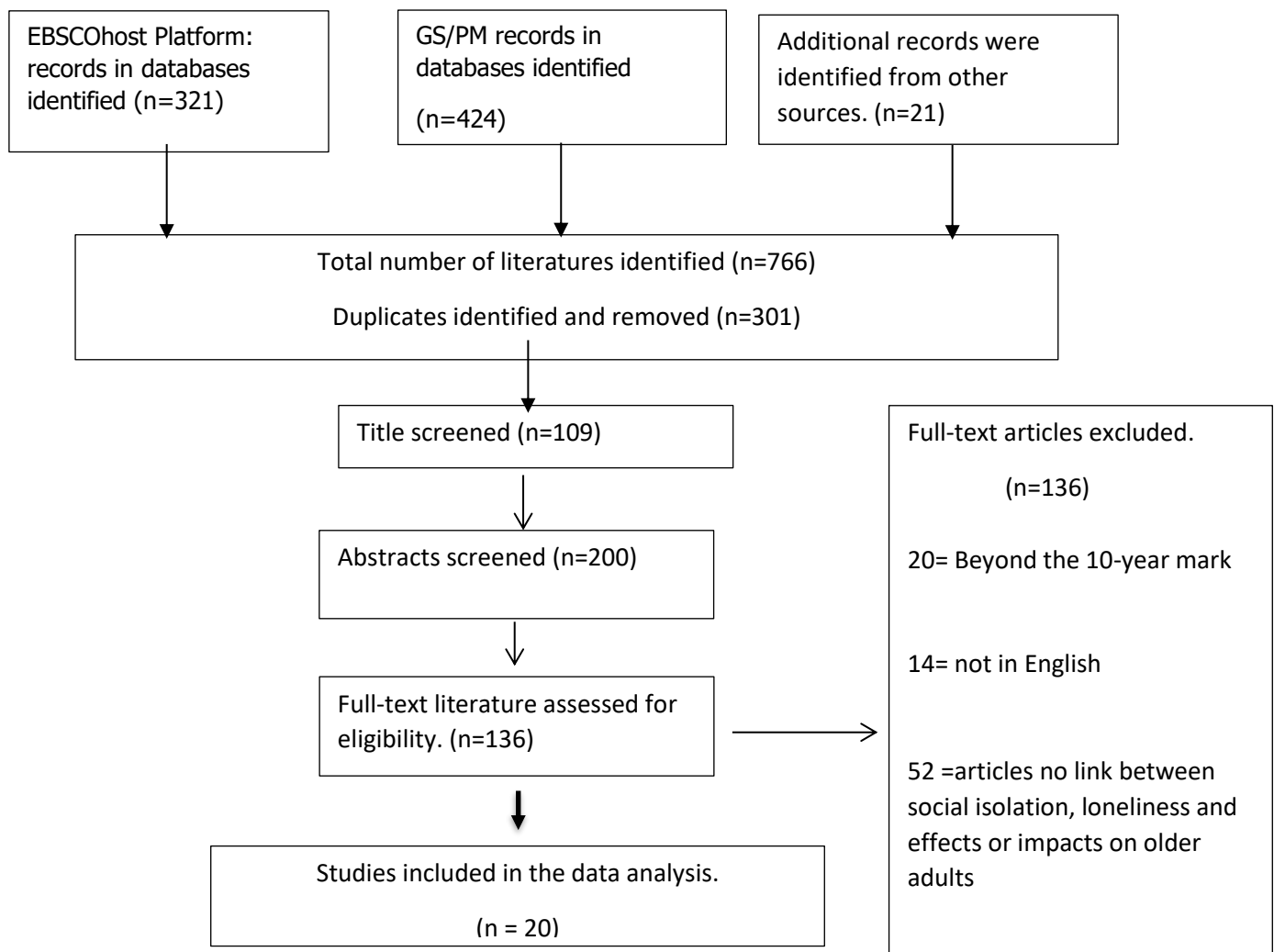


Figure 1: PRISMA diagram showing the sifting process.

Results

The inclusion and exclusion criteria provided the basis for the identification of

twenty-one peer-reviewed papers (Refer to Table 1).

Table 1: Review of Literature

Author (Year)	Methodology	Sample	Age	Findings & Conclusion
Hodgson et al. (2020)	Systematic Review	122 Articles	>=65	There is an association between loneliness, social isolation, and mortality.
Steptoe et al. (2013)	Longitudinal panel study	6500 participants	>=52	Both social isolation and loneliness were associated with increased mortality
Hakulinen et al. (2018)	Survey with a questionnaire	502 632 participants	40 and 69	Social isolation, but not loneliness, was associated with increased mortality
Davies et al. (2021)	Longitudinal study	9171 participants	>=50	Social isolation and loneliness lead to the risk of developing frailty
Gale et al. (2018)	Longitudinal study	2,817 participants	>=60	High social isolation increases the risk of becoming physically frail in men
Shankar et al. (2011)	Longitudinal study	8,688 participants	>=50	Social isolation and loneliness have effects of inactive, smoking, multiple health-risks behaviours and cardiovascular diseases. Social isolation has effects on blood pressure, C-reactive and fibrinogen.
Philip et al. (2020)	Longitudinal study	8,780 Participants	>=50	Loneliness, isolation and social disengagement have effects on lower physical performance (worse sit-to-stand ability, balance and slower walking speed)
Kobayashi et al. (2018)	Longitudinal study	3,392 participants	>=50	Both Social isolation and loneliness are associated health-related behaviours such as mortality.
Valtorta et al. (2018)	Longitudinal study	11,391 participants	>=50	Loneliness, but not social isolation is associated risks of cardiovascular diseases.
Smith et al. (2019)	Longitudinal study	9,299 participants	>=50	Both loneliness and social isolation are associated musculoskeletal pain.
Rafnsson et al. (2020)	Longitudinal study	6,677 participants	>=50	Both loneliness and social isolation are associated with developing dementia.
McHugh et al. (2016)	Longitudinal study	4,714 participants	>=50	Both loneliness and social isolation are associated depression and cognitive function. Social isolation alone is not.
Smith et al. (2017)	Longitudinal study	11,391 participants	>=50	Both loneliness and social isolation have negative physical and psychological on older adults who undergo THA and TKA
Cacioppo et al. (2014)	Longitudinal health survey	8,630 participants	>=50	Loneliness and social isolation are associated with poorer cognitive function.
Saadi et al, (2021)	Longitudinal study	4,672 participants	>=50	Loneliness is associated depression in dementia partner caregiving.
Evans et al, (2019)	Longitudinal study	1,449 participants	>=65	Social isolation is associated with poor cognitive function.
Khondoker et al, (2017)	Longitudinal study	10,055 participants	>=50	Negative social support (loneliness and social isolation) is associated with increased risks of dementia.
Bu et al, (2020)	Longitudinal study	4,478 participants	>=50	Both loneliness and social isolation are associated with respiratory diseases leading to mortality.
Smith et al, (2018)	Longitudinal study	7731 participants	>=50	Higher social isolation is a risk factor to mortality.
Bu et al. (2021)	Longitudinal study	8,218 participants	>=64	Loneliness has a strong association with cardiovascular diseases, whiles social isolation has little evidence of the same relationship.

From Table 1, we outline the emerging themes on the effects of social isolation and loneliness. The study defined recent studies as those within the 10-year mark. That is, all studies that fell beyond the 10-

year mark were treated as outdated and not included in the studies; emphasis is placed on the most recent studies. Through the review process, it was observed that social isolation and loneliness studies are

predominantly studied in developed countries. In most of the studies reviewed, it is evident that studies on the UK and the USA dominate in the most recent studies. Table 1 presents only studies on the UK or with the UK as the study area because this study aims to investigate the effect of social isolation and/or loneliness in the UK. That is, non-UK-related studies on social isolation or loneliness are also excluded. It is also important to acknowledge that there is no developing country study in the studies reviewed.

Again, most of the studies sought to define older adults based on the age brackets used. From Table 1, it can be shown that the minimum age used in the studies to describe older adults is 40 years, while the maximum age is 60 years. It can be inferred that the majority of the twenty studies reviewed in this study used 50 years or older as the average age for older adults.

On average, the majority of the studies in the UK, as reviewed, made use of the longitudinal dataset from the English Longitudinal Study of Ageing, with a few relying on self-administered surveys and systematic reviews. They predominantly focused on examining the relationship between either social isolation and/or loneliness and its effect. The outcomes, which are outlined as the themes, include mortality, frailty, blood pressure, cardiovascular diseases, dementia, and mental health. These themes, with their respective authors, are summarised in Table 2 below.

Analysis of Themes and Sub-themes

Table 2 shows evidence of the themes identified in the studies reviewed to be the effects of social isolation and/or loneliness in the UK. The themes are individually presented and discussed below.

Table 2: Themes and papers from the interpretive analysis

Themes and sub-Themes	Papers
Mortality	Hodgson et al. (2020); Steptoe et al. (2013); Smith et al. (2018); Kobayashi et al. (2018); Hakulinen et al. (2018)
Mental Health/ Dementia	Cacioppo et al. (2014); Smith et al. (2017); Rafnsson et al. (2020); McHugh et al. (2016); Saadi et al. (2021); Khondoker et al. (2017); Evans et al. (2019)
Frailty	Davies et al. (2021); Gale et al. (2018); Shankar et al. (2017) Smith et al. (2017).
High Blood Pressure	Shankar et al. (2011)
Heart Problems	Valtorta et al. (2018); Bu et al. (2020), Bu et al. (2021)

Causes of Loneliness and Social Isolation

Loneliness and social isolation in the UK are commonly driven by changes in social relationships and life circumstances. Bereavement, living alone, and reduced family contact are consistently identified as major contributors, especially among older adults. For example, Shankar et al. (2011) and Steptoe et al. (2013) highlight how weakened social networks and infrequent social contact significantly increase the risk of loneliness. Similarly, Bu et al. (2020, 2021) show that people who live alone or lack regular interaction with friends and

family are more vulnerable to persistent loneliness over time.

Health-related factors are another important cause. Chronic illness, disability, and declining physical functioning can limit individuals' ability to participate in social activities. Gale et al. (2018) and Rafnsson et al. (2020) found that poor physical health and frailty are strongly associated with both social isolation and loneliness. In addition, mental health conditions such as depression can both result from and contribute to loneliness, creating a reinforcing cycle

(Cacioppo et al., 2014; Khondoker et al., 2017). Sensory impairments and reduced mobility further restrict opportunities for engagement, particularly in older populations.

Socioeconomic disadvantage also plays a key role in the UK context. Lower income, limited education, and living in deprived areas are linked to higher levels of loneliness. Studies such as Davies et al. (2021) and Evans et al. (2019) suggest that financial constraints can reduce access to transport, community activities, and social spaces. Digital exclusion is another emerging factor, with Philip et al. (2020) noting that those without access to or skills in using digital technologies may become increasingly isolated as services and communication shift online.

Changes in society and demographics have made loneliness even worse. More people moving around, smaller families, and weaker ties between communities make it harder to have regular social interactions. Valtorta et al. (2018) and Kobayashi et al. (2018) underscore that structural and environmental determinants, including neighbourhood attributes and social capital, affect degrees of isolation. Transitional periods, including retirement or relocation, can also disrupt established social connections (Hodgson et al., 2020; Smith et al., 2017, 2018, 2019).

Effects of Loneliness and Social Isolation Mortality

Generally, mortality simply means the condition of being subject to death or the lifeless state of a person. In the view of Cutler et al. (2006), mortality is the state of not being alive to enjoy the pleasures of life. That is, where the pleasures of life are worth nothing to a person. Just as individuals live life to prevent premature mortality, so do governments enact laws and formulate policies towards promoting good health and

longevity. This concern for mortality has led to several research studies (For example, Pentaris, 2011; Pentaris, 2012; Pentaris and Mehmet, 2019; Pentaris and Jacobs) on mortality. Historically, there is evidence that the mortality rate globally has taken a nosedive, albeit the case of developing countries still leaves much to be desired (Cutler et al., 2006).

From the evidence provided by the studies, which include Komulainen et al. (2026), Hodgson et al. (2020), Steptoe et al. (2013), Smith et al. (2018), Kobayashi et al. (2018), and Hakulinen et al. (2018), there is empirical evidence to support the claim that mortality is the final negative outcome of social isolation and loneliness. The underlying cause of the mortality, as outlined by the studies (see especially Steptoe et al., 2013), has its baseline in mental and physical health challenges. For the gender differences in the outcome variable as caused by social isolation and loneliness, most of the studies found no such evidence. That is, there is no study that reported significant gender differences in these findings. This implies that, be it male or female, mortality is a key outcome of social isolation and loneliness. The evidence so far attests to the fact that mortality is associated with social isolation and loneliness.

Mental Health/ Dementia

The concept of mental health has been described by Boorse (1976) as a complex web of obscurity. Evidence in the literature so far suggests that progress has been made in dealing with mental health issues as well as providing relief for mental health patients (Keyes and Lopez, 2009). Although developed countries have made significant strides in the provision of improved services to mental health patients. That notwithstanding, it goes without saying that mental disorders increase the risk for communicable and non-communicable diseases and contribute to unintentional and intentional injury (Prince et al., 2007). In an

attempt to identify mental health and associated risks, we examine how social isolation and loneliness drive mental health. In line with the present study, one of the reported themes is mental health challenges, poor cognitive function or dementia (see Cacioppo et al., 2014; Rafnsson et al., 2020; McHugh et al., 2016). Another consequence of mental health is the sedative medication that puts patients to bed over a long period of time. This could be described as one of the penultimate health stages participants go through, and if their conditions persist, mortality becomes evident.

Frailty

According to Clegg et al. (2013, p.1), “frailty is a state of increased vulnerability to poor resolution of homeostasis after a stressor event, which increases the risk of adverse outcomes, including falls, delirium, and disability” Frailty has been described as the most problematic condition associated with old age (Clegg et al., 2013). Older adults who fail to mingle and engage in social activities can easily be susceptible to frailty. Thus, confinement as a result of loneliness and social isolation weakens patients physically (frailty) (Example, Davies et al. (2021); Gale et al. (2018); Shankar et al., 2017). If such a frail condition persists without proper care, mortality becomes inevitable.

High Blood Pressure and Heart Problems

Again, social isolation and loneliness lead to inactivity. This can easily contribute to physiological decline and high blood pressure. The associated weight build-up,

lack of exercise, leads to high blood pressure (Shankar et al., 2011). High blood pressure, without its consequences, such as stroke and heart problems (Valtorta et al., 2018), and dementia (Rafnsson et al., 2020), among others. Given that cardiovascular disease is now the world’s top cause of death, accounting for one-third of deaths in the world (Mackay and Mensah, 2004), carers and families must become mindful of the devastating nature of high blood pressure and heart diseases as a result of loneliness and social isolation. Indeed, if this problem persists without the right care, mortality cannot be escaped.

In all, these studies have shown that, generally, social isolation and loneliness are associated with some negative effects. These include mental health challenges, physical health (frailty) challenges, high blood pressure and heart problems, mortality and comorbidities. So far, the studies show no empirical evidence on gender disparity regarding mortality. This seeks to suggest that the effect of social isolation and loneliness on mortality is not gender sensitive, as it affects both males and females alike. Thus, gender disparity is irrelevant when mortality is caused by social isolation and/or loneliness.

So far, it is evident that loneliness and social isolation have psychological, physiological, social and behavioural effects, which can result in diseases and finally death. In the next section, we show the conceptual framework of these four effects, which can lead to disease and mortality.

Conceptual Framework

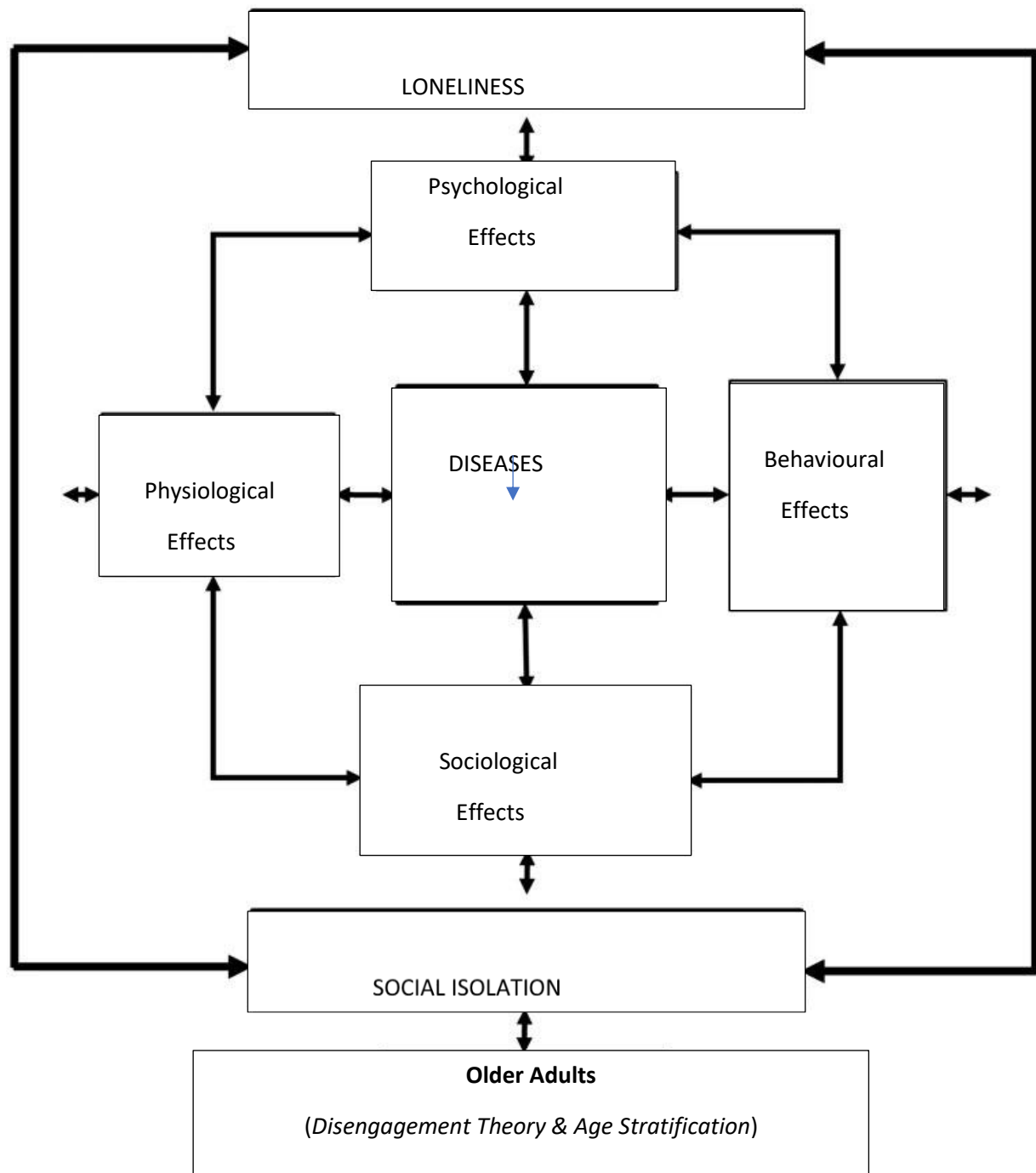


Figure 2: Conceptual Framework¹

Figure 2 presents the conceptual framework of this study. This is best understood from the starting point of older adults depicted as an outer box of the model. Not perceiving

older adults as a homogeneous group, they are likely to experience social isolation and loneliness. Evidently, older people in the UK experience reduced care-related

¹ Source: Adapted from Hodgson et al. (2020).

support, deprived community engagement needs, loss of social contact, negatively impacting their emotions, which were heightened during the COVID-19 pandemic (Ward et al., 2020). Themes such as loneliness and social isolation were further exacerbated by inequalities associated with digital exclusion or older adults living in areas with poor connectivity, or the non-existence of communication networks (Pentaris et al., 2020). Research undertaken by Age UK (2018) shares a similar view that persistent loneliness and social isolation can have a significant negative impact on well-being and quality of life.

It is important to observe that social isolation and loneliness are more pronounced among older adults in the UK and most developed countries. Following the theory (disengagement and age stratification), this interdependence is represented with bi-directional arrows. The broader impact of loneliness and social isolation can also be attributed to further pathways captured inside the model and grouped into four simple concepts of physiological, psychological, behavioural and sociological effects. The psychological impact of loneliness and social isolation can lead to cognitive decline, depression and suicidal ideation. Similarly, the behavioural impact of loneliness and social isolation can lead to alcoholism, smoking, etc. Also, the physiological impact of loneliness and social isolation can lead to excessive sleeping and inflammation. Lastly, the individual sociological impact of loneliness and social isolation can lead to poor health management by health professionals, limited access to frequent health services, among others. Indeed, the rising sedentary lifestyle coupled with poor health care can easily trigger cardiovascular disease, with mortality as the outcome.

Generally, no single individual's impact may follow the same pathway but rather varies according to the importance and the value of connectivity. The power a

community attaches to the individual is vital in reducing the negative impact of social isolation and loneliness. For example, as people age, they, on average, experience reduced connectivity due to loss, disengagement, or how society is stratified. The individual then moves on to the outer pathway of the conceptual framework to experience social isolation and loneliness. These conditions will be further impacted by the effects of the four inner constructs, namely physiological, psychological, behavioural and sociological. The severity and variation of the negative impact of these four constructs on the individual will depend on the value and importance society attaches to them. For example, if the individual is negatively impacted by a psychological effect like cognitive decline, this may result in other diseases, such as dementia, especially where connectivity is toxic, and care and value to the individual is non-existent. These correlates of an increased rate of cognitive decline may promote conditions with known increased mortality risk, as mentioned earlier. In fact, 1 in 14 people over the age of 65 (7 percent) and 1 in 6 people over the age of 80 have dementia (17 percent) (Alzheimer's Research UK, 2019; Alzheimer's Society, 2019b). Reduced cognition, neglect, lack of care or increased hibernation may also fuel social and behavioural risk factors, for example, excessive alcohol consumption and negatively impact daily social living, leading to mortality.

In short, the psychological, physiological, social and behavioural effects of social isolation and loneliness, if no intervention is administered to check the eventual outcome, may lead to mortality.

Discussion

This discussion draws together the key findings of the review, situating them within the broader context of ageing, health inequalities, and social care provision in the UK. Over the past decade, loneliness has increasingly been recognised as a major

public health and social concern, linked to adverse outcomes including dementia, cardiovascular disease, and premature mortality. Its growing prominence has been driven by national initiatives such as Age UK, the Campaign to End Loneliness, and the Jo Cox Commission, culminating in the appointment of a UK Minister for Loneliness in 2018. These developments reflect a shift towards recognising loneliness and social isolation as complex societal challenges requiring coordinated policy and practice responses.

The findings of this review highlight that loneliness and social isolation among older adults are driven by a combination of interrelated individual, social, and structural factors. Key among these are life transitions such as bereavement, retirement, and changes in marital status, which often lead to a reduction in social networks and support systems. Declining physical health, reduced mobility, and chronic illness further restrict opportunities for social engagement, while socioeconomic disadvantage and environmental barriers can exacerbate disconnection. These factors are often compounded by demographic changes, including an ageing population, which increases the number of individuals at risk. Comparative evidence, such as that from the Republic of Ireland (Donnelly et al., 2018), also underscores how reliance on informal, family-based care can leave gaps in support when such networks are limited or absent.

The review demonstrates that the effects of loneliness and social isolation are wide-ranging and extend beyond emotional wellbeing to significant physical and mental health outcomes. Physiologically, social isolation has been associated with elevated blood pressure and inflammatory responses, increasing the risk of cardiovascular disease (Shankar et al., 2011; Hawkley et al., 2010). Prolonged isolation is also linked to frailty and functional decline, with evidence suggesting that it contributes both to the onset and progression of frailty, while

loneliness influences adverse health behaviours (Davies et al., 2021; Gale et al., 2018).

In addition, strong associations were identified between loneliness, mental health disorders, and cognitive decline. Studies consistently show increased risks of depression, dementia, and impaired daily functioning among socially isolated older adults (Cacioppo et al., 2013; Rafnsson et al., 2020). These outcomes are often accompanied by behavioural risk factors such as smoking and poor management of chronic conditions, further compounding health inequalities. Ultimately, both loneliness and social isolation are significant predictors of mortality, operating through behavioural and biological pathways (Steptoe et al., 2013; Kobayashi et al., 2018; Hakulinen et al., 2018). Together, these findings reinforce the notion that social disconnection is a critical determinant of health in later life.

Addressing these challenges requires comprehensive and multi-level intervention strategies. Primary prevention approaches delivered through primary care and community-based services are essential for early identification and support. General practitioners, community pharmacies, and allied health professionals are well-positioned to identify at-risk individuals and facilitate timely interventions. Social prescribing schemes, in particular, have emerged as a promising approach, enabling healthcare providers to connect older adults with community resources such as social groups, physical activities, and voluntary services (Bu et al., 2020). Tailored support for individuals with chronic conditions is especially important, as this group is at heightened risk of isolation and its associated health consequences.

Broader community and policy-level initiatives also play a vital role. Campaigns and programmes such as the Campaign to End Loneliness, as well as international

initiatives like age-friendly cities promoted by the WHO and EU, highlight the importance of fostering inclusive environments that support social participation. Interventions such as befriending and mentorship schemes, including those adapted during the COVID-19 pandemic, further demonstrate the value of sustained social engagement (Amoah and Amoah, 2020; Kugbey et al., 2021). However, despite these efforts, gaps remain in identifying the most effective and scalable interventions. Critiques of current systems also point to fragmentation in care provision due to marketisation and the division between voluntary, charitable, and statutory sectors (Pentaris et al., 2020).

Moving forward, a coordinated, person-centred approach is essential. Interventions must be tailored to the diverse needs of older adults, particularly those experiencing major life transitions or living with complex health conditions. Strengthening collaboration between government, healthcare providers, and community organisations will be critical to delivering sustainable solutions. Furthermore, continued research is needed to evaluate intervention effectiveness, particularly in relation to frailty and long-term health outcomes, and to establish clearer causal pathways. In the context of a rapidly ageing population in the UK, such efforts will be vital to reducing the burden of loneliness and social isolation and improving the overall health and wellbeing of older adults.

In summary, as highlighted by Philip et al. (2020), research evidence is essential for informing social prescribing, clinical practice, and policy development in the UK. There remains a clear need for further research to evaluate the effectiveness of social interventions, particularly in relation to frailty, and to establish any causal relationships.

Conclusion

This review has provided a comprehensive synthesis of the current evidence on the

causes, effects, and intervention strategies associated with social isolation and loneliness among older adults in the UK. The findings demonstrate that loneliness and social isolation are multifaceted phenomena, shaped by an interplay of life transitions such as bereavement and retirement, declining physical and mental health, socioeconomic disadvantage, and environmental as well as demographic changes. These interconnected factors highlight the complexity of the issue and the need for holistic and sustained responses.

The review further establishes that the consequences of loneliness and social isolation extend beyond social and emotional domains, significantly affecting physical and mental health outcomes. Evidence consistently links these conditions to increased risks of depression, cognitive decline, frailty, hypertension, cardiovascular disease, and ultimately, mortality. Such outcomes not only diminish the quality of life for older adults but also place a growing burden on health and social care systems, particularly in the context of an ageing UK population.

Importantly, the study identifies a range of intervention strategies that show promise in mitigating these adverse effects. Primary health prevention approaches, community-based support systems, and the expansion of social prescribing schemes offer practical pathways for early identification and engagement of at-risk individuals. In addition, person-centred and group-based interventions tailored to the specific needs of older adults can enhance social connectedness and improve overall wellbeing. However, despite these advances, the review highlights persistent gaps in the evidence base, particularly regarding the long-term effectiveness and scalability of such interventions.

The findings underscore the necessity for coordinated cross-sectoral collaboration involving healthcare providers,

policymakers, community organisations, and voluntary services. Strengthening integration across these sectors will be critical in delivering sustainable and inclusive solutions. Furthermore, there is a pressing need for continued research to evaluate intervention outcomes, establish causal pathways, and identify best practices that can be adapted across diverse contexts within the UK.

Overall, this study reinforces the importance of prioritising loneliness and social isolation as key public health concerns. By implementing evidence-based, targeted, and person-centred interventions, there is significant potential to reduce their impact, enhance quality of life, and support healthier ageing among older adults in the UK.

Searched Keywords

Keywords	Lists
Social Isolation / Loneliness Terms	“social isolation”, loneliness, “social exclusion”, “social disconnectedness”, “social disconnection”, “social relationships”, “social participation”, “social engagement”, “social support”, “living alone”, “perceived isolation”, “emotional isolation”, “objective isolation”, “social networks”, “community connectedness”
Older Adult Terms	“older adults”, elderly, ageing, aging, “older people”, seniors “older persons”, “older population”, retirees, geriatric, “later life” “aged 60 and over”, “aged 65 and over”
UK Context Terms	“United Kingdom”, UK, Britain, British, England, Scotland, Wales “Northern Ireland”
Outcome / Contextual Terms	Health Outcomes Depression, anxiety, wellbeing, “mental health”, dementia “quality of life”, mortality, and frailty. Causes / Risk Factors Bereavement, widowhood, retirement, disability, “digital exclusion”, mobility, poverty, “housing conditions” Interventions Intervention, program, initiative, “social prescribing”, “community intervention”, “befriending services”, “support groups”

References

- Alzheimer’s Research UK (2019). Behind the headlines: Is a new Alzheimer’s treatment in sight? Available at: <https://www.alzheimersresearchuk.org/blog/behind-the-headlines-is-a-new-alzheimers-treatment-in-sight> [Online].
- Alzheimer’s Society. (2019). <https://www.alzheimers.org.uk/news/2019-12-06/alzheimers-society-responds-biogen-aducanumab-results-clinical-trials-alzheimers>[Online].
- Age UK (2018). The UK’s leading charity helping every older person who needs us. Available at <https://www.ageuk.org.uk/>
- Amoah, A., & Amoah, B. (2022). The COVID-19 pandemic lockdown: a buzz of negativity with a silver lining of social connectedness. *Journal of Economic and Administrative Sciences*, 38(1), 178-197.
- Bandari, R., Khankeh, H. R., Shahboulaghi, F. M., Ebadi, A., Keshtkar, A. A., & Montazeri, A. (2019). Defining loneliness in older adults: protocol for a systematic review. *Systematic reviews*, 8(1), 26.
- Barry, B. (2002). Social exclusion, social isolation, and the distribution of income. In J. Hills, J. Le Grand, & D. Piachaud (Eds.), *Understanding social exclusion* (pp. 13–29). Oxford: Oxford University Press.
- Boorse, C. (1977). Health as a theoretical concept. *Philosophy of science*, 44(4), 542-573.

- Bu, F., Abell, J., Zaninotto, P., & Fancourt, D. (2020). A longitudinal analysis of loneliness, social isolation and falls amongst older people in England. *Scientific reports*, 10(1), 20064.
- Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and Personality Psychology Compass*, 8(2), 58–72.
- Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and personality psychology compass*, 8(2), 58–72.
- Clegg, A., Young, J., Iliffe, S., Rikkert, M. O., & Rockwood, K. (2013). Frailty in elderly people. *The lancet*, 381(9868), 752–762.
- Cotterell, N., Buffel, T., & Phillipson, C. (2018). Preventing social isolation in older people. *Maturitas*, 113, 80–84.
- Courtin, E., & Knapp, M. (2017). Social isolation, loneliness and health in old age: A scoping review. *Health & Social Care in the Community*, 25(3), 799–812.
- Cutler, D., Deaton, A., & Lleras-Muney, A. (2006). The determinants of mortality. *Journal of Economic Perspectives*, 20(3), 97–120.
- Davies, K., Maharani, A., Chandola, T., Todd, C., & Pendleton, N. (2021). The longitudinal relationship between loneliness, social isolation, and frailty in older adults in England: a prospective analysis. *The Lancet Healthy Longevity*, 2(2), e70–e77.
- Donnelly, S., Prizeman, G., Coimín, D. Ó., Korn, B., & Hynes, G. (2018). Voices that matter: end-of-life care in two acute hospitals from the perspective of bereaved relatives. *BMC palliative care*, 17(1), 117.
- Evans, I. E., Martyr, A., Collins, R., Brayne, C., & Clare, L. (2019). Social isolation and cognitive function in later life: a systematic review and meta-analysis. *Journal of Alzheimer's disease*, 70(s1), S119–S144.
- Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: Where is the evidence? *Ageing & Society*, 23(5), 647–658.
- Gale, C. R., Westbury, L., & Cooper, C. (2018). Social isolation and loneliness as risk factors for the progression of frailty: The English Longitudinal Study of Ageing. *Age and Ageing*, 47(3), 392–397.
- Hakulinen, C., Pulkki-Råback, L., Virtanen, M., Jokela, M., Kivimäki, M., & Elovainio, M. (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK Biobank cohort study of 479,054 men and women. *Heart*, 104(18), 1536–1542.
- Halmos, P. (1952). *Solitude and Privacy: A Study of Social Isolation, Its Causes and Therapy*. London.
- Hawkey, L. C., Thisted, R. A., Masi, C. M., & Cacioppo, J. T. (2010). Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. *Psychology and aging*, 25(1), 132.
- Hodgson, S., Watts, I., Fraser, S., Roderick, P., & Dambha-Miller, H. (2020). Loneliness, social isolation, cardiovascular disease and mortality: A synthesis of the literature and conceptual framework. *Journal of the Royal Society of Medicine*, 113(5), 185–192.
- Keyes, C. L., & Lopez, S. J. (2009). *Toward a science of mental health*. Oxford handbook of positive psychology, 2, 89–95.
- Keyes, C. L., & Simoes, E. J. (2012). To flourish or not: Positive mental health and all-cause mortality. *American Journal of Public Health*, 102(11), 2164–2172.
- Khondoker, M., Rafnsson, S. B., Morris, S., Orrell, M., & Steptoe, A. (2017). Positive and negative experiences of social support and risk of dementia in later life: An investigation using the English Longitudinal Study of Ageing. *Journal of Alzheimer's Disease*, 58(1), 99–108.

- Killeen, C. (1998). Loneliness: An epidemic in modern society. *Journal of Advanced Nursing*, 28(4), 762–770.
- Kobayashi, L. C., & Steptoe, A. (2018). Social isolation, loneliness, and health behaviors at older ages: longitudinal cohort study. *Annals of Behavioral Medicine*, 52(7), 582–593.
- Komulainen, K., Niemi, R., Gutvilig, M., Cachon Alonso, L., Hakulinen, C., & Elovainio, M. (2026). Loneliness and social isolation in transitions to adverse health conditions and mortality: An analysis of data from the UK Biobank study. *Journal of Epidemiology and Community Health*, 80(4), 237–244.
- Kugbey, N., Amoah, A., Dotse, S. Q., Amoako-Asiedu, E., Delalorm, C., & Nyarko-Sampson, E. (2021). "The angel within the devil": COVID-19 silver linings. *Pan African Medical Journal*, 40(1).
- Luskin, M. L. (2013). More of the same? Treatment in mental health courts. *Law and Human Behavior*, 37(4), 255.
- Mackay, J., & Mensah, G. A. (2004). The atlas of heart disease and stroke. World Health Organization.
- Malcolm, M., Frost, H., & Cowie, J. (2019). Loneliness and social isolation causal association with health-related lifestyle risk in older adults: a systematic review and meta-analysis protocol. *Systematic reviews*, 8(1), 48.
- McHugh, K. A., Yammarino, F. J., Dionne, S. D., Serban, A., Sayama, H., & Chatterjee, S. (2016). Collective decision making, leadership, and collective intelligence: Tests with agent-based simulations and a Field study. *The Leadership Quarterly*, 27(2), 218–241.
- Mughal, I. (2021). The Cooperative Human. Available at <https://medium.com/@201520004/the-cooperative-human-d3d19d6e0621>
- Pentaris, P., Hanna, S., & North, G. (2020). Digital poverty in social work education during COVID-19. *Advances in social work*, 20(3), x-xii.
- Philip, K. E., Polkey, M. I., Hopkinson, N. S., Steptoe, A., & Fancourt, D. (2020). Social isolation, loneliness and physical performance in older-adults: fixed effects analyses of a cohort study. *Scientific reports*, 10(1), 13908.
- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet*, 370(9590), 859–877.
- Rafnsson, S. B., Orrell, M., d'Orsi, E., Hogervorst, E., & Steptoe, A. (2020). Loneliness, social integration, and incident dementia over 6 years: Prospective findings from the English Longitudinal Study of Ageing. *The Journals of Gerontology: Series B*, 75(1), 114–124.
- Shankar, A., McMunn, A., Banks, J., & Steptoe, A. (2011). Loneliness, social isolation, and behavioral and biological health indicators in older adults. *Health Psychology*, 30(4), 377.
- Shankar, A., McMunn, A., Demakakos, P., Hamer, M., & Steptoe, A. (2017). Social isolation and loneliness: Prospective associations with functional status in older adults. *Health Psychology*, 36(2), 179.
- Sheldon, J. H. (1948). *The Social Medicine of Old Age. Report of an Enquiry in Wolverhampton*.
- Smith, T. O., Dainty, J. R., & MacGregor, A. J. (2017). Changes in social isolation and loneliness following total hip and knee arthroplasty: longitudinal analysis of the English Longitudinal Study of Ageing (ELSA) cohort. *Osteoarthritis and Cartilage*, 25(9), 1414–1419.
- Smith, S. G., Jackson, S. E., Kobayashi, L. C., & Steptoe, A. (2018). Social isolation, health literacy, and mortality risk: Findings from the English Longitudinal Study of Ageing. *Health Psychology*, 37(2), 160.
- Smith, T. O., Dainty, J. R., Williamson, E., & Martin, K. R. (2019). Association between musculoskeletal pain with social isolation and loneliness: analysis of the English Longitudinal Study of

- Ageing. *British Journal of Pain*, 13(2), 82-90.
- Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*, 110(15), 5797–5801.
- Valtorta, N. K., Kanaan, M., Gilbody, S., & Hanratty, B. (2018). Loneliness, social isolation and risk of cardiovascular disease in the English Longitudinal Study of Ageing. *European Journal of Preventive Cardiology*, 25(13), 1387–1396.
- Victor, C. R., & Bowling, A. (2012). A longitudinal analysis of loneliness among older people in Great Britain. *The Journal of Psychology*, 146(3), 313–331.
- Victor, C. R., Scambler, S. J., Bowling, A., & Bond, J. (2005). The prevalence of, and risk factors for, loneliness in later life: A survey of older people in Great Britain. *Ageing & Society*, 25(6), 357–375.
- Ward, S., Lindsley, A., Courter, J., & Assa'ad, A. (2020). Clinical testing for COVID-19. *Journal of Allergy and Clinical Immunology*, 146(1), 23–34.
- Wenger, G. C., Davies, R., Shahtahmasebi, S., & Scott, A. (1996). Social isolation and loneliness in old age: review and model refinement. *Ageing & Society*, 16(3), 333-358.
- Wright-St Clair, V. A., Neville, S., Forsyth, V., White, L., & Napier, S. (2017). Integrative review of older adult loneliness and social isolation in Aotearoa/New Zealand. *Australasian Journal on Ageing*, 36(2), 114–123